

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

OUTPATIENT TELEHEALTH CLIENT INFORMED CONSENT

Telehealth is the use of electronic information and communication technologies by a Mental Health Provider to deliver services to an individual when he or she is located at a different site than the client.

I, Jeff Doe, agree to participate and receive therapy via the use of a HIPAA compliant platform video telehealth delivery system. I will be receiving mental health services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of mental health care delivery and that my therapist will not be physically in the same room as me.

By signing below, I/we understand and agree to the following:

- I understand that I have the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which I am currently receiving or would otherwise be entitled. I understand that my participation in this is voluntary, and I may decide to terminate my treatment at any time.
- I also understand that there are several benefits of receiving telehealth services that have been identified including increased access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services.
- I understand that there are potential risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist and Integrated Therapy Solutions of Ok, LLC, that the transmission of my telehealth session could be disrupted or distorted by technical failures. Furthermore, with telehealth, I understand there is the risk of being overheard by anyone near me if I do not place myself in a private area and protected from other's intrusion. I understand that I maintain sole responsibility for ensuring the privacy of my surroundings when participating in telehealth sessions. I also understand with any form of mental health services despite my efforts and the efforts of my therapist that my mental health issues may not get better.
- I understand that telehealth is not always appropriate for emergency medical and suicidal ideations and if such emergencies arise, I will be required to seek face to face consultation and evaluation, and by signing this consent, I agree in advance to seek such care if I or my provider deem this necessary.
- I understand that my privacy and confidentiality will be protected in the same manner if I were to receive therapy face to face with my therapist in the same room. I understand that I am responsible for providing a confidential setting in my location. I understand the laws that protect privacy in the confidentiality of medical information also apply to telehealth. As always, OHCA will have access to medical records for quality review/audit.
- I understand that there will be no recordings of my therapy sessions. I also agree to not record my own therapy sessions without my therapist's knowledge or permission.

I give my consent to receive mental health services through a telehealth HIPPA compliant platform that I agree to use with my therapist. I also understand that the telehealth services I receive will become part of my mental health records.

Jeff Doe

Client Signature

8/21/2025

Date

Client Parent/Guardian Signature

Date

M. Lee MA LPC-S 8/21/2025

Staff Signature & Credentials

Date

Doe, Jeff

-all intakes

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Court Action/Legal Fees Agreement

Records Requests – PER CLIENT/PER REQUEST

A charge of up to \$10.00 may be collected for administrative costs.

A fee, not to exceed \$5.00, for certifying the medical records may also be charged. The cost of postage may also be charged.

Fees for copying documents may be: \$25.00 flat rate for the first 100 pages /\$0.10 for each page copied in excess of 100 pages

Writing a Treatment Summary - PER CLIENT/PER REQUEST

A flat rate fee of \$200 may be charged for each treatment summary requested. We do require 10 business days turnaround when requesting this information.

Court Related Fees: PER CLIENT/PER REQUEST

I/we understand that clients are discouraged from having their therapist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that the testimony will be solely in your favor. Your provider can only testify to the facts of the case and not to any professional opinion. By initialing this line, you acknowledge that your provider's testimony cannot include anything other than fact, per state licensing regulations and acknowledge that your provider is not an expert witness.

I/we acknowledge that if any court involvement is required and the court orders the therapist to participate, or if a subpoena is received for the therapist, or the therapist attendance is requested, the following fees are due *before* the therapist will take any action.

The minimum charge for a court appearance: **\$1500**

A retainer of \$1500 is due 14 days in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 72-hour notice there will be an additional \$500 "express" charge.

Additionally, if the case is reset with less than 72 business hours' notice, then the client will be charged \$500 (in addition to the retainer of \$1500 becoming non-refundable). In order to appear in court, the therapist must cancel sessions and rearrange services for other clients who may not be able to reschedule on short notice.

The following fees apply for court involved cases: (PER COURT APPEARANCE/SUBPOENA)

- | | |
|--|--|
| ➤ Preparation time (including submission of records): \$200/hour | ➤ Mileage: \$0.40/mile |
| ➤ Phone calls/consultations related to the case: \$200/hour (with any attorney/GAL, legal representation, DHS case worker, etc.) | ➤ Time away from office due to depositions or testimony: \$200/hour (includes travel time to and from) |
| ➤ Depositions: \$200/hour | ➤ All attorney fees and costs incurred by the therapist as a result of the legal action. |
| ➤ Time required in giving testimony: \$250/hour | ➤ Additional fees not specifically covered. |

I/we understand that non-compliance with the fee schedule or non-payment will result in immediate termination of the counseling relationship and immediate discharge of the client.

I/we have read the Court Action/ Legal Fees Agreement, understand all of its content and sign my/our name(s) here freely, voluntarily and without coercion.

Angie Doe 8/21/2025
Signature of Client (if 12 years or over) Date

James Doe 8/21/2025
Signature of Parent/Guardian Date

Malen Maypc-s 8/21/2025
Signature of Staff with Credentials Date

Doe, Angie

- medicaid only

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FEE SCHEDULE AGREEMENT

Client Fiscal Responsibility Policy

I understand that I am expected to pay the agreed upon fee at the time services are rendered.

Proof of income may be required. (Copy of income tax return or recent pay stub.)

The fee for intake services is \$250.00 per intake.

The fee for psychotherapy services is \$200.00 per hour.

The fee for psychosocial rehabilitation and case management is \$50.00 per hour.

Group Psychotherapy is \$20.00 per person per hour.

Group Psychosocial rehabilitation is \$10.00 per person per hour.

I will talk to my therapist if I am unable to for any reason to abide by the above regulations.

*****Requests for court-related services may incur additional costs as they are not SoonerCare approved services. These services have a base rate of \$200 PER HOUR.***

Medical Records Requests: Base rate is \$25 for the first 75 pages and \$0.10/per page after + cost of mailing (if requested). Invoice must be paid in full before request is processed.

I understand that I am expected to pay my insurance co-payment in the amount of \$ 0 at the time services are rendered for therapy services. (Court costs and medical records requests not included)

Sliding Scale Fee has been adjusted from 100% to 0 %, due to: SoonerCare Coverage.

(We) agree to the (adjusted) fee of \$ 0. (Court costs and medical records requests not included)

I acknowledge that failure to provide appropriate insurance information, including coverage other than SoonerCare will result in full financial responsibility for any sessions and services accrued.

Angela Doe 8/21/2025 Malene MA LPC 8/21/2025
Client/Guardian Signature Date Staff Signature with Credentials Date

-all intakes

**Client Acknowledgement of
HIV/A.I.D.S./STD & TB EDUCATION & REFFERAL**

Integrated Therapy Solutions of Oklahoma, LLC offers information and referral for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD), and Acquired Immunodeficiency Syndrome (AIDS) and Tuberculosis (TB). Information/Education/Referral is for consumers, all drug dependent persons, and the significant other(s) of the consumer(s). Documentation of this is either by acknowledgement of Client Handbook or Clinical Consultation note in the consumers record. Referral and documentation is confidential.

CONFIDENTIAL AND ANONYMOUS COUNSELING AND TESTING SITES IN OKLAHOMA:

HIV/STD: GUIDING RIGHT * 7901 NE 10th, Suite A-111 in Midwest City, OK 73110 * 405-733-0771
RAIN Oklahoma * 600 NW 23rd, Suite 101 in Oklahoma City, OK 73103 * 405-232-2437
RED ROCK BH SCIENCES * 4400 N. Lincoln Blvd in Oklahoma City, OK 73105 * 405-425-0473
COMMUNITY HEALTH CENTER * 12716 NE 36th in Oklahoma City, OK 73140 * 405-769-3301
TB: OKLAHOMA COUNTY HEALTH DEPT. * 400 NE 50th in OKC, OK 73105 * 405-419-4000
MED-EVAL CLINIC * 4001 N. Classen Blvd, #101 in Oklahoma City, OK 73118 * 405-840-2180

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION BY CLIENT:

(Both lines must be completed – N/A on Significant Other if needed)

AD I, (and my significant other, if applicable) have received the HIV/A.I.D.S./STD & TB Education Information and have been offered referrals for testing for these conditions.
_____, I, as the significant other of _____, have received the HIV/AIDS/STD & TB Information and have been offered referrals for testing for these conditions.

I DO WISH to be referred* for testing for (circle as many as desired): HIV/A.I.D.S. - STD - TB

* Client was referred to: (if they want referred, write place in here)

* Significant other was referred to: _____

-- OR -- *(Both lines must be completed – N/A on Significant Other if needed)*

PD I DO NOT WISH to be tested or referred for HIV/A.I.D.S./STD & TB (client)
_____, I DO NOT WISH to be tested or referred for HIV/A.I.D.S./STD & TB (significant other)

Acceptance of this form in the client record indicates that this Integrated Therapy Solutions of Oklahoma, LLC client has received basic HIV/A.I.D.S./STD/TB prevention education.

Amelia Doe 8/21/2025
Client/Guardian Signature Date

Significant Other (if applicable) Signature Date

Malee Maype 8/21/2025
Therapist Signature with Credentials Date

05.2023

-all intakes

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CLIENT ORIENTATION REVIEW & ACKNOWLEDGEMENT

I/we received the Integrated Therapy Solutions of Oklahoma, LLC Client Handbook, and reviewed it with the intake counselor. By signing below, I/we acknowledge that I/we have reviewed each area below and asked questions as needed to fully understand each section and subject below.

Welcome to ITS-OK, LLC (p.2)

ITS-OK, LLC Privacy Policy (p.12-15)

Descriptions of Services Offered (p.8)

HIV/AIDs/STD Education & Testing Locations (p.18)

Program and Participation Rules (p.6)

Emergency Evacuation Procedures (p.11-12)

Confidentiality of Records (p.8)

Consent for Follow-Up/Satisfaction Survey (p.7)

Consumer Rights (p.3-6)

Grievance Policy (p.6)

Good Faith Estimate (p.16-17)

Discharge Policy (p.10)

Consent for Follow Up

I, Amelia Doe (Patient, Parent/Legal Guardian if applicable) authorize Integrated Therapy Solutions of Oklahoma, LLC to contact me by phone/mail/in person for the purpose of evaluation of treatment progress, service satisfaction and other information as deemed necessary in order to enhance the quality of care. ☒ Yes ☐ No

By signing below, I/we understand and agree to the following:

I/We agree to notify the agency in advance if unable to keep a scheduled appointment.

I/We agree to notify the agency of any changes to my address or phone number.

I/We understand that missing *three consecutive scheduled appointments* may result in discharge.

I/We have received the synopsis of the Consumer Bill of Rights in the Client Handbook.

I/we acknowledge that failure to provide appropriate insurance information, including coverage other than SoonerCare will result in full financial responsibility for any sessions and services accrued.

****Requests for court-related services may incur additional costs as they are not SoonerCare approved services. These services have a base rate of \$200 PER HOUR.**

Medical Records Requests: Base rate is \$25 for the first 75 pages and \$0.10/per page after + cost of mailing (if requested). Invoice must be paid in full before request is processed.

Amelia Doe 8/21/2025

Signature of Client, 12 and older

Date

Signature of Parent/Guardian (if applicable)

Date

Malu Mays 8/21/2025

Signature of Staff with Credentials

Date

Doc, Amelia

- not required
- all intakes

Integrated Therapy Solutions of Oklahoma, LLC

Release of Confidential Information

I understand that the medical records requested are protected under the Federal and State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for in the regulations. State and Federal laws and regulations prohibit any further disclosure without the specific written consent of the subject or as otherwise permitted by such regulation. I also understand that the signing of this consent may be revoked **(in writing to the program coordinator or designee)** at any time unless action has already been taken based upon it and that in any event this consent expires one year from the date of signature.

I, Angela Doe
(Name of requesting party)

Request That Information Concerning: Jane Doe
(Print Name of Client)

DOB 7/11/2012

Be released and authorized from:

Ivy Psychiatry 555 NW 5th Moore, OK 73160
(Name/Agency) (Address) (City, State, Zip)

To exchange with:

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D
Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

The following written verbal and/or electronic information – **including an explicit description of the substance use disorder information that may be disclosed:** (Kind and/or extent of information to be released) progress notes,

treatment plan, diagnoses, verbal/written communication with therapist

To be released for the following purpose(s): Care coordination

I understand that the information I authorize for release may include records which may indicate the presence of a communicable or venereal disease, which may include but are not limited to, substance use or abuse disorders; diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). **The release of information form has been explained to me and the consent has been given of my own free will.**

It has been explained to me that my treatment services are not contingent upon or influenced by my decision concerning the release of information.

Angela Doe
(Signature of client or legally authorized representative)

8/21/2025
Date

I request this Consent for Release to expire on 8/21/2026

Client/Guardian Initials AD

Malu Mayors
(Signature of staff requesting release)

8/21/2025
Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RIsofInfo.01.05.2025

Doe, Jane

-all intakes

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TRANSITION PLAN

Client's name Jane Doe Insurance# _____ (referral date) Admit date 8/2/2025

How will you know that you are nearing completion of services and ready to transition into your community? (to be asked of client at assessment- direct quote required):

"When I feel like the trauma doesn't control me."

Below this line to be completed at Discharge:

Progress (In client's own words): ↓ all this is for discharge

Gains (In client's own words): _____

Strengths/abilities _____

Needs/liabilities _____

Presenting problem (from intake) _____

The following care services have been developed with my knowledge and cooperation. My response regarding these plans is as follows: _____

Referral Source: (Name, contact information, agency, hours available) _____

Below this line to be completed at Discharge:

Client Signature (if over 12) _____

_____ Date

Guardian Signature _____

_____ Date

Therapist Signature & Credentials _____

_____ Date

Doe, Jane

-private insurance
only

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FEE SCHEDULE AGREEMENT – PRIVATE INSURANCE

Client Fiscal Responsibility Policy

I understand that I am expected to pay the ***agreed upon fee*** at the time services are rendered.

Proof of income may be required for sliding scale options. (Copy of income tax return or recent pay stub.)

****These are the cash rates charged by ITS of OK and the rates billed to insurance – contracted rates can vary by insurance company.**

The fee for intake services is \$250.00 per intake.

The fee for psychotherapy services is \$200.00 per hour.

The fee for psychosocial rehabilitation and case management is \$50.00 per hour.

Group Psychotherapy is \$20.00 per person per hour.

Group Psychosocial rehabilitation is \$10.00 per person per hour.

*****Requests for court-related services may incur additional costs. These services have a base rate of \$200 PER HOUR.***

I understand that I am expected to pay my session fees not covered by insurance, fees due as part of co-insurance or deductibles required by insurance at the time services are rendered – or if a missed appointment fee is charged.

I agree to provide Integrated Therapy Solutions of Oklahoma, LLC with a credit/debit card to keep on file to bill sessions fees AND MISSED APPOINTMENT FEES; I consent to the billing of session fees through a remote biller.

Past Due Accounts: If your account becomes past due, and we have to refer your account to a collection agency, you agree to pay a collection fee of 35% of your delinquent amount. If the collection agency is unable to collect your balance due and pursues litigation, you agree to pay an increased collection fee of 50% of your delinquent amount.

Angela Doe

Client/Guardian Signature

Date

8/21/25

Maureen Mayors

Staff Signature with Credentials

Date

8/21/2025

08.2023

Client Name: Doe, Angela

-cash pay/intern/
probono only

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Opt Out Insurance Form

By signing below, I/we understand and agree to the following:

- I have selected not to use my insurance for my counseling sessions.
- I understand that opting out of using my insurance means I must pay out of pocket for the counseling sessions. I am eligible for the sliding fee scale if I choose to opt out. The agreed fee for opt out services is: \$125
- I have made my therapist aware that I have opted to not use my insurance for counseling sessions even if she/he is in network or out of network.
- I have agreed to let my therapist know if anything changes and I either obtain alternative insurance and/or decide that I would like my sessions billed to my insurance.
- I understand that if I opt out of using my insurance, I cannot use the payment of sessions towards my deductible because I have elected to opt out of using my insurance.
- I understand that if I choose to later use my insurance my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance. My opt in to use insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.

Jane Doe 8/21/2025 Angela Doe 8/21/2025
Signature of Client (if 14 years or over) Date Signature of Parent/Guardia Date

Mallory MA LPC-S 8/21/2025
Signature of Staff with Credentials Date

-all intakes

INTEGRATED THERAPY SOLUTIONS OF OKLAHOMA, LLC

CONSENT FOR TREATMENT

1. I, We (Parent, legal guardian if applicable) authorize **Integrated Therapy Solutions of Oklahoma, LLC** and representative mental health and substance abuse providers to administer treatment to me and to continue such treatment as deemed professionally necessary.
2. I/We do hereby authorize psychiatric, psychological, diagnosis or treatment by a physician, therapist and /or authorized mental health provider by **Integrated Therapy Solutions of Oklahoma, LLC**. Treatment may be rendered to said client under general, specific or special consent of **Integrated Therapy Solutions of Oklahoma, LLC**, whether such diagnosis or treatment is rendered at the office of the psychiatrist, therapist, or provider. I understand that this consent is given in advance of any specific diagnosis of treatment being required, but is given to encourage and authorize those persons, (physicians, providers) to exercise their judgment as to the requirements of such diagnosis or psychotherapeutic treatment.
3. I/We further agree to be actively involved in the treatment plan as prescribed by the treatment team of **Integrated Therapy Solutions of Oklahoma, LLC** while the client is in treatment. I/We understand that included in such treatment plan would be my/our involvement in regular family, individual, or group therapy sessions, scheduled in accordance with State, Federal and/or pay or source guidelines.
4. No guarantees or assurance have been given by anyone to the results that may be obtained.

This consent shall remain in effect commencing on the date of admission to **Integrated Therapy Solutions of Oklahoma, LLC** unless sooner revoked in writing and delivered to said physician, therapist, or provider of **Integrated Therapy Solutions of Oklahoma, LLC**.

By signing below, I/we understand and agree to the following:

I/We understand that **Integrated Therapy Solutions of Oklahoma, LLC** provides these services regardless of the client's ability to pay. If able I/we agree to pay when services are rendered and charged.

I/We have read the Consent for Treatment form, understand all its content and sign my/our name(s) here freely, voluntarily and without coercion.

I/We agree to give 24-hour notice of cancellation if not participating in planned services and understand that by consistently not showing up for planned services, the treatment plan may be reviewed by treatment staff to determine the appropriateness of continued treatment or discharge.

I/We have provided the information in the Initial Intake Packet and, upon review, find it to be accurate to the best of my/our knowledge.

I/We have read and received the Privacy Practice Notice Forms and this information been discussed with me, and I/we understand how my health information will be handled and used through **Integrated Therapy Solutions of Oklahoma, LLC**.

I/We have read and received the Client Grievance Policy and Procedure Form and has been discussed with me, and I/we understand that if there is a grievance I/we may file a complaint with the Grievance Officer.

Amelia Doe 8/21/2025
Signature of Client (if 12 years or over) Date

Signature of Parent/Guardian Date

Malen Mays 8/21/2025
Signature of Staff with Credentials Date

- CASH pay /
intern / probation
intake only

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FEE SCHEDULE AGREEMENT

Client Fiscal Responsibility Policy

I understand that I am expected to pay the agreed upon fee at the time services are rendered.

Proof of income may be required. (Copy of income tax return or recent pay stub.)

The fee for intake services is \$250.00 per intake.

The fee for psychotherapy services is \$200.00 per hour.

The fee for psychosocial rehabilitation and case management is \$50.00 per hour.

Group Psychotherapy is \$20.00 per person per hour.

Group Psychosocial rehabilitation is \$10.00 per person per hour.

I will talk to my therapist if I am unable to for any reason to abide by the above regulations.

*****Requests for court-related services may incur additional costs. These services have a base rate of \$200 PER HOUR.***

I understand that I am expected to pay my session fee in the amount of \$ 75 at the time services are rendered – or if a missed appointment fee is charged. Missed session fee: \$50

Client Gross Income (Yearly) \$ 86,000
Family Size, including dependents 4

Sliding Scale Fee has been adjusted from 100% to \$75, due to: sliding scale

(We) agree to the (adjusted) fee of \$ 75.

By signing below, I agree to provide Integrated Therapy Solutions of Oklahoma, LLC with a credit/debit card to keep on file to bill sessions fees AND MISSED APPOINTMENT FEES; I consent to the billing of session fees through a remote biller.

Past Due Accounts: If your account becomes past due, and we have to refer your account to a collection agency, you agree to pay a collection fee of 35% of your delinquent amount. If the collection agency is unable to collect your balance due and pursues litigation, you agree to pay an increased collection fee of 50% of your delinquent amount.

Angela Doe
Client/Guardian Signature

8/21/2025
Date

DMallen MA LPC-S
Staff Signature with Credentials

8/21/2025
Date

Fee Sched Cash Pay 01.2025

Client Name: Doe, Angela

-priv insurance only

Integrated Therapy Solutions of Oklahoma, LLC

620 NW 5th St. Suite D. Moore, OK 73160
Phone: (405) 208-4469 Fax: (405) 208-4472

Consent to Bill Private Insurance

By signing below, I/we understand and agree to the following:

Consent for Release of Information:

I hereby voluntarily consent for Integrated Therapy Solutions of Oklahoma, LLC to submit claims to My Health Care Insurance Company for billing purposes and coverage.

I authorize the release of any medical or other information from Integrated Therapy Solutions of Oklahoma, LLC to process insurance claims to my insurance company, for billing purposes and coverage.

Authorize Payment:

I authorize payment of medical benefits to Integrated Therapy Solutions of Oklahoma, LLC by my Health Care Insurance Company, for mental/behavioral health services provided.

Payment Responsibility:

I understand that I am responsible for keeping my insurance active.

I understand that late cancellations/missed appointment fees are not covered by insurance.

I understand that court-related services are not covered by insurance and have a base rate of \$200/hr.

I understand that health insurance companies require a diagnosis in order for them to cover service fees. If you have met your deductible (according to your insurance company) you will only pay your usual co-pay amount. If you have not reached your deductible (according to your insurance company), you will pay the full session fee at the time of the session, and that amount will be added to help you reach your deductible. At first contact, Integrated Therapy Solutions of Oklahoma, LLC can help you determine what your copay may be but be aware that insurance companies cannot guarantee what they will cover ahead of time.

Please understand that if you do have secondary insurance and don't provide the information, the first insurance company can demand a refund of what they have covered, in which you will be responsible for covering that cost. There is no guarantee that the secondary will cover that cost.

I agree to provide Integrated Therapy Solutions of Oklahoma, LLC with a credit/debit card to keep on file to bill co-pays; I consent to the billing of co-pays through a remote biller. Integrated Therapy Solutions of Oklahoma, LLC agrees to contact me before billing any amount other than the co-pay in the event that insurance does not cover the full amount. (with the exception of VA clients which covers at 100%)

By initialing this box, you acknowledge and understand the terms and conditions described above. THIS IS REQUIRED TO RECEIVE TREATMENT

Angela Doe

8/21/2025

Signature of Client (if 18 years or over)

Date

Signature of Parent/Guardian

Date

Malu Anapc-s

8/21/2025

Signature of Staff with Credentials

Date

- all intakes and
all extensions

- every page in signature
page folder

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

Client Name: Amy Doe

Client Age: 41

Date Completed: 8/24/2025

Start Time: 3:45

Stop Time: 4:18 PM

SERVICE PLAN SIGNATURE PAGE

CLIENT ACTIVE PARTICIPATION STATEMENT: I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

"I worked with Destani to create a plan to work on my old symptoms."

Amy Doe
Member Signature, 12 or older

8/21/2025
Date

Parent/Guardian Signature

Date

*Adult members: Has the Treatment Plan Advocate form been completed and signed? ☒ Yes ☐ No

Has the Advanced Directive/Living Will form been completed and signed? ☒ Yes ☐ No

(Attach to signature page and submit together – required by OHCA and ODMHSAS)

If unable to legibly sign, document reason: _____

Onalene MA LPC-S
Responsible LBHP Signature, Degree/License/Under Supervision

8/21/2025
Date

Agency Supervising LBHP Signature & Credentials

Date

TREATMENT TEAM:

Service Type	Treatment Methodology	Frequency of Service(Week/Month)	Provider Name & Credentials
Individual Therapy	<u>CBT</u>	<u>1x week</u>	<u>Onalene MA LPC-S</u>
Group Therapy			
Family Therapy	<u>family systems</u>	<u>biweekly</u>	<u>Onalene MA LPC-S</u>
Rehab-Individual	<u>learn & practice</u>	<u>4 units/week</u>	<u>rehab provider</u> <u>name & credentials</u> <u>case manager</u> <u>name & credentials</u>
Case Management	<u>refer, link, monitor, advocate, follow-up</u>	<u>up to 12 units/mo</u>	
Telehealth	<u>CBT</u>	<u>as needed</u>	<u>Onalene MA LPC-S</u>
Other			

All intakes (18+)

Integrated Therapy Solutions of Oklahoma, LLC

620 NW 5th St. Suite D

Moore, Oklahoma 73160

Ph: (405) 208-4469 Fax: (405) 208-4472

Client Name: Amy Doe

Insurance ID #: _____

Treatment Advocate Form

All adult clients receiving mental health and/or substance abuse services have the right to name a family member or other individual as a Treatment Advocate. Each consumer has the right to determine the level of involvement and decision given to the Treatment Advocate, and there will be no limitation preventing communication or collaboration between the client and their Treatment Advocate. The consumer may revoke this designation at any time, and for any reason.

Would you like to name a Treatment Advocate? ☒ Yes ☐ No (Must select one)

Please provide the following information to establish your Treatment Advocate:

Name: JAMIE DOE

Address: 620 NW 5th OKC, OK 73122

Phone Number: 405 555 2222

E-mail Address: jamie@doe.net

Please initial the level of involvement you would like to establish for your Treatment Advocate"

- ☒ Attend intake/assessment sessions
- ☒ Assist with treatment planning
- ☒ Receive written copies of the treatment plan
- ☒ Attend therapy sessions
- ☒ Access to Medical Records
- ☐ Other: _____

Amy Doe
Client Signature

8/21/2025
Date

*Treatment Advocate:

I, JAMIE DOE agree to serve as the Treatment Advocate for the above named client. I agree to comply with all confidentiality obligations and will only serve in the capacity stated above by the client.

JAMIE DOE
Treatment Advocate Signature

8/21/2025
Date

All intakes (18+)

Advance Directive for Health Care

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

- (1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

☐ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

☐ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

☐ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

AD See my more specific instructions in paragraph (4) below.

- (2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

☐ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

☐ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

☐ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

AD See my more specific instructions in paragraph (4) below.

- (3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

___ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration

___ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

___ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

AD See my more specific instructions in paragraph (4) below.

(4) OTHER. Here you may:

- (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,
- (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or
- (c) do both of these:

Edraine

AD
Initial

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of _____, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

- ☐ transplantation
- ☐ therapy
- ☐ advancement of medical science, research, or education
- ☐ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the "yes" line below, I specifically donate:

☐ My entire body

Or

☐ The following body organs or parts

- | | |
|---------------------------------------|---|
| ☐ Lungs | ☐ Liver |
| ☐ Pancreas | ☐ Heart |
| ☐ Kidneys | ☐ Brain |
| ☐ Skin | ☐ Bones/Marrow |
| ☐ Blood/Fluids | ☐ Tissue |
| ☐ Arteries | ☐ Eyes/Cornea/Lens |

IV. General Provisions

- a. I understand that I must be eighteen (18) years of age or older to execute this form.
- b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
- c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

- d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
- e. This advance directive shall be in effect until it is revoked.
- f. I understand that I may revoke this advance directive at any time.
- g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
- h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
- i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this 21 day of Aug, 2025.

Amy Doe
(Signature)

Bethany

City of

OKLAHOMA

County, Oklahoma

8/20/1984

Date of birth (Optional for identification purposes)

This advance directive was signed in my presence.

Donald W. M. L. P. S.
Witness

Oklahoma City, Oklahoma
Residence

Witness

_____, Oklahoma
Residence

Adverse Childhood Experience (ACE) Questionnaire

Name: Amy Doe

Date: 8/21/2025

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

Swear at you, insult you, put you down, or humiliate you?

Or

Act in a way that made you afraid that you might be physically hurt?

☒ Yes ☐ No

If Yes, enter 1 1

2. Did a parent or other adult in the household often:

Push, grab, slap, or throw something at you?

Or

Ever hit you so hard that you had marks or were injured?

☐ Yes ☒ No

If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever:

Touch or fondle you or have you touch their body in a sexual way?

Or

Attempt or actually have oral, anal, or vaginal intercourse with you?

☐ Yes ☒ No

If Yes, enter 1 _____

4. Did you often feel that:

No one in your family loved you or thought you were important or special?

Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☒ Yes ☐ No

If Yes, enter 1 1

5. Did you often feel that:

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☒ Yes ☐ No

If Yes, enter 1 1

6. Were your parents ever separated or divorced?

☐ Yes ☒ No

If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

Often pushed, grabbed, slapped, or had something thrown at them?

Or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

Or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ Yes ☒ No

If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

☐ Yes ☒ No

If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

☒ Yes ☐ No

If Yes, enter 1 1

10. Did a household member go to prison?

☐ Yes ☒ No

If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): 4

Adverse Childhood Experience (ACE) Questionnaire

PROVIDER INSTRUCTIONS (Revised April 11, 2019)

Beginning June 1, 2019, the ACE Questionnaire shall be given to all adults ages 18 and older* who are seeking behavioral health services from the ODMHSAS and the OHCA (SoonerCare/Medicaid); with minimal exception**. The ACE score shall be reported on all CDC/PA 23 (admissions) and CDC/PA 42 (6-month updates/extensions). The questionnaire only has to be given once per person, per provider- but the score must be reported/carried forward on all subsequent CDCs like some of the other CDC responses (ex: gender and race are typically reported/carried forward on each CDC and rarely change). Valid ACE Scores should be entered on the CDC in one of the following formats: 00 to 10 or 0 to 10 (00 to 10, double digits, is preferred). For currently admitted/open adult clients, the ACE Questionnaire shall be given at the next 6-month treatment update and reported on the CDC/PA 42 (6-month update/extension).

*Note: This questionnaire should only be given to adults ages 18 and older; it should not be given to children or youth under the age of 18.

**Exceptions: Due to the nature of some levels of care and program types, there are circumstances in which the ACE Questionnaire shall not be required. They are as follows:

- *Community Living (CL) Level of Care* (ex: Homeless, Housing, Residential Care)
- *Service Focus-* 11 (Homeless, Housing, Residential Care); 23 (Day School); 24 Medication Clinic Only; and 26 Mobile Crisis.

GIVING THE ACE QUESTIONNAIRE

The ACE Questionnaire is to be given at the time of clinical assessment (at initial clinical assessment for new clients, and for currently admitted/open clients- at clinical assessment update completed as a part of the service plan update process at 6-month treatment update). This is to ensure ready access to a therapist should one be needed to address any issue that might arise from revisiting childhood trauma.

It is a self-administered instrument and shall be completed by the individual seeking services without intervention from staff (ex: staff may not reframe the question or give explanation regarding the intent of the question). The only assistance that staff may provide is with regard to literacy or vision challenges, and in that instance the introduction statement and questions must be read aloud to the individual exactly as written on the questionnaire. To ensure a trauma informed process, it is important that the introduction statement on the questionnaire is either read by the client or read to the client.

Due to the sensitive nature of the questions, the individual completing the ACE Questionnaire should be given a confidential space in which to complete it. They may choose to have someone with them in the room for support (ex: Peer Support Specialist, family, friend).

Scoring

For each of the ten (10) questions on the questionnaire, the individual will give a Yes or No answer. When scoring, each "Yes" answer will be given one (1) point. These points will be tallied to determine the individuals ACE Score.

Patient Health Questionnaire (PHQ-9)

Patient Name: Jane Doe

Date: 8/21/2025

Time: 12 minutes

Start: 3:01 PM

DO NOT BILL

Stop: 3:13 PM

Not at all Several days More than half the days Nearly every day

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

- a. Little interest or pleasure in doing things ☐ ☒ ☐ ☐
- b. Feeling down, depressed, or hopeless ☐ ☒ ☐ ☐
- c. Trouble falling/staying asleep, sleeping too much ☐ ☐ ☒ ☐
- d. Feeling tired or having little energy ☐ ☐ ☒ ☐
- e. Poor appetite or overeating ☐ ☐ ☐ ☒
- f. Feeling bad about yourself or that you are a failure or have let yourself or your family down ☐ ☐ ☐ ☒
- g. Trouble concentrating on things, such as reading the newspaper or watching television. ☐ ☐ ☒ ☐
- h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual. ☐ ☒ ☐ ☐
- i. Thoughts that you would be better off dead or of hurting yourself in some way. ☐ ☒ ☐ ☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) <u>0</u>	x 0=	<u>0</u>
Several Days	(#) <u>4</u>	x 1=	<u>4</u>
More than half the days	(#) <u>3</u>	x 2=	<u>6</u>
Nearly every day	(#) <u>2</u>	x 3=	<u>6</u>

Total Score: 16

Interpreting PHQ-9 Scores			Actions Based on PH9 Score
		Score	Action
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 – 14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

*PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website [www. Depression-primarycare.org/clinicians/toolkits/materials/forms/phq9](http://www.Depression-primarycare.org/clinicians/toolkits/materials/forms/phq9)

DMallin MArpc-S 8/24/2025
Clinician Signature Date