ENLIGHTEN THERAPEUTIC & CONSULTING SERVICES, LLC

"Transforming Minds One Person at a Time"

Date: _____

CLIENT INFORMATION

Name: _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Race: _____ Sex: □M □F Marital Status: _____ Date of Birth: _____

Age: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security: _____

Living Situation: □ Spouse/Significant □ Parent □ Children □ Other _____

Employer/School: _____

If client is a minor: Name of
Parent(s)/Guardian(s):_____

REFERRAL SOURCE:

Name: _____ Relationship: _____

Phone: _____Fax: _____

Address: _____City:_____ State: ____ Zip: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship: _____

Address: _____City: _____State: ____Zip:_____

Home Phone: _____ Work Phone: _____

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INSURANCE INFORMATION

Please provide a copy of your insurance card. If you do not have your insurance card, please complete the information below.

Insurance Details

Policyholder's Name: _____ Policyholder's SSN: _____

Date of Birth: _____ Primary Insurance Co. Name: _____

Insurance Company's Customer Service Phone #: _____ Insurance ID # _____

Policyholder's Employer: _____ Group #: _____

Co-pay$ _____ Deductible □ Yes □ No Amount $_____

Authorization Required? □ Yes □ No Authorization #: _____

Number of Sessions Authorized: _____

Maximum Number of Sessions Allowed Per Year: _____

Is the client covered under a secondary insurance policy? □ Yes □ No

By signing below, you are providing Enlighten Therapeutic & Consulting Services, LLC with authorization for release of information for transactions and assignment of benefits for claims associated with each session.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

Enlighten Therapeutic & Consulting Services, LLC will only complete filing of primary insurance provider. If there is additional filing required, client or parent/guardian will be responsible for any unpaid balances or additional filing with insurance provider

Phone: 301.356.3818 ▪ Fax: 240.250.5521 ▪ Email: khall@enlightentherapeutic.com

CLIENT BILL OF RIGHTS

- Every client has the right to be treated with dignity and respect.
- Every client has the right NOT to be discriminated against regardless of age, color, disability, ethnicity, gender, national origin, race, religion, or sexual orientation.
- Every client has the right to privacy (unless specialized circumstances require disclosure – see Notice of Privacy Practices).
- Every client has the right to receive individualized treatment, in an appropriate therapeutic setting, and participate in the treatment planning process.
- Every client has the right to review and revise their treatment plan.
- Every client has the right to review their treatment record. A written summary of services provided, and your progress can be provided, with written request and permission.
- Every client has the right to have their records kept strictly confidential (unless specialized circumstances require disclosure – see Notice of Privacy Practices).

I,_____(Name), was given the Client's Bill of Rights. I have read it in its entirety and/or had it read to me in its entirety – and was explained to my satisfaction.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

Client Name _____

ACKNOWLEDGEMENT OF CONSENT OF SERVICES & AGENCY POLICIES

Your signature below indicates that you agree to participate in therapy services.

Your signature below indicates that you have received and read the consents and policies listed below.

- Client's Bill of Rights
- Informed Consent
- Notice of Privacy Practices
- Telehealth Policy
- Email Communication Policy

By signing below, you agree to abide by the terms set during our professional relationship.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize Enlighten Therapeutic & Consulting Services, LLC to release and/or exchange the following written and/or verbal information about myself or my child's treatment, to the agency or person listed below:

Agency Name: _____

Contact Person: _____

Address: _____

Phone: _____

Information to be released or exchanged:

____ Verbal Communication Exchanges

____ Discharge Summary

____Mental Status

____Substance Abuse History

____Treatment Plan

____Biopsychosocial Assessment/Intake

____Summary of Treatment Progress

____Verbal or Written Verification of Attendance Record (Dates/Times)

This authorization expires, _____ one (1) year from the date of signature below, unless revoke prior to that date.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

PRIMARY CARE PHYSICIAN

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize Enlighten Therapeutic & Consulting Services, LLC to release and/or exchange the following written and/or verbal information about myself or my child's treatment, to the agency or person listed below:

Agency Name: _____

Contact Person: _____

Address: _____

Phone: _____

Information to be released or exchanged:

____ Verbal Communication Exchanges

____ Discharge Summary

____Mental Status Exam

____Substance Abuse History

____Treatment Plan

____Biopsychosocial Assessment

____Summary of Treatment Progress

____Verbal or Written Verification of Attendance Record (Dates/Times)

This authorization expires, _____ one (1) year from the date of signature below, unless revoke prior to that date.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

APPOINTMENT REMINDERS

You have the option to receive an appointment reminder. Please choose one of the optionsbelow:

□ I do not wish to receive any reminder.

□ I consent to Email Only (See Email Consent)

□ I consent to Text Only

□ I consent to Text and Email (See Email Consent)

□ I consent to Text or Call, and Email (See Email Consent)

Email reminders are sent about 2 days before your appointment and text (SMS) or phone reminders are usually sent 1 day before your appointment.

If you are choosing to receive your appointment reminder via email, please add khall@enlightentherapeutic.com to your address book. This will reduce the change that reminderemails will go into spam/junk folders.

If you are choosing to receive your appointment reminder via text (SMS), please note that additional rates may apply. You are encouraged to check your cell phone carrier regarding thoserates.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

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TREATMENT PLAN SIGNATURE PAGE

Client Name: _____

Treatment Plan Start Date: _____ Treatment Plan End Date: _____

Your signature below indicates your collaboration and agreeance of your current treatment plan. A copy of this treatment plan is available for records, per your request.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____

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Telehealth Informed Consent Form

I, _____, consent to engaging in telehealth with Enlighten Therapeutic & Consulting Services, LLC as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications. I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Enlighten Therapeutic & Consulting Services, LLC that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be bettered served by other interventions I will be referred to a mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Zoom, Facetime, GoToMeeting, and Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Enlighten Therapeutic & Consulting Services, LLC or its staff liable for gathering or use of client information by these service providers.

5) Should telehealth option fail, I would like to use the following back up option:

_____

6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

Your signature below indicates that you have read the information in this Telehealth Notice of Privacy Practices and agree to abide by its terms during our professional relationship. You need only print this last page together with the other requested forms.

Client's Signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

Therapist Signature: _____ Date: _____