

# ACTUALIZE PSYLUTIONS, LLC – CLIENT's Acknowledgement/CONSENT TO TREAT

Last Name	First Name	MI	Date of Birth
[Your/client name assumed here]	[Your/client name assumed here]	[Your/client info assumed here]	[Your/client info assumed here]
Address		City/State	Zip
[Your/client info assumed here]		[Your/client info assumed here]	[Your/client info assumed here]

**By acknowledging this form/information via Headway, you are agreeing and effectively e-signing this LIABILITY & FINANCIAL/WAIVER RESPONSIBILITY, NOTICE OF PRIVACY POLICY and HIPAA laws/rights related to your concurrent agreement with Headway and all terms therein.**

I/we, above-named and undersigned, Client(s)\*, give full consent to engage in Services/Treatment\*\*; I fully understand that all Services and I guarantee total liability, release of all risk, and waiver of litigation charges to The Indicated\*\*\* for 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, counseling/therapy, and para-therapy benefits, which would otherwise be payable to me, to The Indicated for Services rendered. Liability extends, generally, to designated practice/service locations- releasing The Indicated from litigation risk.

*Consent for Care and Release of Mental Health/Psychological/Medical/Health Information:* I voluntarily and 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 the use and disclosure of Protected Health Information (PHI) about me, including potential audio/video recordings for staff/internal Company training, assessment, treatment, payments, pro-bono arrangements (if/as applicable), and related Services (i.e. hypnosis, EMDR). I have read this form. I have had the opportunity to ask questions and 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, hypnotherapeutic, paratherapeutic offerings/techniques). (dba active licensures w/DOH\*\*\*\* and NPI 1962021212 and the licensed Company: Actualize Psylutions LLC, dba Actualize Psylutions, Ted Carroll Counseling, Dr. Ted Carroll, Ted Carroll, PhD. \*\*\*The Indicated" means primary therapist/therapist, Dr. Theodore "Ted" L. Carroll and clinical administrator Tanya M. Carroll (and any Company employee, contractor, associate, or representative thereof, whomever serves the above-named "Client" including Nicholas Navarro, Jennifer Kapelos, Anita Navarro, Kelsi-Lyn Milligan Smith, Dr. William Gibson, &/or Madison Jennings, &/or any other contractor/staff/employee. \*\*\*\*Active WA DOH licenses: LH61050462, MG60947452, HP61066617; & PhD CES (earned via CACREP acrdtd prgm); & NCC-1231775 (Nat'l cert. is via NBCC). Services are professionally insured by CPH Policy# AR160481; all services covered. BA in place with Doxy.me LLC, Headway ( fully HIPAA compliant). The Client is responsible for compensating The Indicated for additional unexpected services at three-hundred dollars per hour 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 mediation, and/or civil or criminal legal business (proceedings/hearings, meetings, or the like).

REGARDING SCHEDULED SESSIONS IN/OUT OF HEADWAY: CANCELATIONS, NON-ATTENDANCE OR REQUEST TO RESCHEDULE WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN THE FULL SESSION FEE CHARGED TO YOUR HEADWAY PAYMENT METHOD ON FILE (NO LESS THAN \$120)..or as agreed upon outside of insurance/Headway terms aka "private pay" arrangement.

This signature/acknowledgement 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 including HIPAA laws (via Headway) 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, Dr. Theodore/Ted &/or Mrs. Tanya Carroll or by request via Actualize Psylutions LLC (incl. former DBA, 'Ted Carroll Counseling')(www.ActualizePsylutions.com; 509-870-7853; YesActualize@gmail.com; 719 Jadwin Ave #31, Richland, WA, 99352 &/or alternative physical/online/remote/temporary service locations (such as those associated with independent contractors and other company representatives or employees).

**SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE(Acknowledgement) OF CLIENT OR AUTHORIZED PERSON: X.[Acknowledging in Headway serves as your signature/consent/agreement\_ DATE: \_[effective the date you sign/acknowledge via Headway or in-person or via agreed upon online platform such as Simple Practice or Doxy.me or Zoom Pro or Psychology Today 'Sessions']**

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:** \_\_\_\_\_