ACTUALIZE PSYLUTIONS, LLC / Dr. Ted Carroll – CLIENT INFORMATION/ TREATMENT CONSENT

Last Name	First Name	MI	Date of Birth

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	Date of Birth	SSN

Responsible Party Address	City/State	Zip	Phone #

Insurance Co. Name	Policy #	Group #	Address & 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 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 or representative thereof, whomever is served by above-named "Client.".* ****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).

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. 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 #603D, Richland, WA, 99352 &/or alternative physical/online/remote/temporary service locations.

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:** _____