Turning Leaf Counseling

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Client Informed Consent and Information Form

Client Name: _____ Birth Date: _____

Address: _____ Age: _____

City, State, Zip: _____ Gender: □ Female □ Male

County of Residence:_____ Race:_____

Relationship Status: □ Single □ Married □ Domestic Partner □ Separated □ Divorced □ Widowed

Full Time Student? □ Yes □ No Occupation: _____Social Security # _____

Your Phone # (_____) _____ (_____)_____
Home/Cell OK to contact there? Y N **Work** OK to contact there? Y N

Emergency Contact: _____ _____ (___) _____
Name Relationship to client Phone Number

Parent/Guardian Names if applicable: _____

Parent Guardian E-mail for Contact:_____

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Appointment Reminders: Please indicate form of reminder that will work for you. □ Phone □ E-Mail □ Text

Phone # for Reminders: (____) _____ Email for Reminder: _____

Credit Card

Would you like to have a credit card on file to pay copays and outstanding bills?
□ Yes (Ask about additional form to be filled out) □ No

Insurance

Primary Insurance Information
Insured Name _____
Insured DOB _____
Employer _____
Payer/Health Plan_____
Relationship to Insured: □ Self □ Spouse □ Dependent
Member # _____
Policy/Group # _____
Address if Different from Client
_____

Secondary Insurance Information
Insured Name_____
Insured DOB _____
Employer _____
Payer/Health Plan_____
Relationship to Insured: □ Self □ Spouse □ Dependent
Member #_____
Policy/Group #_____
Address if Different from Client
_____

Client Rights and Informed Consent

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better, because psychotherapy is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my provider report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the Basic Rights of Individuals including:
    - The right to be informed of the various steps and activities involved in receiving services.
    - The right to share in the formation of the plan of care/treatment plan.
    - The right to confidentiality under federal and state laws relating to the receipt of services.
    - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
    - The right to make an informed decision whether to accept or refuse treatment.
    - The right to contact and consult with counsel at my expense.
    - The right to select practitioners of my choice at my expense.

Turning Leaf Counseling Attendance/Payment Policies

No Show and Cancelation Policy: On the Third NO SHOW, you will be removed from the schedule and placed on same day appointment status. You will be automatically charged the $50.00 No Show fee. You may have no more than 2 Cancelation/Late Cancelations in a 6-month period, or will be placed on same day appointment status. You will be automatically charged the $35.00 Late Cancelation fee. ***Co-Payments/Private Pay/Sliding Fee:*** Co-pays, Private Pay, and Sliding Fee are due at time of service. This includes minors, parent/guardian should send co-pay or make arrangements prior to appointment. New patients: If you have No Co-Pay listed on Insurance Card, you will be charged a $50.00 Co-Pay, until Billing indicates Co-payment amount.

Account Amount Due: If you owe more than $200.00 after insurance has been applied, then you need to make a payment towards your account, or establish a payment plan with the front desk. If neither is done, you will be removed from the schedule until this policy is followed.

I understand that my provider, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, discuss medical and medication needs, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan. I further authorize and request that my treating provider carry out mental examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand and accept that my insurance company may request but not limited to, (progress notes, treatment plan, diagnosis, treatment dates, and number of sessions). I authorize TLC to bill my insurance as provided. I assume responsibility for any part of services not covered by my insurance plan. I understand that I will be responsible for any deductibles that have been applied to your account. TLC follows all HIPAA policies as required by the Federal Government, by signing this form you acknowledge that our HIPAA policy is posted in our office and a copy is available upon request.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. A copy will be given upon request only. Other Policies are posted at the front desk, copies will be given upon request only.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent/Guardian/Conservator or Authorized Representative, if required Date

1. Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:

_____

_____

2. What result(s) do you expect from treatment?

_____

_____

3. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Alcohol/Drug Usage	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your tempter	1	2	3	4	5	N/A

EMOTIONAL/PSYCHIATRIC HISTORY

Prior psychotherapy?

Prior provider name City State Date Seen

_____

Prior inpatient treatment for psychiatric, emotional, or substance use?

Inpatient facility name City State Date

_____

List any family history of Psychiatric issues:

_____

MEDICAL HISTORY Current Medication Dosage/Frequency Physician

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____ _____ _____

List name of primary care physician:

Name_____ _____ _____ _____

List name of psychiatrist: (if any)

_____ _____ _____

_____

Are You Allergic to any Medication? □ Yes □ No _____ _____ _____

Please List:_____

_____ _____ _____ _____

Permission to Notify Primary Care Physician

I give permission to contact my primary care physician. Information to be shared is notification letter that I have been seen here for continuum of care. I also authorize contact with my primary care physician as indicated to discuss medical and medication needs.

Doctor's Name: _____

Clinic where they practice:_____

_____ I give permission for Turning Leaf Counseling to notify my primary care physician that I am receiving services and pertinent medical information for continuum of care.

____ I decline to have my primary care physician notified that I am receiving services with Turning Leaf Counseling.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

Office Use Only:

Date letter Sent_____