Embodied Wellness, Inc.

New Client Intake & Consent Form

Date ______________________

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can. Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

General Client Information Name: (Legal/Chosen)__________________________________
Gender: _____________ Pronouns:______________ Age:_________ DOB: ____________
Partner)s) name:____ DOB: ____________
Children name/ages:____
____
Address ____
City: ____________________________ State: ___________ Zip code: __________________
Phone:___________________________ May I leave a Voice Message or TEXT? YES / NO
Email address: _____________________________ Emergency Contact:________________
Relationship: __________________________________ Phone: ________________________
Sexual Orientation: ____________________ Ethnic/Cultural Background: ______________
Religion: _____________ Relationship Status: _______________________________________
Education (highest degree/grade/level):____
Occupation: __________________________ Employer: _______________________________
Referred by: ____________________________

Challenges Checklist -Please check all that apply to you:

_ Depression
_ Fatigue
_ Low self-esteem
_ Poor concentration
_ Lack of interest/enjoyment in life
_ Feeling hopeless
_ Feeling worthless
_ Feeling guilty or shameful
_ Sleep changes (+/-)
_ Loneliness
_ Bad dreams/nightmares
_ Feeling abandoned
_ Appetite changes
_ Mood swings
_ Isolation/withdrawal
_ Feelings of sadness/loss
_ Weight gain/loss
_ Anxiety/tension/worry
_ Panic attacks
_ Finances
_ Insecurity
_ Jealousy
_ Eating Issues
_ Obsessive Thinking
_ Thoughts racing
_ Procrastination
_ Anger/frustration
_ Damaged Trust
_ Easily agitated
_ Postpartum depression
_ Menopause
_ Perfectionist behavior
_ Impulsiveness
_ Compulsive Behaviors (porn)
_ Sexual dysfunction
_ Self injurious behaviors

_ Social support
_ Feeling detached from yourself
_ Grief/bereavement
_ Infidelity
_ Marital/relationship
_ Physical abuse
_ Loss/death
_ Gender Dysphoria
_ Fetish/ Kink
_ Codependency
_Sexual Orientation

_ Family Challenges
_ Feeling “hyper”
_ Health problems
_ Job/career problems
_ Parent/child challenges
_ Sexual abuse
_ Desire Discrepancy
_ Gender Transition
_ Non-Monogamy
_ Co_parenting

_ Feeling “not real”
_ Financial problems
_ Sexual Avoidance
_ Self-criticism
_ Use of alcohol/drugs
_ Trauma
_RelationalAgreement
_ Communication skills
_ Divorce
_ Existential/Spiritual

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:____

Has anything happened that may have brought on/intensified the challenges you are experiencing? Yes No If yes, please explain:

When (month/year) did you first begin to experience these challenges? ________________

How much is/are the challenges affecting you? Mildly Moderately Severely

In what areas do your challenges impact your life?______________________________________

Have you ever attempted suicide? YES NO If yes, when?

Have you been thinking about suicide? YES NO Engaging in Self harm? YES NO

Have you been thinking about harming or killing someone else? YES NO

What medications do you currently take?____

Name of Physician/Prescriber?____

Current Life Experiences

My sources of satisfaction: ____

My support system: ____

My sources of stress: ____

My self-care: ____

____

My leisure activities/hobbies/interests: ______________________________

____

My current life goals: ______________________________________

____

What I hope to gain from counseling/therapy: ____________________________

____

History of Counseling or /Therapy

Are you currently being treated by a counselor, psychologist, psychiatrist, and/or other physician for the challenges noted above? Yes No

Please provide information regarding previous treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other challenges: Date(s) Name of Professional Address Treatment Type Why treatment ended

____

____

Have you ever been admitted for a psychiatric hospitalization? Yes No If yes, please provide the following information: Date(s) Name of Hospital or Facility Address Reason for Hospitalization ______________________________________

____

Medical History · Please complete the information below regarding past and current medical conditions and treatment: Date(s) Physician Name / Address Condition Treatment Results ______________________________________

____

Please list all current prescription and over the counter medication use: Beginning (date) Medication Dose Frequency of use Condition Treated ______________________

____

Please list any current or previous use of non-prescription drug, or alcohol: Date(s) Type Used Frequency of Use Amount Typically Used When ended (if applicable)

____

____

Is there anything else you think would be important for me to know:

____

____

Embodied Wellness, Inc.
2596 N. Stokesberry Place, Suite 120
Meridian, Idaho 83646
(208)724-0426
Fax (208) 505-5067

Insurance Information

Client Name:____

DOB:______________________

Subscriber/Insured Name:______________________________________

DOB:______________________ Employer: ______________________

Name of Insurance Company: ___________________________________

Member ID:____

Group ID:____

Co-Pay amount: $_____________

I, as a client or insured family member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services by Amy Elisa Hedrick.

Signature Date

Embodied Wellness, Inc.

Notice of Privacy Practice (HIPAA)

Your information, Your rights. My responsibility.
.This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices: You have some choices in the way that we use and share information as we:

- Talk with your family about your condition (as needed)
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures: We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
  Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
  Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
  Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

Our Uses and Disclosures: we never market or sell personal information

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on my web site.

See Attached Informed Consent for further details about confidentiality and client information. Please ask questions if desiring further information. Please sign below, acknowledging your receipt of this notice. Thank you.

____

Client Signature Date

Telehealth/Virtual Session Consent Form

Required form for Online Therapy

Confidentiality Policy in Emergencies

Given we will not be meeting in person, it is important that I know your location so Iam able to get you help should a medical or psychological emergency arise. Please share the location from which you will be conducting our sessions. Physical Location of Client Receiving Services:

____

____

Your signature below confirms that you agree to share your location with me prior to or at the beginning of your session should it be different from the location listed above.

____

Client Signature Date

Please provide me with two emergency contacts just in case you need emotional assistance that doesn't meet the criteria of needing to be hospitalized. Please name two emergency contacts, their relationship to you, their phone numbers, and email address. By signing below, you agree that I may, but am not required to, contact either of these people if I am concerned for your safety. In the case that I have dire concerns for your safety, I will do all that I can to protect you, including calling 911 or other emergency responders.

Name____

Relationship ______________________________Phone number______________________________

Email ____

Name____

Relationship ______________________________Phone number______________________________

Email____

International Clients

Please ensure that your emergency contacts speak both English and the native language of the country you are living in so that I am able to get help to you. Please also list below major country contacts I may need to get help to you (e.g. medical transportation process/contact information; mental health resources youor I could use in case of emergency,etc.). Please providecontext about each.

____

____

____

Methods of communication

Reminders sent via text or email, paying invoices via email, or sharing information electronically can sometimes be helpful and convenient for clients. Given the limitations of security for electronic communication, I would like to know which of the following you are comfortable with. Please sign next to each that you are comfortable using for administrative issues like scheduling, invoicing and collecting paperwork if not submitted through my client portal.

___Email ___Cell Phone ___Internet ____Text ____Voicemail

Please list your preferred email and phone number:
Email ____
Phone Number____

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material.

Platforms used for telehealth/virtual sessions include HIPAA compliant platforms via Psychology today and Zoom. Due to variations in access to technology clients may agree to use platforms that cannot ensure or guarantee HIPAA compliance and protection of privacy. These include: cellular phone, Facebook instant messenger, FaceTime, etc. If a non-HIPAA compliant platform is acceptable please initial below acknowledging that you understand the potential risks of using these platforms..__________

Please initial next to each item you consent to:

____I consent to allow Amy Elisa Hedrick to use unsecured email, cell/VoIP phone text messaging, calls, faxes, or voicemail to transmit to me the following protected health information:
____ Information related to the scheduling of meetings or other appointments
____Information related to billing and payment
____Information that is clinical in nature (e.g. treatment summaries, diagnosis)
___ I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means.
___I understand that I am not required to sign this agreement in order to receive treatment.
___ I also understand that I may terminate this consent at any time.

____

Signature Date

INFORMED CONSENT AND AGREEMENT FOR CLINICAL SERVICES

Please read the following information carefully. After you have read the Agreement, please sign your name below to accept the terms of this Agreement.

This document (the Agreement) contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice). The Notice explains HIPAA and its application to your personal health information in greater detail.

This document also contains important information about psychotherapy, professional services and business policies related to the psychotherapy your clinician delivers. Please read it carefully and ask any questions you might have. By signing this form you indicate that you agree to and understand the psychotherapy process and business policies between you and your therapist. This document represents an agreement between you and your clinician.

A. INFORMED CONSENT

As a legally consenting individual, you agree to permit the clinician to provide evaluation, treatment, and therapy to yourself, or any individual under your guardianship. You understand that the clinician has the right to terminate evaluation, treatment, or therapy at any time without incurring additional costs.

Psychotherapy can have benefits and risks. As with most other forms of treatments, results cannot be guaranteed.

Participation in therapy can result in a number of benefits to you, including increased insight into your patterns of feeling, thinking, behaving and relating to others; improvement in your relationships; solutions to specific problems you bring forward in therapy; and improvement in symptoms of distress.

Benefits to therapy require openness on the part of the therapy client. When information about your feelings, thoughts, behaviors, relationships, or other difficulties are withheld, it is not possible for the therapist to help you with them or to help you understand how they may be related (or not) to the issue for which you are seeking treatment. Benefits also require consistent attendance in therapy and work both in and outside of therapy sessions.

Since evaluation and/or therapy often involves discussing unpleasant aspects of your life, you may experience difficult emotions. For some symptoms and emotions get better when shared, and for others they may get worse before getting better.

When these feelings come up, it is important to talk to your therapist about them. They maybe a natural, tolerable, and expected reactions to your work in psychotherapy. Other times it may be necessaryor preferable to change the pace of your therapeutic work if the feelings are too uncomfortable. Or, if the treatment is not helping, it is important to talk about other treatment options.

B. EMERGENCY SITUATIONS

I operate by appointment only and do not provide 24-hour crisis services. If you have a life threatening crisis, please call 911, a crisis line, or go to a hospital emergency room. You can also contact 211, or 988 for psychological crisis support. If you anticipate needing additional support, please let your clinician know and we can sure we come up with a support plan that meets your needs.

C. CONFIDENTIALITY

Confidentiality is incredibly important to psychotherapy. Information shared with your clinician will remain confidential and I will not share it with anyone without your written authorization. However, there are circumstances in which I am required to disclose information without either your consent or authorization, including:

If you are involved in a court proceeding, information pertaining to your evaluation, diagnosis, or treatment is protected by the clinician-patient privilege law. The clinician cannot provide any information without either: o Your or your personal representative's written authorization

- Receipt of a subpoena with documentation of satisfactory assurances of notice to the client and a certification that no objection was made by the client, or that the time for filing objection has elapsed, and no objection was filed, or all objections filed were resolved by the court, and the disclosures are consistent with the resolution OR a court order signed by a judge.
- Your clinician may be required to provide information if a government agency is making a request for the information to be used in health oversight activities.
- Your clinician may disclose relevant information regarding a patient in order to defend himself/herself if a patient files a complaint or lawsuit against him/her.

If you participate in court ordered therapy and the court requests records or documentation of your participation in services, your clinician will discuss the information being sent to the court with you prior to submitting it.

In the case of a credit card dispute, your clinician reserves the right to provide the needed and adequate documentation (i.e. your signature on the “Therapy Agreements and Consent” that covers the cancellation policy) to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you make other arrangements.

There are some situations in which your clinician may be legally obligated to take actions in order to protect you or others from harm. At this time, I may have to reveal some information about your treatment, including:

- If your clinician has reasonable cause to suspect that a child under 18 is abused, abandoned or neglected, or I have reasonable cause to believe that a vulnerable adult is abused, neglected or exploited, the law requires that I file a report with the appropriate government agency.

• If your clinician believes that you present a clear and immediate probability of physical harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization of the patient.
• Your clinician may be required to seek hospitalization for you or to contact family members or others who help provide protection if I believe that you present a clear and immediate danger to yourself.

Additionally, your confidentiality may be waived in the event your clinician chooses to enlist a collection agency and/or claims court to recover any unpaid balance for which you are responsible. In this case, only information relevant to payment would be released such as dates and types of service, no clinical information would be conveyed.

I sometimes find it helpful to consult with other professionals regarding clients. When doing so, a client's name and other identifying information is not disclosed. Confidentiality is maintained during these consultations and the client's identity remains anonymous.

At times I use an administrative assistant for scheduling, filing and. All administrative staff have been given training about protecting your privacy and have agreed not to release any information without being legally required or with the permission of the client or clinician.

If you sign an authorization to release information form and specify the information you want released, I will release that information to the agency or person you approve unless releasing the information could be harmful to you.

D. CONFIDENTIALITY OF EMAIL, CHAT, CELL PHONE, VIDEO, AND FAX COMMUNICATION
Communication with your clinician via any online or electronic means (e.g. email, text, video chat) is limited in security and thus your confidentiality may not be guaranteed. In the event of an injury, illness, or other unexpected emergency situation that results in your clinician being unavailable, your basic contact information (name and contact numbers or email) may be provided to a fellow clinician or associated professional. This will allow for your timely notification of appointment cancellations, as well as provide you with an opportunity to obtain further information regarding your continued care.

Considering all of the above exclusions, if it is still appropriate, upon your request, your clinician will release information to any agency/person you specify unless he/she concludes that releasing such information might be harmful in any way.

Ecounsel email, chat, and video exchanges are secure. By signing this document, you agree to work with online email, chat, video services determined to be suitable by Ecounsel. If you choose to use your personal email account, please limit the contents to administrative issues (e.g., cancellation, change in contact information, etc.). Remember that unless we are both on landline phones, the conversation is not confidential. Similarly, text messages are not confidential. If you are working online, your clinician asks that you determine who has access to your computer and electronic information from your location, including family members, coworkers, supervisors, and friends. We advise you to communicate through a computer that you know is safe (i.e. wherein confidentiality can be ensured). Finally, be sure to fully exit all online counseling sessions and emails before leaving your computer.

E. APPOINTMENTS
The clinician should be notified at least 24 hours in advance if an appointment cannot be kept or you will be responsible for the fee for the missed appointment.

F. RIGHT TO DISCONTINUE TREATMENT
The clinician has the right to discontinue evaluation, treatment, or therapy for any appropriate reason, including but not limited to, repeated lateness and excessive cancellations. In such cases, the patient or the patient's personal representative agrees to accept full responsibility for pursuing alternate professional services. A letter will be sent informing you or your personal representative that treatment is being discontinued.

G. PROFESSIONAL RECORDS
You have access to your clinical record, unless such access is determined by the clinician to be harmful to you. If that access is restricted, the patient or his/her legal representative, will receive written notice of that fact and the reasons for the restriction will be recorded in the clinician's clinical record. If you are a parent, you understand that you have the right to general information about your child's treatment but may not necessarily have access to the complete record. You agree to provide information to the clinician that will enable her to deliver appropriate care and assistance. I also agree to actively participate in my treatment.

It is important for you to know that the clinician is independently providing you with clinical services and is fully responsible for those services.

H. PATIENT RIGHTS
HIPAA provides you with a number of rights, which briefly include the right to amend the information in your record and to request restrictions as to how you are contacted. Please review the Notice of Privacy Practices carefully.

I. MEDICAL EXAMINER'S OFFICE
In the event of my death, you hereby release and hold harmless the clinician as the custodian of your Clinical Record from any and all liability resulting from or arising out of the release of your record to the Medical Examiner's Office pursuant to state law.

J. ELECTRONIC COMMUNICATION AND SOCIAL MEDIA POLICY
Multiple types of electronic communications are common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put client privacy at risk and can be inconsistent with the law and with the standards of this profession. Consequently, the clinician has prepared this policy to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with the clinician.

<u>Email Communications</u>
The clinician uses email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. Any email communication or text

messages with the clinician, should be limited to things like setting and changing appointments, billing matters, and other related issues. If you need to discuss a clinical matter with the clinician, please do not email but rather feel free to call him/her to discuss it on the phone or wait so to discuss it during your therapy session. Emails will be responding to during business hours only, unless otherwise specified.

Text Messaging
Because text messaging is a very unsecure and impersonal mode of communication, I do not use text messaging to contact clients or respond regarding treatment. Please discuss with me if you need to use a messaging platform for any reason.

Social Media
The clinician does not communicate his/her clients through social media platforms (e.g., Twitter, Facebook, Instagram, etc). If the clinician discovers that an accidentally established online relationship with the patient exists, he/she will cancel that relationship. This is because these types of casual social contacts can create significant security risks for the patient. The clinician participates on various social networks, but not always in professional capacity. If you engage in online forums, there is a possibility that you may encounter the clinician by accident. If that occurs, please discuss it with him/her during scheduled time together. Please do not try to contact him/her via social media. The clinician will not respond but rather terminate any online contact no matter how accidental.

Websites
The clinician has a professional website that is used for professional reasons to provide information to others about the clinician and his/her practice. You are welcome to access and review the information that on that website and, if you have questions about it, it should be discussed during your therapy sessions.

Web Searches
The clinician will not use web searches to gather information about you without your permission. The clinician believes that this violates your privacy rights; however, he/she understands that you might choose to gather information about the clinician that way. There is an incredible amount of information available about individuals on the internet, much of which may be inaccurate. If you encounter any information about the clinician through web searches, or in any other fashion for that matter, please discuss this with him/her during scheduled time together so that it can be processed.

Patients may sometimes want to review their health care provider various websites. Unfortunately, mental health professionals cannot respond to potentially inaccurate comments or related errors because of confidentiality restrictions. If you encounter a review of the clinician, please share it in treatment so that it can be discussed. Please do not rate his/her work on any of these websites while in treatment together as it could potentially damage the therapeutic relationship.

Limitations of Online Psychotherapy
Telephone, chat, and video sessions have strengths and limitations compared to sessions provided in a shared physical space. It is important to consider if those limitations may impact your therapeutic progress and if so, select an in-person provider. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

Online psychotherapy providers, like many in-person providers, do not provide 24-hour crisis services. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room. Should your clinician determine that you are at risk, she may call local police to assess your safety in person.

Your clinician follows the laws and professional regulations of the state in which the provider is licensed, and the sessions will be considered to take place in the state and country in which the provider is licensed.

K. MINORS & PARENTS

Emancipated Minors do not need parental consent for mental health care. Their private health information is confidential and cannot be released to anyone without the client's consent.

Unemancipated Minors must have the consent of their personal representative (e.g., natural or adoptive parents, legal custodians or guardians, or a person acting as the minor's parent) for non-emergency mental health care. Unless the personal representative agreed in advance to a confidential status between the child and the clinician, they have access to the minor's record. Confidential status means that a clinician asks a personal representative to step out so that the provider may talk confidentially to the minor client (i.e., the representative agrees to a confidential relationship between the child and the provider, and may only know what the conversation was about if the child authorizes it).

It is our center's policy to require authorization for treatment from all legal guardians of the minor child except under specific situations which may require an affidavit. Furthermore, if consent is revoked by any of the legal guardians or parents, it is our center's policy to terminate treatment except in emergencies.

L. TERMINATION OF SERVICES

You are free to end service at any time for any reason, whether or not the clinician considers it advisable. The clinician prefers that you tell him/her when you plan to terminate treatment instead of just not returning and that you schedule one final appointment in order to review your progress and discuss any referrals that might be beneficial to you.

There are a few situations in which the clinician may end service regardless of your wishes:

- If the clinician is convinced that you no longer need service and cannot benefit from continuing.
- If the clinician is convinced that your needs surpass his/her ability to help you, he/she will refer you to a suitable source of help. If you do not comply with our mutually developed treatment plan, and there is no benefit in continuing service.
- If you do not abide by the policies and procedures of this setting as set forth in our working agreement, including missing appointments or failing to be current in payments.
- If our service relationship becomes compromised, troubled, or deteriorates. In such instances, we will discuss potential issues as part of therapy.
- If the problems cannot be resolved, it will be necessary to end our service relationship. The clinician will then refer you to another source of service.

- If you are in crisis, the clinician will make every effort not to end the relationship until the crisis is resolved.

M. TIME OF APPOINTMENTS
Each of our appointments is scheduled to last 45-60 minutes. The clinician usually begins at the scheduled time. If the clinician is ever late, he/she will try to let you know in advance. If the late start is due to the clinician, the session's duration will still be for a full 50 minutes. If you arrive late for an appointment, we will end the meeting 50 minutes after it was originally scheduled to begin. The charge to you for these shortened meetings will be for the full amount; however, you will not be charged for a session if you cannot keep it and let me know at least 24 hours in advance. You will be charged if you fail to keep a scheduled appointment or do not notify me 24 hours ahead of time. Serious immediate emergency conditions will be considered.

In the event that you are called away for an emergency or have a sudden illness or accident, please make every effort to contact, or have someone else contact, the clinician as soon as possible. He/she will be concerned about you and will want to know your circumstances. The clinician will want to reschedule the appointment if possible. In the event that the clinician is called away for an emergency or has a sudden illness or an accident, the clinician will make every effort to contact you as soon as possible, to apprise you of the circumstances, and to reschedule the appointment.

N. RESPONSIBILITY OF PAYMENT
You understand that the fee for service is $ 120.00 per 60-minute therapy hour or whatever was agreed upon at the time the appointment was made. You understand that there is a full fee charge for appointments that are not cancelled with at least 24 hours of notice.You understand this cancellation policy and agree to the terms. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the clinician has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require disclosure of otherwise confidential information.

O. AUTHORIZATION FOR INSURANCE BENEFITS BILLING
You hereby authorize the release of any medical or other information necessary to process claims. You also authorize payment of medical benefits to the clinician for the services described in the submitted claims.

P. THE THERAPEUTIC PROCESS
1. Participating in therapy may have several beneficial consequences, including improving personal relationships and resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). Major benefits that may be gained from participating in therapy include: a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress; greater understanding of personal and relational goals and values; greater maturity and happiness as an individual and increased relational harmony; and resolving specific concerns brought to therapy. The clinician cannot guarantee the ultimate outcome of therapy.
2. Homework assigned in therapy is an essential aspect of change and the clinician may assign tasks between sessions related to your goals. It is imperative that you commit to work as efficiently as possible. At times, you may feel as if therapy progress slower than you anticipated. The clinician and

you will work together to identify your therapeutic goals and then periodically, review your progress toward the identified goals.

3. In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort in several ways, including through intense, unexpected feelings or relational changes that may not be originally intended. It is important to understand that albeit the collaborative effort of the clinician and patient, there is a possibility that the goals of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

R. LENGTH OF THERAPY

Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but the clinician will continuously assess, together with you, how much longer therapy is recommended.

S. TRIAL, COURT ORDERED APPEARANCES, LITIGATION

Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if the clinician gets called into court by you or your attorney, you will be charged $150.00/hour (e.g., travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc.)in addition to a flat fee of $500.00.. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to your practice location or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks. Discharged from care.

Psychotherapy is best ended with a process of termination and a scheduled final appointment. This will allow you to review therapeutic gains achieved during treatment; develop a plan of action to maintain those gains; identify what other services or activities may still be needed; and to process any emotions that may exist regarding the ending of the therapeutic relationship. If you decide to end therapy without engaging in the process of termination by not scheduling appointments or by not returning at least two telephone calls, it will be assumed that you are no longer a client off your clinician and you are, therefore, discharged from care. Both the therapist and the client have the right to end counseling at any time.

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 me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initial of arbitration. The mediator shall be a neutral third party chosen by agreement of Therapy, your clinician and you (the client). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. The

prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case or arbitration, the arbitrator will determine that sum.

Agreement

Your signature indicates that you have read this contract in its entirety; that you understand all that it contains; that you agree to abide by its terms; and that you voluntarily consent to treatment. Additionally, your signature below indicates that you understand that I, Amy Elisa Hedrick., am an independent practitioner; therefore, ecounsel, and associated providers arenot responsible for or involved in your care or treatment unless you directly contracted with that provider.

______________________________ ______________

Client Signature Date

______________________________ ______________

Client Signature