In Sync Counseling
Office: 501-679-0232
Fax: 833-373-0348

CLIENT INFORMATION SHEET

Full Name:		Today's Date:	
Birth Date:		Age:	
Social Sec.:		Sex:	M / F
Address:		City, St. Zip	
Marital Status:		Email Address:	
Home Phone:		Cell Phone:	
Employer:		Occupation:	
Regular Therapist:		Local Hospital/Dr. #:	
Household Income:		# of Dependents:	

Emergency Contact	
Relationship to Client	
Phone Number	

If under 18, Responsible Party Information:

Responsible Party Name: _____Relationship to Client:_____
Birth Date: _____ SSN: _____ Sex: M / F

Marital Status: S / M / D / W / Sep Phone: _____

Full Address:_____

Email: _____

Employer: _____ Occupation: _____

Primary Insurance Provider	
Subscriber	
Member ID#	

For office use only below this point

Insurance Verified:

Assigned Clinician:

Date of Intake:

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ADDITIONAL INFORMATION FOR MINOR INTAKE

Areas of Concern (please check all that apply)

Personal/Social Adjustment

☐ Unduly Sad

☐ Overly Anxious

☐ Overly Aggressive

☐ Temper Tantrums

☐ Withdrawn or shy

☐ Disturbing Habits or mannerisms

☐ Strange or Bizarre behavior

☐ Problems in peer relationships

☐ Drug or Alcohol problems

☐ Problems with the law

☐ Harms self or others

☐ Hyperactivity

☐ Other (please specify):_____

Family Adjustment

☐ Parent-Child Problems

_____

☐ Marital Conflict or Co-parenting

_____

☐ Sibling Conflict

_____

☐ Recent Family Changes

_____

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☐ Neighborhood Difficulties

_____

☐ Mother experiencing difficulties

_____

☐ Father experiencing difficulties

_____

☐ Sibling experiencing difficulties

_____

☐ Drug or Alcohol Problems in the family

_____

☐ History of Trauma or Loss

_____

☐ Domestic Violence

_____

☐ Abuse

_____

☐ Other

_____

Physical/Developmental Factors (please indicate if the child has had any difficulties with any of the following)**:**

☐ Eating

☐ Sleeping

☐ Toileting

☐ Grooming

☐ Language or Speech

☐ Perceptual/Visual functions

☐ Motor Coordination Problems

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☐ Other:_____

Past Psychiatric History (check all that apply)

☐ Outpatient psychotherapy

☐ Family Therapy

☐ Individual Therapy

☐ Group Therapy

☐ Inpatient (hospital or residential)

☐ Psychiatric medication

Past Suicidal Ideation

☐ Yes

☐ No

☐ History of a plan

Medical History

Previous Diagnosis

_____

_____

Other Significant or Relevant Medical Problems (e.g. allergies, medication allergies, asthma, accidents & dates, surgery & dates, abuse & dates)

_____

_____

_____

_____

_____

Chronic conditions or Disabilities (Intellectual or developmental)

_____

_____

_____

Please provide the name and phone number of your child's primary care doctor:

Name:_____ Phone:_____

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Name of Clinic

_____

Please list any medications, their dosage, frequency, and purpose of each one

_____
_____
_____
_____
_____

Has the child ever been evaluated in a clinical setting other than their primary care physician's office?

☐ **No**

☐ **Yes**

If yes, please list the type of evaluation, date of examination, name and number of the evaluator, and results from the exam.

_____
_____
_____
_____
_____

By signing below, you consent to sharing the information on this document.

_____
Child's Name

_____
Guardian Name

_____
Guardian's Signature

_____
Date

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INFORMED CONSENT AND CONFIDENTIALITY POLICY

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below. Initial each section showing you have read and understood.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service. This includes the use of social media.

The therapist(s) orientation is mainly from a Cognitive Behavioral Perspective intertwined with a Client-Centered perspective. At In Sync, we approach each client with the same respect and warmth regardless of race, religion, non-religious beliefs, sexual orientation, political beliefs, national origin, color, height, weight, marital status, sex, gender identity, expression, or identity.

- ____Please initial here

SOCIAL MEDIA POLICY: The therapist will not add, follow, request, or search for you on any form of social media to maintain professional boundaries and confidentiality unless there is a danger to self or others and a breach of confidentiality could serve as a duty to warn or protective mechanism. Should you find the professional on Facebook despite privacy settings, understand the therapist will not respond or acknowledge the message. Please understand that should you use Facebook and have the therapist name saved in your phone, it can transmit data linking you to your therapist and is not a function of In Sync Counseling but a function of social media linking. In Sync Counseling does have a Facebook page and a website. Please understand this website and Facebook page are not HIPPA compliant and should not be used for crisis emails, to inquire about services, or expect a MH professional to consult on protected information. Should you need to reach out to In Sync Counseling or a counselor, please call the number provided during business hours or follow the emergency numbers provided below after hours or in event of an emergency. The therapist may respond to text messages for scheduling needs but will not conduct therapy via text message. You will need to schedule an appointment for issues outside of scheduling. Clients should use the office number provided to contact for scheduling, consultation, telehealth, or other needs.

- ____Please initial here

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

- ____Please initial here

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IN CASE OF EMERGENCY:
In life-threatening emergencies (such as the presence of homicidal or suicidal thoughts, abuse situations, or medical emergencies), call 911 or go to the nearest hospital emergency room. In the event the need(s) of you and/or child require immediate attention, you may then go to the nearest hospital emergency room or call either of the following resources:

Arkansas Crisis Center Crisis hotline and online chat 1-888-CRISIS2 (274-7472) www.arcrisis.org	Conway Regional Hospital/ER 2302 College Ave Conway, AR 72034 501-329-3831	Baptist Health Hospital/ER 1555 Exchange Ave Conway, AR 72032 501-585-2000

- ____ Please initial here

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions, group sessions, or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office *at least 24 hours in advance*, whenever possible. This will free your appointment time for another client. If cancellation at least 24 hours in advance is not made, you will be charged a fee of $5.. After 3 no calls, no shows, you will be terminated from In Sync Counseling, Inc and sent a list of referrals for services elsewhere.

- ____Please initial here

FEE SCHEDULE:

Type of Appointment	**Length of Service**	**Clinic Price**
Initial Intake Session	60-90 minutes	$250
Regular Office Visit (Follow-up)	53 minutes	$200
Family Session	60 minutes	$250
	90 minutes	$300
Couples Session	60 minutes	$250
	90 minutes	$300
Court Appearance	Per hour (4 hour minimum retainer)	$250 (per hour, per therapist) *
Group Sessions	60 minutes	$25 (per hour, per person)
Assessments		$250 (includes written report)**
Written Reports (for insurance companies, lawyers, supervisors, etc.)	Pro-rated	$100 per hour
Returned check		$25
No-show/Cancelation within 24-hour notice		$50

*No refund will be given if less than ***72 hours*** notice of court cancellation.
** Price is dependent upon type of assessment. Some assessments can only be given by licensed psychologists and may cost more.

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A reasonable fee will be charged for copies of any records requested by the Client this varies between $25-$50 dollars depending on time spent, copy/ink fee, and number of places records may be sent to.

For those clients who have agreed to pay for services through payment means other than insurance or are using Out of Network benefits, you will be emailed a good faith estimate with agreed upon fee and predicted cost of services for the remaining year. This will need to be renewed each year at the start of the next year.

We require a credit card on file for the processing of payments and no show/cancel fee(s) without a 24-hour notice. Please verbally give this information to your therapist who will input this into the secure system. This will be charged at the end of each session unless other payments in writing are made prior to the session.

If you or your loved one are experiencing financial difficulties and cannot afford services, or your insurance provider is not covering enough of the charge, please ask our administrator about our Sliding Scale Policy.

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. We request that payment be made before your session begins. We will provide a statement of services rendered upon request. Please note that if we can bill your insurance, you will be responsible for providing the therapist with the necessary information and we will help you file the claim with your insurance. Also note that if your insurance will not cover services provided that you are responsible for making sure payment is received in full. Payment plans are available for those in need of this service. Please note when we do a verification of benefits, this is a courtesy service and only an estimate of benefits. At times, when the explanation of benefits comes back, there can be a balance on the account. At that time, our staff will contact you to explain the change of benefits. Verification of benefits is not a guarantee that your insurance will cover certain or all services.

- ____Please initial here

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the/any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

_____

Name Telephone Number

- ____Please initial here

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the Undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

- ____Please initial here

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CONFIDENTIALITY: In Sync Counseling follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. *Possible exceptions to confidentiality include but are not limited to the following situations:*

- child abuse
- abuse of the elderly or disabled
- abuse of patients in mental health facilities
- sexual exploitation
- AIDS/HIV infection and possible transmission
- criminal prosecutions
- child custody cases
- suits in which the mental health of a party is in issue
- situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose
- fee disputes between the Therapist and the client
- a negligence suit brought by the client against the Therapist
- The filing of a complaint with the licensing or certifying board.

If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

If services are rendered outside of the traditional office setting, we can no longer insure confidentiality due to lack of control of other extraneous factors. This lowered level of confidentiality could happen in settings such as home settings, courts, jails, churches, or schools. Alternate counseling settings must be approved by In Sync Counseling administration and documented regarding risks and benefits.

Understand that having your smart phone, tablet, or other device with assistive technology in the office can create a confidentiality breach. To ensure this does not happen, it is recommended that you follow one of the following or turn off your device to maintain the integrity/confidentiality of your session. Understand that should you decline to do so, you risk confidentiality. Your therapist is assured to have followed these steps on their devices.

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For Iphones and Ipads, to turn off Siri, complete the following directions: 1) Open your settings 2) Click Siri and Search 3) Toggle OFF, listen for "Hey Siri" 4) Toggle OFF, Press Home (or side button) for Siri 5) Toggle OFF, allow Siri when locked	To turn off "Hey/OK Google," complete the following directions: 1) Open your settings 2) Under Google Assistant, tap Settings again 3) Under Devices, tap Phone 4) Turn OFF Access with Voice Match/Assistant	To turn off Amazon Alexa, complete the following directions: 1) Open your settings 2) Select Alexa Privacy 3) Tap Manage How Your Data Improves Alexa 4) Turn "Help Improve Amazon Services and Develop New Features" OFF by tapping the switch 5) Confirm your decision

- ____Please initial here

COURT MANDATED CLIENTS: If you are mandated to counseling by the courts, it is your responsibility to schedule and attend therapy. The fee schedule and your responsibility for following appointments is the same for non-mandated clients. After 3 no shows, you will be terminated from therapy and a non-compliance letter will be sent to the judge. Progress towards therapeutic goals outlined in the agreement with the courts will be followed in therapy sessions. Non-compliance with the therapist will also result in a non-compliance letter being sent to the court or referring council. Please note the only types of recommendations the therapist will give to the referring council are compliance or non-compliance recommendations including attitudes, goal-attainment, and motivation.

- ____Please initial here

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, In Sync Counseling, Inc. will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

I agree to receive reminders via text, email, or automated telephone system to remind me of my appointment.

_____Yes _____ No * Please check and fill out your preferred method of reminders**

	Phone	
	Email	
	Text	

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I, _____, understand that by signing this form, I consent to the confidentiality agreement and to the terms outlined in this document. By signing this form, I understand my role as a client and the practitioner's role as a therapist and will respect our agreement. If I have any questions, I understand it is my responsibility to ask them.

_____

Signature – Client/Parent Date

_____

Signature – Spouse/Partner/Parent Date

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INFORMED CONSENT FOR TELEHEALTH CONSULTATION

Definition of Telehealth: Telehealth involves the use of electronic communications to enable In Sync Counseling, Inc.'s mental health professionals to connect with individuals using interactive video, telephone, and audio communications. This will not include text messages and the therapist will not respond to text messages. Clients should contact the office for needs related to scheduling, consultation, or other needs.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, and referral to resources, education, and the transfer of medical and clinical data. In Sync Counseling follows HIPPA and HITECH laws in accordance with their policies in using technology to deliver services.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons, or could be unintentionally breached through electronic transmissions. WSC utilizes secure, encrypted audio/video transmission software to deliver telehealth. Email transmissions will be placed in the client file.

A. In the event of technology related failure:

The therapist will re-engage the technology attempting to contact the client 3 times before considering this a technology failure. The therapist will then try the client via the telephone number provided on file. Should each of these methods prove unsuccessful, the therapist will follow up within 24 hours of the technology failure being restored to reschedule the session.

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B. Other risks include that telehealth may not be effective for all diagnosis and other forms of therapy (couples, families, etc.) and is still in the early forms of research looking at efficacy with these populations.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse. I understand this evaluation will take place at EACH session and I/my surroundings will be assessed for appropriateness at each time.

5. I understand that the current email system my provider uses is not encrypted, therefore not confidential, and should limit my communication to the provider via email. For scheduling and other inquiries I should call In Sync Counseling and ask to speak with my provider.

6. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video and/or audio conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy. I understand my sessions will not be recorded, nor will I record my counselor for any reason unless first disclosed and each party has granted permission to proceed with the recording. This will then be documented in my record.

7. I understand that I may expect the anticipated benefits such as improved access to care, convenience, ease of communication, flexibility in scheduling, check-in sessions, and reduction of travel but that no results can be guaranteed or assured.

8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

(1) Omit specific details of my medical history that are personally sensitive to me,

(2) Ask non-clinical personnel to leave the telehealth room, and/or

(3) Terminate the consultation at any time

9. I understand that my express consent is required to forward my personally identifiable information to a third party.

10. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

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11. I understand that my therapist can only practice telehealth in the state he/she is licensed but is willing and capable of directing me to resources should I leave the state for any reason (i.e leisure, private, relocation, etc.).

12. In Sync Counseling complies with HITECH laws and in the event of a breach will notify me of my rights, steps taken related to the breach, and how to protect my privacy.

13. I understand that different states have different regulations for the use of telehealth. In Arkansas, telehealth may only be conducted between certified office locations. I understand that, in Arkansas, I am not able to connect from an alternative location for the provision of audio-/video-/computer based psychotherapy services.

14. I understand that I am to create a passcode either in words/phrase or numbers to verify my identity when using technology assisted services. The therapist will ask me this for each encounter that we have before beginning therapy. Should I forget the passcode; the therapist will disconnect the call immediately. I understand that I will then need to come into the office and show my ID to retrieve my passcode.

15. I understand that no data is saved or sold to third party companies as a means to sale or solicit personal client information. The data is encrypted on a HIPPA compliant system.

16. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand that should technology failure occur that I will be given referrals for someone who can assist me or provided with in-person sessions.

Payment for Telehealth Services: In Sync Counseling, Inc. will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount may be available. We will provide you with a statement of service to submit to your insurance company if you wish. Should insurance not cover these services, you will be responsible for making the payment.

We require a credit card on file for the processing of payments and no show/cancel without a 24-hour notice. This will be collected upon intake and input into our secure billing system. This will be charged at the end of each session unless other payments in writing are made prior to the session.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

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By my acknowledgement signature below, I hereby state that I have read, understood, and agree to the terms of this document

Client Name Date Signature

NO SHOW/CANCELATION POLICY

In Sync Counseling has a 24-hour cancelation policy and "no show" fee. Should you cancel within that 24 hour window or no show, without prior notification, you will be charged a $50 fee for therapy appointments and $75 fee for Psychiatric Advanced Practice Nurse or Psychiatrist. Your card on file will be charged automatically.

The standard meeting time for psychotherapy is 53 minutes and 20-60 minutes for medication management appointments depending on whether it is an intake or follow-up. It is up to you, however, to determine the length of time of your sessions. Requests to change the 53-minute session needs to be discussed with the therapist in order for time to be scheduled in advance. Should you arrive late for

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services, you will receive that amount of time left for the scheduled appointment and billed accordingly. If you arrive more than 15 minutes late for session, the provider has the option to cancel your appointment and charge the $50-$75 fee.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a $50-$75 charge if **NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE.** This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

Should this occur, you will be required to pay your account balance in full, before you are able to schedule another appointment with our clinic.

By signing the following, you acknowledge the receipt and understanding of this policy as it is written.

I,_____, acknowledge that I have read and understood the above policy regarding In Sync Counseling's No Show and Cancelation policy.

_____ _____

Signature Date

CONTROLLED SUBSTANCE AGREEMENT AND INFORMED CONSENT

The purpose of this agreement is to provide you with information regarding the risks and benefits of using controlled substances. It also specifies your responsibility in the proper use of these medications and the role you will play in your treatment. The overall goal of treatment is to provide the best quality of life possible given the realities of your clinical condition. I understand that I have the following responsibilities:

____ I will take the medications at the dose and frequency only as prescribed.

____ I will not increase or change how l take my medications without the approval of this healthcare provider.

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____ I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or weekends.

____ I will obtain all refills for these medications only at my designated pharmacy with full consent for my provider and pharmacist to exchange information in writing or verbally.

____ I will be upfront with the provider about all medications, controlled substances and supplements I am taking. Due to some severe interactions it is up the the provider to discuss what medications are appropriate for that client. An issue can absolutely arise whenever a client is on controlled pain medication as well as a benzodiazepine. However, nothing is ever set in stone but a client should be respectful whenever provider raising concerns about medicine and the provider has the ultimate say about what they are will to prescribe as it will affect their license.

____ I will inform my other health care providers that I am taking controlled substances and of the existence of this agreement. In the event of emergency, I will provide this same information to emergency department providers. I will inform this provider of any Emergency Room (ER) visit within 48 hours of discharge from the ER. I understand and give my permission that all treatment providers can communicate with each other and discuss my care and treatment.

____ I will protect my prescriptions and medications and will keep them safe and secure. I understand that lost, stolen, accidently destroyed or misplaced prescriptions will not be replaced. I will keep medications only for my own use and will not sell, lend, share, or give any of my medication to others. Failure to uphold this term may constitute a criminal offense. I will keep all medications away from children. I agree to comply with all components of my overall treatment plan including medical, psychological, or psychiatric assessments recommended by my provider. I will actively participate in any program designed to improve function, including social, physical, psychological, and daily or work activities

____ I will not use illegal or street drugs or another person's prescription. I will use no alcohol or other sedating medications without discussing it with this provider. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, and I agree to follow through. If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

____ I will consent to drug screening which may include urine, blood, hair, saliva, or nails to conduct a laboratory test to check to see what drugs I have been taking. A positive screen for medications not prescribed may result in termination. No evidence of the prescribed medication may be grounds for termination. Refusal to test may be grounds for termination.

____ I will bring in my medications to each visit in their respective prescription containers and remaining medication to determine if medications are being taken as prescribed.

____ I understand that my provider will verify through the Arkansas prescription monitoring database for controlled substances. Receiving controlled substances from another provider may be grounds for termination.

____ I will keep all my scheduled appointments. If l need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled.

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____ I understand that this provider may stop prescribing controlled substances if I do not show any improvement in anxiety or my activity has not improved; if I develop rapid tolerance or loss of improvement from the treatment; if I develop significant side effects from the medication; and/or if l violate any one of the above conditions.

____ I understand that driving while taking the controlled substance as prescribed is driving under the influence under currently law and I understand that I have been directed not to drive while taking the controlled substance.

INFORMED CONSENT: Controlled substances shall be used in a judicious manner due to their substantial risks. These medications are potentially dangerous, and the side effects and risks are discussed with you. Side effects/risks include but are not limited to the following:

- Allergic reactions
- Sedation
- Somnolence
- Respiratory depression (slow breathing)
- Dizziness
- Confusion
- Nausea
- Vomiting
- Urinary retention
- Suppression of menstrual cycle
- Hormonal imbalance
- Constipation
- Itching
- Physical dependence
- Tolerance
- Addiction
- Death

____ Psychological dependence is the feeling of well-being produced by long-term use of some medications; absence of the medication may produce feelings of anxiety, irritability, depression or cravings.

____ Tolerance is a physical state resulting from regular use of a medication, which an increase dosage is needed to produce the same effect. Tolerance does not always occur using controlled substances and does not, alone, indicate addiction.

____ Addiction is the lack of control over drug use, including taking drugs more often than prescribed by a provider. Genetic, psychosocial, and environmental factors may contribute to the addiction.

____ Usually, most side effects of controlled substance use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated, if necessary.

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____ If the decision is to discontinue controlled substance therapy, you agree to wean off the medication rather than abrupt discontinuation in order to prevent withdrawal symptoms, which can be serious or even life threating depending on the medication.

____ Controlled substances may cause drowsiness. You should not drive or operate heavy machinery while taking controlled substances.

____ Alcoholic beverages should be avoided as it may cause dangerous side-effects with your controlled substances.

____ Taking doses higher than prescribed and directed; taking doses with alcohol; taking doses with other medications may cause a fatal overdose.

____ I understand that no guarantee has been made to me with regard to my treatment. My provider cannot guarantee a cure of any condition. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I hereby give my informed consent to be prescribed and use controlled substances for my condition and acknowledge receipt of this agreement. I have been given a copy of this document.

DISCLAIMER:

Affiliated physicians and nurse practitioners are independently practicing professionals utilizing In Sync Counseling for their practice management services. They are not employees or agents of In Sync Counseling. Patients receiving independent care from our affiliated physicians are not required to receive counseling or any other type of therapy from employed professionals with In Sync Counseling, however, are recommended to be in services somewhere.

MEDICATION MANAGEMENT POLICY

Medication management will occur in the office ONLY We will not call in refills nor accept a faxed request from refills from the pharmacy. You are given the approved amount of refills until next appointment at each visit

Medication changes will be done in the office ONLY

Please try medications at least 4-6 weeks or wait until your next appointment before calling the office to discuss medication changes. Most medications take several weeks to produce the desired effect and work properly. Should you have any adverse reactions, please let us know and we can facilitate a sooner appointment based on necessity.

If on an any OPIATE pain medication, you will NOT be prescribed any benzodiazepines or central nervous suppressants, such as the following:

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- Ativan
- Klonopin
- Xanax
- Valium

You will not be able to see two different doctors at the same time to request the same type of medication. Doing so can result in the termination of your services with In Sync Counseling.

Approximately 30 minutes are set aside for a medication check. Please come prepared to ask questions, request refills, and discuss any concerns that you may have.

In order to continue medication management with one of the psychiatric professionals affiliated with our clinic, you must be in therapy during the course of treatment. The combination of psychotherapy and psychiatric medications has been shown to increase treatment efficacy by at least 80%

The same cancelation policy that was reviewed with regards to psychotherapy services applies when an individual "no shows" or cancels within 24 hours of their scheduled appointment. After three "no shows", your services with In Sync Counseling can be terminated and you will be referred to outside agencies for additional services. You will not be allowed to reschedule until the fee or your balance has been paid in full

A positive drug screen for any illicit substances for which you do not have a CURRENT prescription can be cause for termination of services

By signing below, I acknowledge that I have read and understand In Sync Counseling's Medication Management policy. I understand that failure to adhere to this policy can result in termination of my services with In Sync Counseling.

Name (Print): _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY POLICIES & LIMITS OF CONFIDENTIALITY

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect August 2018 and will remain in effect until it is replaced.
We reserve the right to change our privacy practices as long as it complies with applicable law. If we make any material revision to this Notice, we will post a copy of the revised Privacy Notice in each of our offices which will specify the date on which the revised notice is effective.
We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. You may request a copy of our notice at any time.

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For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.
I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:
Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Arkansas law to report the matter immediately to the Arkansas Department of Social Services.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Arkansas law to immediately make a report and provide relevant information to the Arkansas Department of Welfare or Social Services.

Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena.

Serious Threat to Health or Safety: Under Arkansas law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if

under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. [This sentence is now required under the HIPAA "Final Rule."]

III. Patient's Rights and Provider's Duties:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the

information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a copy of this notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: You have the right to present a complaint, knowing that your care will not be compromised in anyway. If you have a problem concerning your care, which you cannot solve with your therapist please call our office at 501-679-0232. You have the right to make a complaint to the Division of Medical Services.
You can file a grievance in person, by mail, or by email. You can also file a civil right compliant with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave SW, Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

IV. Uses and Disclosures of Health Information

For any purpose other than the ones described below, we may use or disclose your health information only when you give us your written authorization to do so. Specifically, authorization is required for disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures of PHI that constitute a "sale". In Sync Counseling, Inc. will use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. You have the right to restrict this disclosure when services are paid in full by you and not by the health insurance provider.

Healthcare Operations: We may use and disclose your health information in connection with, our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

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Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patients' Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree, in writing, that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care. Revised March 13, 2020: In Sync Counseling, Inc. will not contact you or use your protected information for fundraising activities.

Required by Law: We may use or disclose your health information when we are required by law to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to authorize federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, letters).

For Patient Related Communications: We may use or disclose your health information to provide patient related communications such as telephoned in prescriptions, etc.

Exception to the Disclosure Process Under the Confidentiality of Substance Abuse Records: For individuals who receive treatment, diagnosis, or referral for treatment from our drug and alcohol abuse program, the confidentiality of drug or alcohol abuse records is protected by federal law and regulations 42 CFR Part 2.
Disclosures of your record cannot be made unless:

- You authorize the disclosure in writing.
- The disclosure is permitted by a court order.
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes.
- You threaten to commit a crime either at the alcohol and drug program or against any person who works for our alcohol and abuse program

As a general rule, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

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- A violation by us of the federal law and regulations governing drug or alcohol abuse is a crime. Suspected violations may be reported to the United States Attorney in the district where violation occurs.
- Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities. Please see 42 U.S.C. 290dd2 for federal law and 42 C.F.R. for federal regulations governing confidentiality of alcohol and drug abuse patient records.

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of In Sync Counseling, Inc. "Notice of Privacy Practices."
We have discussed these policies, and I understand that I may ask questions about them at any time in the future.
I consent to accept these policies as a condition of receiving mental health services.

Client Printed Name: _____

_____ _____
Client Signature Date

ILP (INDEPENDENT LICENSED PRACTITIONER) RULES

General Rules

A. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to Outpatient Behavioral Health Services Specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS Policies/Forms/By Policy.aspx
2. Conform to professionally recognized behavioral health rehabilitative treatment models. 3. Be established by contemporaneous documentation that is accurate and demonstrates compliance.

Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

B. Applicants and Independently Licensed Practitioners must:
1. Be a legal entity in good standing;
2. Maintain all required business licenses;
3. Adopt a mission statement to establish goals and guide activities;
4. Maintain a current organizational chart that identifies administrative and clinical chains of command;

C. Applicants/Providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:
1. Compliance;
2. Cultural competence;
3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:
   a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.
   b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary Outpatient Behavioral Health Services. Coordinated referral plans must:
      i. Identify in the client record the medically necessary Outpatient Behavioral Health Services that the provider cannot or will not furnish;
      ii. State the reason(s) in the client record that the provider cannot or will not furnish the care:
      iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

Requirements for Certification

A. Independently Licensed Practitioner may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license action.

B. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:
1. Is excluded from Medicare, Medicaid, or both;
2. Is debarred under Ark. Code Ann. § 19-11-245;
3. Is excluded under DHS Policy 1088; or
4. Was subject to a final determination that the provider failed to comply with professionally recognized stnadards of care, conduct, or both. For purposes of this subsection, "final determination" means court or administrative adjucation, or the result of an alternative dispute resolution process such as arbitration or mediation.

C. Independently Licensed Practitioner must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before Outpatient Behavioral Health Services are delivered except in emergencies. Such forms must at a minimum:
1. Disclose that the services to be provided are Outpatient Behavioral Health Services;
2. Explain Outpatient Behavioral Health Services eligibility, SED and SMI criteria;

3. Contain a brief description of the Independently Licensed Practitioner services;
4. Explain that all Outpatient Behavioral Health Services care must be medically necessary;
5. Disclose that third party (e.g., Medicaid or insurance) Outpatient Behavioral Health Service payments may be denied based on the third party's policies or rules;
6. Identify and define any services to be offered or provided in addition to those offered by the Independently Licensed Practitioner, state whether there will be a charge for such services, and if so, document payment arrangements;
7. Notify that services may be discontinued by the client at any time;
8. Offer to provide copies of Independently Licensed Practitioner and Outpatient Behavioral Health Services rules;
9. Provide and explain contact information for making complaints to the provider regarding care deliver, discrimination, or any other dissatisfaction with care provided by the Independently Licensed Practitioner;
10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III (G)(1).

D. Outpatient Behavioral Health Services maintained by the Independently Licensed Practitioner must include:

1. Outpatient Services, including individual and family therapy at a minimum
2. Ability to provide Pharmacologic Management at the certified site or the agreement of collaboration with a physician to provide Pharmacologic Management for clients of the Independently Licensed Practitioner.
3. Ability to refer clients to other practitioners or agencies for Outpatient Behavioral Health Services.

E. Providers must tailor all Outpatient Behavioral Health Services care to individual client need. If client records contain entries that are materially identical, DHS and the Division of Medical Services will, by rebuttal presumption, that this requirement is not met.

F. Outpatient Behavioral Health Services for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

G. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;
2. The applicant/provider must:
    a. Provide the 24-emergency telephone number to all clients;
    b. Post the 24-hour emergency number on all public entries to each site;
    c. Include the 24-hour emergency phone number on answering machine greetings;
    d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.
3. Direct Access to mental health professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;
4. Response strategies based upon:
    a. Time and place of occurrence;
    b. Individual's status (client/non-client);
    c. Contact source (family, law enforcement, health care provider, etc.)

5. Requirements for a face-to-face response to requests for emergency intervention received from hospital or law enforcement agency regarding a current client
6. All face-to-face emergency responses shall be:
    a. Available 24 hours a day, 7 days a week;
    b. Made by a mental health professional within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).
7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.
8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.
9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;
10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:
    a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and
    b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

H. Each applicant/provider must establish and maintain procedures, competence, and capacity:
1. For assessment and individualized care planning and delivery;
2. For discharge planning integral to treatment
3. For mobile care;
4. To assure that each mental health professional makes timely clinical disposition decisions;
5. To make timely referrals to other services;
6. To refer inpatient services or less restrictive alternative.

I. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;
2. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.
3. Regularly (at least quarterly) quality assurance meetings that include:

Site Requirements

A. All Independently Licensed Practitioner sites must be located inside the State of Arkansas;

B. The Independently Licensed Practitioner site shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

C. C. All Independently Licensed Practitioner site staff shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment and fire detection systems. All fire fighting equipment shall be annually maintained in appropriately designated areas within the facility.

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D. The Independently Licensed Practitioner site shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather. All exits must be clearly marked.

E. The Independently Licensed Practitioner site shall be maintained in a manner, which provides a safe environment for clients, personnel, and visitors.

F. The Independently Licensed Practitioner site telephone number(s) and actual hours of operation shall be posted at all public entrances.

G. The Independently Licensed Practitioner site shall establish policies for maintaining client records, including policies designating where the original records are stored.

H. Each Independently Licensed Practitioner site shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

Release of Information Consent

Client's name: _____ **Date:_____**

I authorize _____to:

- € Send
- € Receive

The following information:

- € Medical history and evaluation(s)
- € Mental health evaluations

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- € Developmental and/or social history
- € Educational records
- € Progress notes, and treatment or closing summary
- € Psychiatric evaluation and/or follow ups
- € Medication Summary
- € Other _____

_____

_____

_____

To / From (Where are we sending the information to or receiving the information from? Please list name and address): _____

_____

_____

Your relationship to the client:

- € Self
- € Parent/legal guardian
- € Personal representative
- € Other_____

The above information will be used for the following purposes:

- € Planning appropriate treatment or program
- € Care Coordination
- € Continuing appropriate treatment or program
- € Determining eligibility for benefits or program
- € Case review
- € Updating files
- € Other _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

I consent to sharing the information provided here.

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Client Signature

Date

Witness Signature (if client is unable to sign)

Witness Date

ADOLESCENT CONSENT FORM
&
PARENT AGREEMENT TO RESPECT PRIVACY

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. IF you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____Date_____

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

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- □ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress and/or may be asked to participate in therapy sessions as needed.

- □ Although I know I have the legal right to request written records/sessions with my child. I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

- □ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgement and may sometimes be made in confidential consultation with a consultant.

MINOR WAIVER CONSENT FORM

I, _____, do hereby give In Sync Counseling permission to allow my minor child to have a friend sit in the room.

I understand that the minor child is being asked to sit in the room by a friend as "support" and is not a participant of the session.

I understand that this may violate my child's confidentiality should the non-patient disclose information talked about in the session and I am aware of the limits of confidentiality. I am aware the therapist has also discussed these limits and possible violations with my minor child and my minor child is still agreeing to her support participating in the session.

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_____
Signature

_____
Date

_____
Witness Signature

_____
Witness Date

INFORMED CONSENT FOR CHILD THERAPY: SEPARATED/DIVORCED PARENTS

Separated/Divorced Parents' Agreement Form

I have brought my child _____, age_____, to In Sync Counseling, Inc. for evaluation and/or treatment. I understand that In Sync Counseling's patient is my child – not me, any other sibling, or my spouse. This is true no matter who pays In Sync for the evaluation/treatment of my child.

I understand that In Sync Counseling's primary responsibility is my child's best interest and that In Sync may decide to involve me in my child's evaluation/treatment at their sole discretion. I understand that if payment is not received promptly for services rendered by In Sync to my child, the services may be

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suspended or terminated at In Sync's sole discretion, pursuant to the ethical guidelines governing psychological care.

I understand that In Sync and/or her employees are not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. I understand that staff with In Sync may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at their sole discretion. In Sync will also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court or counseling for my child.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Date_____, _____

Date_____, _____

Date_____, _____

Date_____, _____

Date_____, _____

Date_____, _____