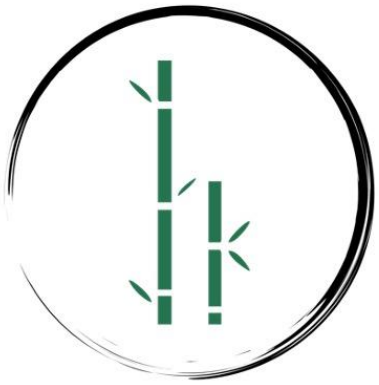

ABHA

ADVANCED BEHAVIOR HEALTH ANALYSIS

124 E Miracle Strip Pkwy #503 Mary Esther, FL 32569
Office: 844-729-2242 Fax: 844.308.4990

CLIENT DEMOGRAPHIC FORM

NAME: _____ DATE: _____

SSN: _____ DOB: _____ AGE: _____ SEX: _____

ADDRESS: _____ CITY: _____ZIP: _____

HOME: _____WORK: _____CELL: _____

MAY WE LEAVE MESSAGES AT ABOVE LISTED NUMBERS? __YES__NO
EMAIL:
_____

MAY WE CONTACT YOU AT THIS EMAIL? _____YES _____NO

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION

GUARANTOR NAME: _____ DOB: _____ SEX: _____

SSN: _____ MARITAL STATUS: _____ STREET

ADDRESS: _____ CITY: _____ ZIP: _____

NAME AND NUMBER OF EMERGENCY CONTACT PERSON:

_____

HOW DID YOU HEAR ABOUT ABHA LC?

_____

BRIEFLY DESCRIBE THE ISSUES/PROBLEMS THAT LED YOU TO SEEK THERAPY TODAY:

_____

_____

_____

_____

Insurance Information – Please Fill out COMPLETELY

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Do you know of any co-pay or cost share amounts? _____

If Tricare, is the sponsor: □ active duty □ retired □ guard/reserve

Out-Of-Network Insurance Statement

I am aware that my insurance, _____, is NOT contracted with ABHA LLC. I also understand that there will be NO contractual adjustment made on my account, as there would normally be for In-Network Providers. I understand that in addition to any co-insurance, co-payments or deductibles applied by my insurance, I am FULLY responsible for the difference in what ABHA LLC charges for services rendered and what my insurance allows for those same charges.

I understand this statement above. Any questions I have regarding my insurance benefits have been asked and answered to my satisfaction. I choose to seek treatment with ABHA LLC.

Guarantor's Signature: _____ Date: _____

Guarantor's Printed Name: _____

Witness's Signature: _____ Date: _____

Non-Coverage of Services Statement

I understand that according to the benefits quoted by my insurance company to Advanced Behavioral Health Analysis, LLC may NOT be a payable service due to diagnosis conflicts, refusal of referral, refusal of authorization, etc. If I still choose to seek treatment through Advanced Behavioral Health Analysis LLC, I understand that I will be FULLY liable for the financial obligations of services rendered if my insurance company denies the charges.

Guarantor's Signature: _____ Date: _____

Guarantor's Printed Name: _____

Witness's Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

The following information is provided to inform you of what to expect from the counseling services at Advanced Behavioral Health Analysis, LLC. and to ensure that you understand the professional relationship between you and your counselor. In order to receive treatment, your signed consent is necessary.

Counseling Process

Counseling presents an opportunity to make an investment in your personal growth and well- being within the context of a professional, helping relationship. Initially, your counselor will take a personal history and explore your reasons for seeking counseling at this time. The counselor will then assist you in creating a treatment plan and clarifying your goals. Your commitment and personal involvement is vital to the counseling process and in order to find the best results, you will be encouraged to focus on your goals in between sessions and be willing to

try new behaviors and skills. Periodically, a review and evaluation of your progress will be addressed and your treatment goals will be revised as needed. If you are signing this consent on behalf of your child, both you and the child are required to be involved in the process.

Counseling Benefits and Risks

Please note that participating in counseling offers both risks and benefits. Counseling often addresses difficult aspects of life experience and it may cause you to experience more intense or uncomfortable feelings, like sadness, shame, guilt, and even anxiety. This occurrence is expected and usually will only last a short time. In the long run, however, research has consistently revealed the benefits of counseling and Advanced Behavioral Health Analysis, LLC. is committed to employing evidence-based therapies to provide you the best quality care. While there are no guarantees, counseling often leads to a better quality of life overall, including for example, improved self- concept, better relationships, and more effective management of emotions.

Continuation and Maintenance of Treatment

One of the primary treatment goals of Advanced Behavioral Health Analysis, LLC. is to lessen the need for treatment. Ideally, as you improve, the frequency of your sessions will start to decrease to a maintenance phase where you will need less and less counseling, and then you may come only as needed.

Explanation of Dual Relationships

While a healthy counseling relationship is at times very personal and intimate in nature, it is important to be clear that your relationship or your child's relationship with your counselor is a professional one. Our counselors hold their role in the highest esteem and believe the safety of the therapeutic relationship to be a vital part of the process of healing and growing. Professional boundaries will be maintained at all times. We will respect your privacy in public and will not speak to you

or acknowledge you unless you choose to speak to us.

Confidentiality

The relationship between client and counselor is confidential and protected legally and ethically. Advanced Behavioral Health Analysis, LLC adheres to the American Counseling Association's ethical guidelines, which can be found at http://counseling.org/Resources/aca code-ofethics.pdf. The confidential information in your file is used within Advanced Behavioral Health Analysis, LLC to provide treatment and every effort is made to keep it protected and secure. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Some noted exceptions include: 1) the duty to warn and protect a client in danger of harming him/herself or another person; 2)

when there is suspected child or elder abuse or neglect; 3) in the case of a court order or legal matter; and 4) in consultation and/or supervision. Please see the HIPAA form attached for the detailed regulations regarding confidentiality.

Length of Sessions

Sessions normally last 45-50 minutes. Typically, our counselors see clients for one 45-50-minute session per week, unless it is decided that there is a higher need. In that case, they may recommend meeting more than once a week. If you arrive late for your session, it will still end at the scheduled time. If you arrive later than 15 minutes after your scheduled time, our counselors have the right to cancel the session. Please understand that we will do our absolute best to run on time and we usually are punctual, though crises do occur and sessions may be extended if required. If we are running behind for some reason, we will still honor the full 50 minutes of your session.

Fee and Method of Payment

Advanced Behavioral Health Analysis, LLC accepts cash and checks. You are expected to pay-in-full at the time of your session unless prior

arrangements have been made. Please be prepared with your check pre-written ready to pay at the beginning of each session so that the majority of the session can focus on your clinical needs. Also, if you pay by cash, please have the proper amount because Advanced Behavioral Health Analysis, LLC does not have cash on hand to provide change. Upon setting up your initial appointment, please let us know if you will need a monthly statement or a receipt for insurance reimbursement. If you are paying by insurance, fees may vary and our office manager will discuss this with you as appropriate.

In Case of an Emergency

Counselors of Advanced Behavioral Health Analysis, LLC. do not provide emergency services. We will make every attempt to be available to you as soon as possible should a crisis occur. If you cannot wait for our return call, please call 911 or go to the nearest hospital and we will attempt to contact you as soon as possible. Otherwise, you may leave a message on the main number for Advanced Behavioral Health Analysis, LLC at (850) 301-0438. Please note that though our counselors cannot often answer the phone directly because they are in session, we do have a receptionist and additional administrative support and we check our messages frequently and will call you back as soon as possible.

Cancellation Policy

If you need to cancel a therapy session, you must notify Advanced Behavioral Health Analysis, LLC 24 hours before the scheduled counseling session. You may leave a message or text us at **844-729-2242**. This consideration helps us accommodate all families considering scheduling and availability.

Our policy states that we will charge you $40.00 after 2 consecutively missed appointments without proper notification and the fee will not be covered by insurance.

Sick/Illness Policy

This facility is a well-client facility. This means that if you or your child are not feeling well, for any reason, you will need to reschedule your therapy appointment. Please do not bring your child if he/she has a contagious illness or exhibits any of the following symptoms: fever above 100 degrees Fahrenheit in the last 24 hours, vomiting in the last 24 hours, diarrhea, conjunctivitis (pink eye), consistent complaints of ear or stomach pain, bleeding other than minor cuts and scrapes, greenish nasal discharge, indicating possible infection, or head lice. In general, if your child is too sick to go outside and play, then your child is too sick to attend therapy. We use play as a part of therapy and sickness or illness is not conducive to therapy.

Legal Involvement

Counselors at Advanced Behavioral Health Analysis, LLC. reserve the right to deny involvement in any court case or legal proceeding. If we are required to share information due to a court order, we will only provide the client's dates of treatment and a brief summary of services. If you have any questions or concerns about this Informed Consent for Treatment, the HIPAA policy or insurance information, please discuss them with our office manager or your counselor in your initial appointment and whenever necessary. Please sign to show that you received this form and agree with the terms. You may request this form for your records.

With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPAA/Privacy Practices implemented here at Advanced Behavioral Health Analysis, LLC.

_____ _____

Signature of Client or Legal Guardian Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This information is effective as of January 2019.

CONFIDENTIALITY

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Advanced Behavioral Health Analysis, LLC. without your permission, except as required by law or needed to file your insurance claim. Information obtained by minors is not generally shared with parents without permission. Exceptions to confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability, or any reported sexual misconduct by a licensed health care provider. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person. HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

This notice describes our policies related to the use and disclosure of the client's healthcare information. Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.