STAND IN HOPE, LLC
Journey Toward Your Purpose

Confidential Intake Form

Please provide the following information for our records. Information you provide here is protected as confidential information.

Date of Intake/Appointment: ____/____/____ **Time of Appointment:** _____ ❑**AM** ❑**PM**

Client's Name: _____ _____ _____
(Last) (First) (Middle)

Birth Date: ____/____/____ **Age:** _____ **Gender:** ☐Male ☐Female ☐Transgender

Religious Preference: _____

Marital Status:
☐Never Married ❑Domestic Partnership ❑Married ❑Separated ❑Divorced ❑Widowed

Current Address: _____ _____ _____ _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ **Work Phone:** _____ **Cell**: _____
May we leave a message? ☐Yes ☐No May we leave a message? ☐Yes ☐No May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ❑No
☐ Please note: Email correspondence is not considered to be a confidential medium of communication.

I am being referred for/am coming to therapy because: _____

_____

Referred By: _____
(e.g. name of physician, website, friend, name of school counselor, etc.)

INSURANCE INFORMATION:
Insurance Carrier: _____ Phone: ( ) _____

Employer: _____ ID# _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

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RESPONSIBLE PARTY INFORMATION:

Name _____

Relationship to patient: ☐Self ☐Spouse ☑Other (please indicate): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

***Legal Guardian if patient is a minor:**

_____ Signature gives consent to treat

Household Income per Month: _____ $0

☐ Less than $500
☐ Less than $1500
☐ Less than $2000
☐ More than $2000

Number of Household Members: _____

☐Please complete above section if seeking financial accommodations.

Two people to contact in case of emergency:

Name: _____ Name: _____
Home Phone: _____ Phone: _____
Cell Phone: _____ Cell Phone: _____
Relationship: _____ Relationship: _____

SCHOOL / EMPLOYMENT INFORMATION:

Employment Information (if applicable):

Are you currently employed? ☐Yes ☐No
If No, please state reason (e.g. unemployed, student, disabled, homemaker): _____
Name of Employer: _____

Have you ever served in the military? ☐Yes ☐No
If Yes, Are you currently active? ☐Yes ☐No
If No, do you have an Honorable or Dishonorable Discharge? _____

School Information:

What is the highest grade you completed: _____
Are you currently enrolled in school? ☐Yes ☐No
Current School (if enrolled): _____

Please identify the following school-related problems (check all that apply):

- ☐ Inattentiveness
- ☐ Bullying
- ☐ Being Bullied
- ☐ Refusal to attend
- ☐ School-related anxiety
- ☐ Refusing to do or complete work
- ☐ Current problems with truancy
- ☐ Suspensions or Expulsion

Is there a history of an IEP? ☐Yes ☐No
Current Special Education Placement: ☐Yes ☐No

MENTAL HEALTH INFORMATION:

Are you currently receiving any type of mental health or addiction services? ☐Yes ☐No

Have you previously received any type of mental health or addiction services (psychotherapy, psychiatric services, etc.)?
☐ Yes ☐ No
Previous therapist/ practitioner: _____

Are you currently taking prescription medication?
☐ Yes ☐ No
Please list: _____

Have you ever been prescribed psychiatric medication?
☐ Yes ☐ No
Please list and provide dates: _____

Please list any known Allergies: _____

Who is your Primary Care Physician: _____

GENERAL HEALTH AND SUBSTANCE USE INFORMATION

1. How would you rate your current physical health? (please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific problems you are experiencing: _____

2. How would you rate your current sleeping habits? (please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific problems you are experiencing: _____

3. Please list any difficulties you experience with your appetite or eating patterns:

_____

4. Are you currently experiencing overwhelming sadness, grief, or depression?

☐ Yes ☐ No

If Yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks, or have any phobias?

☐ Yes ☐ No

If Yes, when did you begin experiencing this? _____

6. Are you currently experiencing chronic pain?

☐ Yes ☐ No

If Yes, please describe? _____

7. Do you drink alcohol more than once a week? ☐Yes ☐No

8. How often do you engage in recreational drug use?

☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

9. Are you currently in a romantic relationship? ☐ Yes ☐ No

If Yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

10. What significant life changes or stressful events have you experienced recently: _____

_____

FAMILY MENTAL HEALTH AND SUBSTANCE HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.):

			List Family Member
Alcohol / Substance Abuse	☐ yes	☐ no	_____
Anxiety	☐ yes	☐ no	_____
Depression	☐ yes	☐ no	_____
Domestic Violence	☐ yes	☐ no	_____
Eating Disorders	☐ yes	☐ no	_____
Obesity	☐ yes	☐ no	_____
Obsessive Compulsive Behavior	☐ yes	☐ no	_____
Schizophrenia	☐ yes	☐ no	_____
Suicide Attempts	☐ yes	☐ no	_____

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? ☐Yes ☐No
If yes, describe your faith or belief: _____

2. Are there any ethnic or cultural practices or beliefs, which we need to be aware of? ☐Yes ☐No
If yes, please describe: _____

3. Please list your hobbies and interests: _____

4. What would you like to accomplish out of your time in counseling services?

_____

PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling (i.e. what are your issues, problems, symptoms, how long,. Use the back if necessary.):

_____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1
❑Stress
❑Anxiety
❑Panic
❑Depression
❑Apathy
❑Fatigue/Lack of Energy
❑Loss of Appetite/Overeating
❑Trouble Sleeping
❑Poor Concentration
❑Feeling Worthless
❑Recent Death
❑Grief
❑Chronic Pain
❑Loneliness
❑Fears
❑Shyness
❑Low Self-Esteem

List 2
❑Marital Problems
❑Other Relational Problems
❑Physical Abuse
❑Emotional Abuse
❑Verbal Abuse
❑Sexual Abuse
❑Sexual Problems
❑Gender Identity Issues
❑Anger
❑Aggressive Behavior
❑Bad Dreams
❑Unwanted Memories
❑Loss of Control
❑Impulsive Behavior
❑Controlling
❑Controlled by Others
❑Obsessive Thoughts

List 3
❑Compulsive Behaviors
❑Seeing Things Others Don't
❑Hearing Voices
❑Racing Thoughts
❑Eating Problems
❑Drug Use
❑Alcohol Use
❑Pregnancy
❑Abortion
❑Legal Matters
❑Work Stress
❑Career Choices
❑Indecisiveness
❑Parenting Problems
❑Financial Problems
❑Spiritual Problems
❑Other

Please circle to indicate how distressing your problem(s) are to you.

☐ Very Minimally Distressing ☐ Moderately Distressing ☐ Very Extremely Distressing

Are you currently experiencing any suicidal thoughts? ☐Yes ☐No

Have you experienced suicidal thoughts in the past? ☐Yes ☐No

Have you attempted suicide in the past? ☐Yes ☐No

Are you currently experiencing any violent or homicidal thoughts? ☐Yes ☐No

What do you hope to gain from this counseling experience?

Client or Legal Guardian Signature **Date**

STAND IN HOPE, LLC
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Authorization to Release Information

I, _____ authorize

Catrina Scott, MS, LPC _____ and

_____

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

_____ All Health Care Information
Initials

_____ Health Care Information or Opinions Relating to any or all of the following treatment(s) and/or conditions:
Initials

_____ 1) Psychiatric or Mental Health Information
Initials

_____ 2) Academic and Confidential School Information
Initials

_____ 3) Testing
Initials

_____ 4) Other _____
Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

_____ _____
Patient Date

_____ _____
Parent or Legal Guardian Date

_____ _____
Witness Date

OFFICE POLICIES and INFORMED CONSENT FOR TREATMENT

***Please print, read thoroughly and sign at the bottom. If you have any questions please let me know and we can discuss them in your first session.*

1. **Services Provided:** I am a licensed psychotherapist that provides mental health counseling, substance abuse counseling, work/life balance, and assistance with problems of daily living for individuals, couples, families, and groups. I see clients who are 18 years or older. Individual, couples, and family sessions are 45-60 minutes. Group therapy sessions are 90 minutes. This may include individual, couples, family, or group psychotherapy. Psychotherapy may also include medication education, psycho-education, and other psycho-therapeutic activities. I will provide these services to clients on a voluntary basis. I am able to provide "distance counseling" and "phone counseling" when appropriate, based on ethical restrictions of licensure, and based on client needs. I reserve the right to include additional services to the scope of practice as education and certification permits. When additional services are offered and utilized by the client additional informed consents and office policies may apply and will be supplemented with addendums. The additional informed consents and office policies will be in keeping with all policies here in.
2. **Excluded Services:** I do not see clients who are in a domestic violence situation, as a victim or perpetrator. I do not see clients who have a history of or are currently seeking treatment for sexual compulsion or gambling. I do not provide consultation, evaluation, or counseling for individuals in regards to child custody of any nature. I do not provide psychological testing services, home assessment evaluations for custody, or make recommendations for child custody. I do not provide fitness for duty evaluations for law enforcement. I do not provide social services, social work, or wrap around services for community-based support. I do not provide "advice" or tell my clients what to do". I do not provide assessment for social security disability. Also, I do not provide medication management for psychotropics. All of the above excluded services are outside the scope of my license, not within my area of expertise or training, or are excluded services.
3. **Client Expectations:** Clients are expected to be on time for appointments and complete treatment assignments in a timely manner. Clients are also expected to follow through with recommendations for treatment such as referrals to providers for consultation or support. ***Treatment is your personal journey to achieve your goals. If you are not committed to the process, then it will not help you. There is no help I can give you that will overcome a lack of motivation or compliance. In order for therapy to be successful you must do the work. I am here to help guide you through that work. Not do the work for you.*** **If at any time the client is not satisfied with the services provided by me for any reason the client has the right to choose services elsewhere.** A client may request referrals to another provider if they choose. For clients who chose to discontinue services and do not request referrals it is recommended that they call their insurance company and request a list of in-network providers or refer to psychologytoday.com and search for therapists. Further, it is the client's responsibility to participate in therapy in an honest and forthcoming manner. It is also the client's responsibility to voice concerns with regards to counseling, psychotherapy, or billing in an honest and forthcoming manner. I cannot be held responsible or accountable for client problems and concerns not voiced to me.

4. **Late Appointment and Cancellation Policy**: Clients are expected to provide 24 hour notice if they will not be able to attend an appointment. Failure to give proper cancellation notice will result in being charged **$40.00**. Clients who arrive late for their appointments are entitled to the time remaining for the scheduled session as long as they are no more than 15 minutes late. For clients that are more than 15 minutes late the therapist has the discretion to charge the full fee for the session. If the client is permitted to begin the session late the session will still end at the scheduled time. Appointments are scheduled at the top of the hour and end at 45 minutes into the hour. If a client presents for an appointment at the incorrect scheduled appointment time and misses their assigned time then this is considered a missed appointment.
5. **Phone calls and Emergencies**: Phone calls to me will be returned **in two business days** in most cases. Please leave a number or method of contact where a message can be left. If a client leaves a phone number for me to return a contact then I make the assumption that this is a secure manner to contact the client and if necessary leave a message unless the client states otherwise. ***Please note that I am not available for after-hours emergencies and that I may not be able to return calls immediately in the event of an emergency. In the event of a mental health emergency please call 911 or go to the nearest emergency room. You may also call 988 Suicide and Crisis Lifeline.***
6. **Professional Boundaries**: As a therapist I am privileged to be someone that clients can trust and confide in. I take my responsibility very seriously. This is a unique relationship where clients can safely explore personal issues. Though there are aspects of the therapeutic relationship that seem to be similar to friendship this is not the case. **I maintain professional boundaries with my clients in order for them to feel comfortable disclosing personal information. The therapeutic relationship is professional and based on timed sessions that are fee for service.** Therefore, it is not appropriate to text message my cell phone, contact me via e-mail for **non-clinical matters**, or to invite me to attend social functions together. Phone calls should be directed towards scheduling and rescheduling appointments. Clinical concerns should be addressed in session. I do not accept gifts from my clients. I do not barter services due to potential conflicts of interests. If the client and therapist should see one another in public the therapist will not acknowledge the client unless the client acknowledges the therapist first. I offer enrichment classes, meditation classes, and other non-therapeutic services.
7. **Fees for Services and Submission of Claims to Insurance:** Fees for outpatient individual therapy are $130.00 for the intake assessment and $130.00 per outpatient 45-50 minute follow up sessions. The client is also responsible for the payment of fees at each session.
8. **Type of Payment Accepted:** I accept cash, checks and credit/debit as payment. I require all clients to have a credit card on file. The payment form must be completed and signed with a current credit card. Clients will receive a receipt in the event the client requests it, in-person or through the mail, each time a credit card, check or cash is charged. If a client would like a financial summary with a list of dates of service then it must be requested and I have one week to provide said information.
9. **Returned Checks: If a check is returned NSF the fee is $35/check**. This amount must be paid in cash or with a credit card prior to scheduling another appointment and future appointments must be paid with cash or credit/debit card.

10. **Client Financial Hardship and Dedication to Provide Care in Fairness to All Who Seek Help:** To honor the greater needs of the client and maintain ethics I offer sliding scale agreements for clients who do not have insurance or report financial hardship which would prevent them from seeking treatment or result in early termination of treatment. I hold to the ethical standard that everyone deserves equal access to treatment and quality of care, therefore; when necessary and able due to scheduling, availability, and census, financial hardship agreements are considered to clients who request them. If a client requests a financial hardship agreement, a signed form will be required to be kept on file. In the event that the client has been offered a sliding scale fee due to financial hardship the client may opt out of the sliding scale fee at any time, however; the choice to opt out is not retroactive to any previous dates of service unless otherwise agreed upon by me.
11. **Additional Fees**: Time required for interviewing, reports, clinical phone conversations, etc., will be charged to the client separately. The fee for report writing and clinical phone conversations is $200.00 per hour. For issues that require less than one hour the time will be rounded into 15 minute increments. I do **NOT** provide court room testimony or testify in court or any type of court proceedings. If subpoenaed a retainer fee of **$2,000.00 two weeks prior** to the appearance, presentation of records, or testimony requested. These services are to be paid by credit/debit card only. The time billed for court room proceedings includes travel time to and from the assigned proceeding as well as any time waiting for the proceedings. If I am unable to receive payment for services rendered I reserve the right to terminate services.
12. **Risk Associated with Treatment:** There are times when psychotherapy can cause emotional distress as you will be addressing issues that may have been upsetting in the past. **Therefore, one should know that there are risks involved with seeking treatment. If you begin to experience an increase in symptoms it is very important to address that with your therapist in order to provide you the support you need.** In the event you do not feel like treatment is assisting you my ethical responsibility is to provide you with an appropriate referral for continuity of care and on-going treatment and it is the client's responsibility to inform me that you feel that therapy may not be helping you.
13. **Treatment Modalities Utilized:** I utilize a variety of treatment modalities in order to assist you in achieving your goal of mental health wellbeing. Some of the theoretical orientations used are Person Centered, Solution Focused Therapy, Cognitive Behavior Therapy, Rational Emotive Behavior Therapy, Collaborative Theory, Narrative Therapy and may include additional approaches as clinically necessary.
14. **I will protect your confidentiality with some exceptions.** The exceptions to confidentiality are: In the event of abuse, neglect, or imminent danger to yourself or others. The other exceptions to confidentiality are when you request for me to coordinate and provide information regarding your treatment to a third party through a release of information, if you invite someone supportive to participate in a treatment session with you, or if I am subpoenaed by law enforcement. I utilize electronic communication such as e-mail, text messages, phone calls, and fax. All of the electronic communications are used with the utmost care for confidentiality and privacy.
15. **Client Safety and Maintaining Safety in the Treatment Environment: I agree to inform Catrina Scott, LPC if I begin to have thoughts to harm myself or others. I also agree to notify her if I begin to experience severe mental health symptoms and am concerned about my wellbeing or safety or**

those around me. I agree to follow through with all recommendations provided by Catrina Scott, LPC. No client is permitted to bring weapons of any kind into my office.

16. **Emergency Situations:** If a mental health emergency should arise I agree to pursue treatment at the **nearest available emergency room or to call 911**. **I understand that Catrina Scott, LPC is not available for mental health emergencies.** It is the client's responsibility to seek emergency treatment for medical or mental health emergencies.
17. **Right to Refuse Services:** I understand that Catrina Scott, LPC has the **right to discontinue or terminate treatment** for non-compliance with the treatment plan, failing to follow through with treatment recommendations, or failing to live up to client financial obligations. **I reserve the right to refuse services or discontinue services to anyone at any time for any reason without prior notice.**
18. **Maintaining Confidentiality and Privacy in the Treatment Session and Environment:** It is not allowed for any client or any person to use any type of electronic device to audio record, video record, or document in any way the private and confidential therapy sessions and phone calls between the client and the therapist. Furthermore, any and all correspondences with the therapist are not allowed to be presented in any public manner. Clients receiving group therapy and family therapy are expected to maintain the confidentiality of all members of those sessions.
19. **Outreach and Discharge Policy:** I will send outreach messages via text, e-mail, or voicemail/phone call to the client to provide continuity of care and ease of rescheduling the next appointment. I will send 2 outreaches. If the client goes more than one month without a scheduled appointment the client will no longer be considered a *current* client and will be considered discharged. As a courtesy Catrina Scott, LPC will send reminder text messages, e-mails, or voicemails for appointments. It is not my responsibility to provide the courtesy of a reminder for appointments. In the event the client reports they did not receive the reminder they are still responsible for the session scheduled.
20. **Social Media:** I maintain a professional website, Facebook page, Instagram account, and LinkedIn account. Clients are not required to participate in any social media. I do not take any responsibility for issues pertaining to privacy or confidentiality with regard to social media with regards to clients.

Stand In Hope, LLC does not allow any audio or video recording. Any violators will be subject to legal action.

I have read, understand and will abide by all informed consent information and office policies as evident by my signature.

Client Name (Print): _____

Client Signature: _____ Date : _____

(Parent/Guardian signature if client is a minor)

STAND IN HOPE, LLC
Journey Toward Your Purpose

Policies and Procedures

Fee Structure: **The client is financially responsible for payment of fees, which will be collected at the time of each service.** Fees for outpatient individual therapy are $130.00 for the intake assessment and $130.00 for the 45-50 minute follow up sessions. The therapist accept insurance, cash, all major credit/debit cards, zelle as payment. The client and therapist can negotiate a payment schedule. You will be charged for cancelled appointments unless notice is received at least ***24 hours** prior to the appointment time so that the time may be scheduled for another patient.

***NOTE:** You are responsible for paying the full fee for "no-shows" or appointments cancelled without sufficient notice (i.e., 24 hours), as determined by your therapist in this event. Except in emergencies, cancellations must be made 24 hours in advance to avoid being charged or termination of the therapeutic relationship. **No further appointments can be made until the No Show Fee or Late Cancelation has been paid**.

Confidentiality: Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent. **Stand In Hope, LLC does not allow any audio or video recording. Any violators will be subject to legal action.**

Client Privacy: Laws have been enacted for client privacy. It is important to know that emails and cell phone conversations are not secure or guaranteed of privacy because they can potentially be intercepted. Therefore, by signing this document you understand that if we have correspondence by email or cell phone, there is a potential for confidentiality to be compromised.

Length of Sessions: Sessions are scheduled at the top of the hour and ends at 45-50 minutes into the hour.

I understand and accept the policies concerning both the cancellations of appointments and payment for services. I will be responsible for the agreed upon payment due of $40.00 or $_____ (_____) per session. Initials

_____ _____

Client's (or responsible party) Signature Date

STAND IN HOPE, LLC
Journey Toward Your Purpose

Court and Legal Proceedings

I understand that Stand In Hope, LLC and Catrina Scott, LPC does **NOT** provide disability determination, custody studies, or handle court issues.

- The legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. The client-therapist relationship is built on trust with the foundation of that trust being confidentiality. It is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify, however factual or in an expert nature, in court or deposition.

- If you are requesting forms for determination of mental illness, disability, court involvement with custody or assessments to be completed, we would be happy to refer you to practitioners in the area who offer this service.

- Should we be called to court by a judge, court order, or are subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a $16.25 processing fee, plus $1.25 per page for copying.

- In the event that it is necessary, (by court order or by subpoena), for the therapist to testify before any court, arbitrator, or other hearing officer or testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her time.

- Including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorney's, reviewing records in preparation of reports @ the rate of **$500.00 per hour when the therapist leave his/her front door until he/she returns, rounded to the nearest half hour.**

- The client further agrees to pay a retainer fee of **$2,000.00 two weeks prior** to the appearance, presentation of records, or testimony requested. These services are to be paid by credit/debit card only.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at Stand In Hope, LLC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. My informed consent signature shows that this litigation limitation is clearly understood and agreed to.

Client Name (Print): _____

Client Signature: _____ Date : _____
(Parent/Guardian signature if client is a minor)

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Returned Checks/Unprocessed Credit Cards

I understand that a charge of $35.00 will be assessed for an unpaid bank transaction and future sessions will require payment in cash (exact amount as change is not kept on the premises) in addition to the $35.00 with no exceptions. Clients paying with credit cards that cannot be processed will be required to provide alternate credit card information when contacted via telephone by their therapist or bring their payment in cash (exact amount as change is not kept on the premises) prior to or at the time of their next session. Future sessions will not be scheduled unless bank transaction/credit card payment is made. Uncollected fees may be recovered by being referred to a collection agency if not paid within 30 days.

By signing below I attest that I have read and agree to the above terms.

_____ _____

Signature of Client/Parent or Guardian if client is a minor Date

Therapist: _____

STAND IN HOPE, LLC
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Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information (PHI) private and secure. Emails and texts are very convenient ways to handle administrative issues like scheduling or receipt requests, but email and texts are not 100% secure. Some of the potential risks you might encounter if we email or text includes:

- Misdelivery of email/text to an incorrectly typed address.
- Email/text accounts can be "hacked," giving 3rd party access to email/text content and addresses
- Email/text providers (e.g. Gmail, Comcast, Yahoo, etc.) keep a copy of each email/text on their servers, where it might be accessible to employees, etc.

For these reasons, I will not use email/text to discuss clinical issues (i.e., the important things we talk about in session).

If ***you are*** comfortable doing so, I am happy to use email/text (text for appointment reminders only) to handle small administrative matters like scheduling and billing.

If ***you are not*** comfortable with these risks, we can handle administrative issues via phone calls.

Please indicate your preference about email/text below and sign.

_____ I do consent to use of email and/or text for administrative matters.
Initials

_____ I do not consent to use of email and/or text for administrative matters.
Initials

If given, consent will expire 2 years after our last appointment. Please remember appointment reminders **will be** sent only via emails or texts. I will respond to you very briefly via email or text.

_____
Patient's Name

_____ _____
Patient/Legal Guardian Signature Date

STAND IN HOPE, LLC
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Property Destruction/Inappropriate Behavior Agreement

At Stand In Hope, LLC we strive to offer the most attractive, tranquil, healing and soothing environment possible while you and/or your loved one receives therapy. That is one of the things that separate us from many other clinics.

In order for us to accomplish this goal we need to make sure everyone respects other people here, the clinic and all property within and without. Unless everyone does his or her part Stand In Hope cannot continue to be the environment that we feel sets us apart and that you know is a safe haven to come and improve your life.

Please read and sign below to indicate you understand your liability should property be damaged while you are here or behaviors become disruptive to the point others are inconvenienced and/or the therapy of another is interrupted.

I understand that I am responsible for the cost of any property including all marketing materials, giveaways, furniture of any kind, artwork, rugs/carpets/floor, walls, fountains, plants, etc. that is destroyed while I or my loved one receives therapy. The minimal fee for destroyed property is $25.00 to be paid prior to you leaving the clinic. The cost will increase per the owner's discretion based on the type and amount of property destroyed.

_____

Patient (Please print)

_____

Responsible Party Date

I understand that if while in the clinic my behavior or the behavior of my loved one becomes offensive and/or disruptive I/we may be asked to leave the clinic.

_____

Responsible Party Date

Thanks for your help in keeping Stand In Hope the place where people feel safe to return.

Catrina Scott, Ms, LPC Owner and all other Stand In Hope Clinicians

STAND IN HOPE, LLC
Journey Toward Your Purpose

Pre-Authorized Charge Form (REQUIRED)

I authorize Stand In Hope, LLC to keep my signature on file and to charge my Insurance or Credit Card listed below for:

_____ All benefits due under said policy/policies by reasons of services rendered
Initial

_____ Balance of charges not paid by insurance within 90 days. N/A for clients treated by LPC Associates.
Initial

_____ Session fee of **$ 40.00** for missed appointments and late cancellations.
Initial

Please be advised 3rd party payers (i.e., insurance companies) will not reimburse your therapist for your missed appointment. Consequently you will be responsible for the above agreed amount when appointments are missed or not cancelled within 24 hours. Medicaid members will not be charged per state law, however your therapeutic relationship can and may be terminated following 3 missed appointments.

I have carefully read and understand the above agreements, and authorizations and any questions have been fully answered. A photocopy of this document shall be considered as effective and valid as the original.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer's Name: _____

Cardholder's Name: _____

Card Type:

☐Visa ☐MasterCard ☐Discover ☐American Express

Card Number: _____ Billing Zip Code: _____

Expiration Date: _____ Card Verification Number: _____

Cardholder's Signature: _____ Date: _____

STAND IN HOPE, LLC
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client's Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: