Conscious Healing Therapies, LLC
302 South Spring Street ▪ Tupelo, MS 38804
Office Phone: 662-841-8020 ▪ Fax: 662-841-8021

CLIENT INFORMATION

Client: ____________________ **Date of Birth:** ____________ **Age:** ______

SS#: ____________________ **Gender:** ____________ **Race:** ____________

Physical Address: ____
Street City State Zip Code

Mailing Address: ____
Street or P. O. Box City State Zip Code

Home Phone: ____________________ **Cell Phone:** ____________________

Email Address: ____

Place of Employment: ____________________ **Work Phone:** ____________

Responsible Party: ____________________ **Relationship:** ____________

DOB: ____________ **Age:** ______ **SS#:** ____________ **Gender:** ______

Address (if different from client): ______________________________
Street City State Zip Code

Home Phone: ____________________ **Cell Phone:** ____________________

Email Address: ____

Place of Employment: ____________________ **Work Phone:** ____________

Other Parent / Spouse: ____________________ **Relationship:** ____________

DOB: ____________ **Age:** ______ **SS#:** ____________ **Gender:** ______

Address (Only if different from client and/or responsible party):

____
Street City State Zip Code

Home Phone: ____________________ **Cell Phone:** ____________________

Email Address: ____

Place of Employment: ____________________ **Work Phone:** ____________

INSURANCE INFORMATION

Primary Insurance: ____________________ **Policy Holder Name:** ____________

Relationship to Client: ____________ **DOB:** ____________ **SS#:** ____________

Address: ______________________________ **Phone:** ____________

ID#: ____________ **Group#:** ____________ **Plan Name:** ____________

Secondary Insurance: ____________________ **Policy Holder Name:** ____________

Relationship to Client: ____________ **DOB:** ____________ **SS#:** ____________

ID#: ____________ **Group#:** ____________ **Plan Name:** ____________

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INFORMED CONSENT FOR COUNSELING SERVICES

Name of person who will be receiving services: ______________________________________ DOB: _____________

******ALL SERVICES ARE VOLUNTARY. YOU DO NOT HAVE TO SIGN THIS FORM UNLESS YOU REALLY AGREE AND WANT TO RECEIVE PSYCHOTHERAPY SERVICES******

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

AVAILABLE SERVICES: Conscious Healing Therapies, LLC (CHT) offers a wide array of counseling services, including individual, family, couples, and group services. Hypnotherapy and other forms of therapies are available. We are staffed by skilled and experienced Licensed Clinicians and licensed clinicians under supervision. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues that may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that CHT can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The therapist uses a wide variety of techniques in therapy. Therapists are trained in a variety of interventions including play therapy, Trauma Focused Cognitive Behavioral Therapy, and other interventions focused on healing mind, body, and spirit. You are encouraged to discuss skill level and training with your therapist. Those therapists trained as Clinical Hypnotherapist and/or Certified Release Therapist may also use closed eye processes including hypnotherapy and breath therapy. These techniques can further enhance the therapy experience and allow for a deeper level of healing. Hypnotherapy is an expanded state of consciousness, which includes both conscious and unconscious awareness. Hypnosis is a powerful technique used to assist you in accessing the incredible inner resources within the subconscious mind to affect positive change in your life. Hypnosis is a powerful way to assist you in reframing negative and unwanted habitual patterns of thinking, feeling, and behaving, with positive, healthy and empowering choices. If you have questions about the techniques or are interested in using hypnotherapy or breath therapy, we can discuss this in more detail during your session.

The goal of CHT is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

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Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Most appointments are approximately 45-55 minutes long. Sessions may last up to 120 minutes for those participating in more intensive therapy or hypnotherapy. If you must cancel or reschedule your appointment, we ask that you call our office at 662-841-8020 at least 24 hours in advance, whenever possible**.**

CANCELATION/NO SHOW POLICY: We understand that schedules change and situations arise that require client's to cancel and/or reschedule appointments. We request cancelations be made within 24 hours whenever possible. You may cancel an appointment by contacting our office telephone, sending an email to info@chtllc.com or texting your therapist directly. The office has a voice mail system which is checked routinely, if no one answers and your voicemail message, email, or text is left in the time allowed, it will serve as your cancelation notice and you will not be charged early cancelation or no show fees. **Cancelations made after 9:00 AM on the date of your appointment will be charged an EARLY CANCELATION FEE of $50. Any appointments missed as a no call/no show will result a NO SHOW FEE of $100.**

FEE SCHEDULE: Each therapist assigns a fee schedule based on level of Licensure, Degree, and Certification. Please talk with your therapist regarding their individual fee schedule. Typically, CHT Clinicians bill $100-$200 per session depending on the length and type of sessions scheduled. *Once again all no show fees are $100.00 per session no show regardless of assigned session fees.* Therapy sessions last an average of 45-90 minutes. However some sessions may be scheduled for differing times based on need and availability.

A reasonable fee will be charged for copies of any records requested by the Client. Telephone conferences are available, however insurance companies do not cover telephone sessions or conferences. Time will be prorated according to the hourly rate for those telephone conferences lasting beyond 15 minutes.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, CHT will file In Network Insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan or using insurance that we are considered Out of Network and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Currently CHT is considered "In Network" with BCBS, United, Medicaid, Medicare, Magnolia, and others. Please ask your therapist or consult with the office staff regarding your specific insurance plan and requirements for payments. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

PAYMENT COLLECTION/LATE FEE POLICY: Payments for services are expected at time services are rendered. All clients are required to have a "Credit Card Recurring Payment Authorization" on file. Any past due balances over 90 days are subject to a $10/month late fee. Payment plans are available for higher balances or to assist in meeting deductibles. All late fees are discontinued at the time a Payment Plan Agreement is signed. Any accounts remaining past due after 6 months will be subject to Justice Court. All fees for claims to Justice Court are the responsibility of the client and will be added to the account. CHT offers a SLIDING SCALE form for those clients needing financial assistance. Please request this form from your therapist or Administrative Assistant to see if you qualify for a reduced rate.

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ACCESS NOTICE: Conscious Healing Therapies LLC and all of it's programs and activities are accessible to and usable by disabled person, including persons with hearing and vision impairment. Access features include: Convenient off street parking designated specifically for disabled persons, Curb cuts and ramps between parking areas and buildings, Level access into first level building, Fully accessible offices, meeting rooms, bathrooms, public waiting areas, conference room, kitchen, patient treatment areas
A full range of assistive and communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids.
If you require any of the aids listed above, please let our office staff/administrator or your provider know.

EMERGENCIES: You may encounter a personal emergency, which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your Therapist's cell phone number will be given during your intake session. Please utilize this number in the event of a serious crisis, and your Therapist will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you may be advised and given the name of an on-call Therapist if needed and deemed appropriate

CONFIDENTIALITY: CHT follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions;

child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. Cases may be discussed with a colleague for the purposes of supervision. In these cases, all professionals involved are bound by the same ethical and legal

considerations to protect your privacy. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT/EMERGENCY CONTACT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
______________________________	______________________
______________________________	______________________

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INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: **By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form.** I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, CHT will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

______________________________	______________________________
Signature – Client/Parent	Date
______________________________	______________________________
CHT Staff	Date

Date of Service: ________________________

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CLIENT ACKNOWLEDGEMENT

Please read the following carefully:

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Conscious Healing Therapies LLC and Melissa Ratliff, LCSW will honor contractual agreement made with those managed health care companies which stipulate specific reimbursement restrictions.

____________________________________ ____________________________

Signature of Client or Guardian Date

I hereby consent to treatment by Conscious Healing Therapies or Melissa Ratliff, LCSW. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

____________________________________ ____________________________

Signature of Client or Guardian Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

____________________________________ ____________________________

Signature of Client or Guardian Date

I authorize the payment of medical benefits to the provider of services.

____________________________________ ____________________________

Signature of Client or Guardian Date

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NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgment of Notice

Patient/Client Name:____

DOB: ________________________________ *SSN:*______________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Conscious Healing Therapies Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 662-841-8020.

____

Signature of Patient/Client

_________________________________ ___________________________________

*Signature of Parent, Guardian or Personal Representative** *Relationship to Client*

____

Date

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* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

❑ *Patient/Client Refuses to Acknowledge Receipt:*

____

Signature of Staff Member *Date*

Date of Service: ______________________