ACTUALIZE PSYLUTIONS CLIENT INFORMATION/ TREATMENT CONSENT

Last Name	First Name	MI	Birthdate

Address	City/State	Zip

Home Phone	Cell Phone	Work Phone	Employer/school

SSN	Age	Relationship Status	Sex	Gender Identity	Preferred Pronouns

Emergency Contact	Relationship to you	Phone #

Responsible Party	Relationship to you	Birthdate	SSN

Responsible Party Address	City/State	Zip	Phone #

LIABILITY & FINANCIAL/WAIVER RESPONSIBILITY, NOTICE OF PRIVACY POLICY

I/we, above-named and undersigned, Client(s), give full consent to engage in Services/Treatment**;* I fully understand that I claim total liability, and release all risk, and waive litigation charges against *The Indicated**** for all Services provided. I understand I am personally responsible for all potential, perceived or actual, risk of harms to whole person, property, character, and/or prestige. If applicable: I authorize any payments of mental health, therapy, and para-therapy benefits, otherwise payable to me, to The Indicated for Services rendered.

Consent for Care & Release of Mental Health/Psychological/Medical Information: I voluntarily & completely consent to mental/psychological healthcare Treatment/Services from The Indicated. I am aware that the practice of mental health/therapy services is not an exact science. The Indicated has made no guarantees to me regarding the result of treatments, assessments, diagnostics development or testing/evaluations or other Services. I consent to use & disclosure of my Protected Health Information (PHI) including potential audio/video recordings for staff/internal *Co.* training, assessment, treatment, billing, pro-bono (if applicable), and related Services. I have read & understand this form including the privacy policy & my rights to privacy. I have had the opportunity to ask questions & my questions have been answered.

**"Client" means the above-named and undersigned; **"Services/Treatment"* means para-therapeutic services including (not limited to) all communications, intake, meditations, coaching/mentoring, counseling, therapy, tele-therapy, coaching, collaboration, guidance, resource-referral, research and business/professional consultations and similar Services as defined by Ted &/or Tanya Carroll, and any/all traditional and non-traditional approaches (including strategic, hypnotic, EMDR-typology, para-therapeutic therapies/techniques). Dba active WA DOH licenses include: LH61050462, MG60947452, HP61066617; & U.S.A: NCC-1231775 (Nat'l' cert. via NBCC).

Services are professionally insured by CPH Policy# AR160481; all tele-health services covered BA in place with Doxy.me, LLC (fully HIPPA compliant). NPI 1962021212, and the licensed (WA) *Company*: *Carroll Solutions, LLC, dba Actualize Psylutions. ***The Indicated" means primary therapist/therapist, Theodore "Ted" L. Carroll and clinical administrator: Tanya M. Carroll (and any Company employee or representative thereof, whomever is seen by above-named "Client."*. The Client is responsible for compensating The Indicated for additional unexpected services at two-hundred dollars per hour (five hour minimum) if The Indicated or company representative's presence is requested or mandated by municipal, county, state, federal court(s), and/or an attorney, ad litem, mediator, or other legal representative for matters of mediation, and/or civil or criminal legal business (proceedings/hearings, meetings, or the like). If a scheduled session is unattended, with less than 24 hours' notice, or without notice, then The Client is responsible for a standard forty-dollar fee per occurrence. I consent to charges as outlined on the website.

[1] SIGNATURE OF CLIENT OR AUTHORIZED PERSON: X.__________________________________ DATE: ____________

This signature also serves Acknowledgement of Receipt of The Notice of Privacy Policy—**as defined here:** I have received a copy of The Notice of Privacy Policy (HIPPA). I am aware that The Indicated are Mandatory Reporters per WAC/RCW (WA) and any/all applicable Federal Law (United States) and that the Notice may be changed at any time. I understand that any perceived or actual threat made to self or others, including any reported active or historical/potential crime or threat of crime or intended harm will be considered reportable to appropriate state and/or federal authorities. I may obtain a revised copy of this Notice by writing to the privacy officer, **Ted &/or Tanya Carroll** or by requesting one via Actualize Psylutions (incl. former business name of 'Ted Carroll Counseling') (www.ActualizePsylutions.com; 509-870-7853; P.O. Box 1374, Spokane Valley, WA, 99037; &/ alternative tele-therapy/therapy locations).

[2] SIGNATURE OF CLIENT OR AUTHORIZED PERSON: X.__________________________________ DATE: ____________

Staff use only: ___Client refused to sign after he/she/they received verbal Notice of Privacy Policy and was informed that signing the form merely acknowledges that the patient actually received the Notice. ___Client was initially evaluated/treated for a triage mental health/psychological/human-services condition.
___Client was given the notice after stabilization or will be given the Notice after transfer (circle one) ___If limited English proficiency or hearing impaired: ___ Interpreter offered (name of personal service used) ___ Interpreter refused____ **SIGNATURE OF STAFF:** ______________________________