OAK HAVEN
Life Coaching & Counseling, LLC
405-315-4593

BEFORE WE MEET:
Please complete the following information and bring all forms to your first session.

CLIENT INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH: _____ SEX: _____

HOME #: _____ CELL #: _____ WORK #: _____
MESSAGE OK? YES NO MESSAGE OK? YES NO MESSAGE OK? YES NO

EMAIL ADDRESS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ LEVEL OF EDUCATION: _____

EMPLOYER: _____

WHAT BRINGS YOU TO COUNSELING AT THIS TIME? _____

_____

WHAT ARE YOUR GOALS FOR COUNSELING? _____

_____

HAVE YOU SEEN A MENTAL HEALTH PROFESSIONAL BEFORE? IF SO, WHAT TYPE/WHEN? _____

_____

SPECIFY ALL MEDICATIONS AND SUPPLEMENTS YOU ARE PRESENTLY TAKING AND FOR WHAT REASON:

MEDICATION:	DOSAGE:	TO TREAT:
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

DO YOU DRINK ALCOHOL? ..... YES NO

DO YOU USE RECREATIONAL DRUGS? ..... YES NO

DO YOU HAVE SUICIDAL THOUGHTS? ..... YES NO

HAVE YOU EVER ATTEMPTED SUICIDE? ..... YES NO

DO YOU HAVE THOUGHTS OR URGES TO HARM YOURSELF OR OTHERS? ..... YES NO

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC ISSUE? ..... YES NO

IS THERE A HISTORY OF MENTAL ILLNESS IN YOUR FAMILY? ..... YES NO

PLEASE LIST ANY ADDICTIONS/POSSIBLE ADDICTIONS:

_____

IF YOU ARE IN A RELATIONSHIP, PLEASE DESCRIBE THE NATURE OF THE RELATIONSHIP AND MONTHS/YEARS:

_____

DO YOU HAVE CHILDREN? IF SO, PLEASE LIST NAMES/AGES…

_____

DESCRIBE YOUR CURRENT LIVING SITUATION. DO YOU LIVE ALONE, WITH OTHERS, FAMILY, ETC?

_____

HOW DID YOU HEAR ABOUT ME? _____ **MAY I THANK THEM?** YES NO

WHAT ELSE WOULD YOU LIKE ME TO KNOW?

_____

_____

_____

_____

_____

_____

PRACTICE POLICIES

APPOINTMENTS: The standard meeting time for psychotherapy is **50 minutes**. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

CANCELLATIONS and RE-SCHEDULED sessions will be subject to a full 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.

TELEPHONE ACCESSIBILITY: If you need to contact me between sessions please leave a message on my voice mail. I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.).

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and email is considered telemedicine by the State of Oklahoma. If you and your therapist choose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine including, but not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as your physical condition including deformities, apparent height and weight, body type, attractiveness relative to any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information that you may not recognize as significant to present verbally the therapist.

MINORS: If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on you own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Please sign below that you are agreeing and have read, understood and agree to the items contained in this document.

_____ _____

Client Signature Date

INFORMED CONSENT

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

THE THERAPEUTIC PROCESS: You have taken a positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may at times result in discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstances will change. I can promise to support you and do my very best to understand you and to help you clarify what it is that you want for yourself.

CONFIDENTIALITY: The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

- If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is substantial risk of incurring serious bodily harm.
- If a client threatens grave bodily harm or death to another person.
- If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
- Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
- Suspected neglect of the parties named in items above.
- If a court of law issues a legitimate subpoena for information stated on the subpoena.
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering and expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW, YOU ARE AGREEING THAT YOU HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICE - THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand the health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and service as you receive from me. I need this record to provide you with quality care to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I am required by law to:

- Make sure that protected health information that identifies you as kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For treatment payment, or healthcare operations: federal privacy rules/regulations allow healthcare providers who have direct treatment relationship with a patient/client to use or disclose the patient/clients personal health information about the patients written authorization, to carry out the healthcare providers on treatment, payment or healthcare operations. I may also disclose your protected health information for the treatment activities of any healthcare provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed healthcare provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Therapists and other healthcare providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of healthcare providers with a third-party, consultations between healthcare providers and referrals of a patient for health care from one healthcare provider to another.

Lawsuits and Disputes: if you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful processed by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information you requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. I do keep “psychotherapy notes” and any use or disclosure of such notes requires your authorization unless the use or disclosure is:
   A. For my use in treating you.
   B. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   C. For my use and defending myself and legal proceedings instituted by you.
   D. For use by the Secretary of Health and Human Services to investigate my compliance with HIPPA.
   E. Required by law and the use or disclosure is limited to the requirements of such law.
   F. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   G. Required by a coroner who is performing duties authorized by law.
   H. Required to help avert a serious threat to the health and safety of others.
2. As a Mental Health Provider, I will not use or disclose your protected health information for marketing purposes.
3. As a Mental Health Provider, I will not sell your protected health information in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your protected health information without your authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder or dependent adult abuse or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individual are performing duties authorized by law.
7. For research purposes, including studying and comparing mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions including ensuring the proper execution of military missions, protecting the President of the United States, conducting intelligence or counter intelligence operations or helping to ensure the safety of those working with an or housed in correctional institutions.
9. For Worker's Compensation purposes. Although my preference is to obtain an authorization from you, I may provide your protected health information in order to comply with Worker's Compensation laws.
10. Appointment reminders and health related benefits for services. I may use and disclose your protected health information to contact you to remind you that you have an appointment with me. I may also use and disclose your protected health information to tell you about treatment alternatives, or other healthcare services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. I may provide your protected health information to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

1. You have the right to ask me not to use or disclose certain protected health information for treatment, payment, or healthcare operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. You have the right to request restrictions on disclosures of your protected health information to health plans for payment or health care operations purposes if the protected health information pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. Other than "psychotherapy notes", you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. You have the right to request a list of instances in which I have disclosed your protected health information for purposes other than treatment, payment, or health care operations, or for which you provided me with an authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last 6 years unless you request a shorter time. I will provide you the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. If you believe that there is a mistake in your protected health information, or that a piece of important information is missing, you have the right to request. That I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. You have the right to get a paper copy of this notice, and you have the right to get a copy of this notice by email.

Acknowledgement of receipt of privacy notice: Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have the certain rights regarding the use and disclosure of your protected health information. By signing below, you are agreeing that you have read, understood and agreed to the items contained in this document.

_____ _____

Client Signature Date

OAK HAVEN
LIFE COACHING & COUNSELING

PREFERRED METHOD OF PAYMENT:

☐ **CASH**

☐ **CHECK: PAYABLE TO AMY HUESMAN**
A $10 service charge will be charged for any checks returned for any reason for special handling.

☐ **CREDIT CARD**

PAYMENT CARD AUTHORIZATION

I authorize Oak Haven Life Coaching and Counseling, LLC to charge the card below for session fees (including violations of the policy on 24-hour notice for cancellations).

Therapy session – phone/zoom/in person, 50 minutes…….$150.00
Any phone session, preparation/completion of written letters/reports/forms:
15 minute – ……$37.50
30 minute – ……$75.00
45 minute – …… $112.50
50 minute – phone/in person – standard hourly rate……..$150.00
Emergency/after hours session via phone (per 15 min.)……$ 45.00

Court Fees:
Travel Time, Court Appearance, Court Preparation……$5,100.00/Day
Emergency Appearance (less than 14-day notice)……$6,650.00 1st Day
After 1st day……$5,100.00/Day

*Appearance must be scheduled at least 14 days in advance to avoid additional "emergency appearance fees". Court fee is due at the time of scheduling the appearance and is non-refundable without a 7-day notice of cancellation. These fees are subject to change without notice.

NAME ON CARD: _____

CARD NUMBER: _____

EXPIRATION: _____

CVC# (on back): _____

BILLING STREET ADDRESS: _____

CITY/STATE/ZIP: _____

SIGNATURE: _____

DATE: _____