Oak River Counseling Referral Form

This form is to determine the insurance information for wanting to participate in counseling at the Boys and Girls Club.

Client Name:_____Date of Birth:_____

Guardian Name:_____

Phone Number:_____

Address:_____

Insurance: __Blue Cross Blue Shield __Medicaid __Other

BCBS/Other:

Contract Number/Member ID:_____

Policy Holder Name:_____

Medicaid:

Medicaid ID Number:_____

****If you have Medicaid they require you to have the Medicaid Referral from the child's primary care physician sent over to our office before the child participates. They can fax it to Oak River Counseling at 334-751-1466.

Days your child attends Boys and Girls Club: Mon Tue Wed Thu Fri

Time you child attends Boys and Girls Club:_____

Oak River Counseling, LLC
828 Andrews Ave, Suite 2
Ozark, Alabama 36360
Office: 334-443-1030 Fax: 334-751-1466

Informed Consent for Therapy

Thank you for choosing Oak River Counseling, LLC and allowing us the opportunity to provide your child with therapeutic services. Please read the following information prior to consenting for therapy. Your signature indicates that you understand and agree to comply with the following policies and give consent to services provided by Oak River Counseling, LLC and its providers.

Confidentiality: What is discussed in therapy is confidential. Information concerning your case will not be released to anyone outside of Oak River Counseling, LLC without your written permission to do so.

Exceptions to confidentiality:

1. Duty to warn: I will abide by the laws of the State of Alabama in regards to the duty of therapists to warn whenever there is a reasonable probability of willful harm to self or others.This includes warning identified victims and informing authorities
2. Judicial Subpoena/Court Order
3. Mandatory reporting of child abuse/neglect: If at any time I suspect child abuse or neglect I am mandated by state law to report it to the state and/or law enforcement for investigation

Insurance: Oak River Counseling, LLC does not file insurance on behalf of the client unless Oak River Counseling is contracted with the insurance company; however, if we don't accept your insurance, we can provide you with a Superbill you could send to your insurance for possible reimbursement. Reimbursements from the insurance company are not guaranteed. If you wish for me to file on your insurance, by signing this informed consent you are agreeing for me to disclose required information from your chart. This will include client demographics, diagnoses, and dates of service.

Court Appearance: I will not make court appearances in a custody case, marital cases, domestic violence cases or individual cases. However, If I receive a subpoena and must attend a court appearance. My court cost is $300 per projected hour paid prior to taking the stand.

Records Release/Attorneys: Each session is subject to a written summary so that I have a record of your attendance and progress throughout therapy. All information exchanged between you and Oak River Counseling, LLC is privileged and confidential. Your record is owned by you but is the property of Oak River Counseling, LLC. Your records will be disposed of seven years after your chart is closed. The purpose of your record is to 1.) Plan your care and treatment, 2.) Communicate among referral sources and health care professionals, 3.) Describe the care that you have received, 4.) Allow third party payers to verify that you received the services, 5.) Assess the appropriateness and quality of care that you received, 6) Improve quality healthcare and achieve better client outcomes. You **HAVE THE RIGHT** to access your record if Oak River Counseling deems that it will not ultimately cause harm to you or others. You must pay for all copying costs ($3/page). You **DO NOT HAVE ACCESS** 1.) Therapy notes. 2.) Information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, 3.) Protected health information, 4.) Information that was obtained from someone other than a health care provider under a promise of confidentiality. If access to your record is denied, an explanation will be provided. If you feel that information contained in your record is incorrect or incomplete, you may ask to add information in order to amend the record. You must submit a request in writing and provide a valid explanation concerning the reason for your request. You may correct or amend information in your record unless 1.) Oak River Counseling, LLC did not create the document to be amended/corrected, 2.) The record is accurate and complete, 3.) IF the record is not available to you for reasons described in the paragraph above. If your request is denied you may file a statement that you disagree, which will be added to your record.

Referral: I am ethically bound to terminate the therapy contract if the therapy relationship is deemed no longer beneficial to the client.

*****NO CLIENT OR OTHER PARTY/PARTICIPANT IS GIVEN PERMISSION TO RECORD ANY PART OF A COUNSELING SESSION (ON-SITE OR TELEHEALTH)**. This can negatively impact the client/therapist relationship. If the therapist learns that sessions have been recorded without permission or consent, therapy services will be immediately suspended in order to discuss future therapeutic services at Oak River Counseling, LLC. If it is determined that the therapeutic relationship cannot be repaired (based on the therapist's discretion), then the therapist will refer the client to another therapist outside of Oak River Counseling, LLC.

Effects/Purpose of Counseling: Counseling is for therapeutic purposes only and is NOT intended for use in legal proceedings. Neither records nor my comments are for or against individuals, but for the reaching of therapeutic goals. While benefits are expected from counseling, no specific outcome is guaranteed. Your time in counseling may lead to major changes in how you choose to view important issues in your life. The exact nature of these changes is not predictable and could

affect relationships and your view of yourself/others. You must consider the potential pros/cons of counseling before undertaking it. During the counseling process, there may be periods of increased discomfort and strong emotions; this is common and tends to improve over time.

Scheduling: You will receive a reminder call, text, or email a day prior to your session. By signing this informed consent, you are giving me permission to contact you via text, phone, or email.

Notice of Privacy Practices: I, a client of Oak River Counseling, LLC., hereby acknowledge that I have been offered a copy of the HIPAA/privacy practices for Oak River Counseling, LLC.

Minor Consent: By signing this informed consent, I, parent/legal guardian of the minor identified below, am giving consent for him or her to participate in therapy at the Boys and Girls Club of Ozark by Oak River Counseling, LLC.

I, the undersigned, understand and acknowledge that neither Maddison Kirschner, my specific therapist, nor Oak River Counseling, LLC., nor any of its officers, agents, directors, affiliates, or employees shall be held responsible for any act, accident, or injury in any way related to my child's therapeutic session.

In consideration for my therapy by Oak River Counseling, LLC therapists, I, the undersigned, for and on behalf of myself, my family, and my estate, heirs, and assigns, do hereby release, indemnify, and hold harmless all therapists at Oak River Counseling, LLC., including its officers, agents, directors, affiliates, and employees, from and against any and all claims, actions, damages, liability and expense in connection with claims (including attorneys' fees), whether in statutory or common law, in law or in equity relating to injury, including death, or damage to my child or property belonging to me, relating to therapy provided by the therapists at Oak River Counseling, LLC.

I hereby certify that I am fully competent to sign this Informed Consent that I have read the Release in its entirety and agree to be fully bound thereby

Client Information

Client's name: _____

Client's address: _____

Phone Numbers: Home_____ Cell_____

Email: _____ Client's DOB: _____

Emergency Contacts

Name:_____**Phone:**_____**Relationship:**_____

Name:_____**Phone:**_____**Relationship:**_____

Please feel free to call us at 334-443-1030 about any concerns you may have. By signing below you indicate that you understand the policies set forth by this informed consent.

Legal Guardian Signature:_____ Date_____

Therapist Signature _____ Date _____

Oak River Counseling, LLC
828 Andrews Ave, Suite 2, Ozark, Alabama 36360
Phone: 334-443-1030 Fax: 334-751-1466

AUTHORIZATION FOR RELEASE AND DISCLOSURE

I, _____(patient), _____ (date of birth) authorize Oak River Counseling, LLC. to: (check one or both below)

_____ Release information from my medical records to the individual or organization listed below.

Name: **Boy's and Girl's Club of Ozark**

Address: **195 Martin Luther King Jr Ave Ozark, AL 36360**

For the following purpose, use or need: **Continuity of Care**

The following information from my psychiatric/medical records may be disclosed:

☐-My entire record.

☐-My information relating to the following treatment or condition:_____

☐-My health information covering the period from _____ to_____

☒-Other: Scheduling and Legal Reports

☐-Exclude the following information:_____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS-related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of Oak River Counseling, LLC and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of the law. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Oak River Counseling, LLC will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event, or condition:**Termination of Treatment**

If you have any questions about this form call our office at 334-443-1030.

Parent/Legal Guardian Signature_____Date_____

Therapist Signature _____Date_____

Oak River Counseling, LLC
828 Andrews Ave, Suite 2, Ozark, Alabama 36360
Phone: 334-443-1030 Fax: 334-751-1466

AUTHORIZATION FOR RELEASE AND DISCLOSURE

I, _____(patient), _____ (date of birth) authorize Oak River Counseling, LLC. to: (check one or both below)

_____ Release information from my medical records to the individual or organization listed below.

Name **(Primary Care Physician):** _____

Address: _____

For the following purpose, use or need: **Continuity of Care** _____

The following information from my psychiatric/medical records may be disclosed:

☒-My entire record.

☐-My information relating to the following treatment or condition: _____

☐-My health information covering the period from _____ to _____

☐-Other: _____

☐-Exclude the following information: _____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS-related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of Oak River Counseling, LLC and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of the law. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Oak River Counseling, LLC will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

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Parent/Legal Guardian Signature _____ Date _____

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