Annual Demographic & Insurance Update

(For SimplePractice Intake Forms)

To help us maintain accurate records and ensure smooth billing and communication, please complete this **annual demographic and insurance update.** Even if your information has not changed, completion is required at the beginning of each calendar year.

Client Information

Full Legal Name: _____

Preferred Name (if different): _____

Date of Birth: _____

Phone Number: _____ ☐ Mobile ☐ Home ☐ Work

Email Address: _____

Mailing Address:
Street: _____
City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information

☐ I plan to use insurance for services this year
☐ I do not plan to use insurance (self-pay)

Primary Insurance Company: _____

Member / Subscriber Name: _____

Relationship to Subscriber: _____

Subscriber Date of Birth if not Client: _____

Member ID Number: _____

Group Number (if applicable): _____

Insurance Phone Number (from card): _____

Effective Date: _____

☐ My insurance information has changed since last year
☐ My insurance information has not changed

Secondary Insurance (if applicable)

Insurance Company: _____

Member / Subscriber Name: _____

Member ID Number: _____

Group Number: _____

Billing Acknowledgement

I understand that it is my responsibility to provide accurate and up-to-date insurance information. I understand that failure to do so may result in denied claims or charges for which I am financially responsible.

Annual Confirmation

By signing below, I confirm that the information provided above is accurate and current to the best of my knowledge. I agree to notify the practice of any changes to my demographic or insurance information as they occur.

Client Name (typed): _____

Client Signature: _____ **Date:** _____

Parent Signature for Minor: _____ **Date:** _____

Thank you for helping us keep our records current.

Annual Demographic & Insurance Update

(For SimplePractice Intake Forms)

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Client Information

Full Legal Name: _____

Preferred Name (if different): _____

Date of Birth: _____

Phone Number: _____ ☐ Mobile ☐ Home ☐ Work

Email Address: _____

Mailing Address:
Street: _____
City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information

☐ I plan to use insurance for services this year
☐ I do not plan to use insurance (self-pay)

Primary Insurance Company: _____

Member / Subscriber Name: _____

Relationship to Subscriber: _____

Subscriber Date of Birth if not Client: _____

Member ID Number: _____

Group Number (if applicable): _____

Insurance Phone Number (from card): _____

Effective Date: _____

☐ My insurance information has changed since last year
☐ My insurance information has not changed

Secondary Insurance (if applicable)

Insurance Company: _____

Member / Subscriber Name: _____

Member ID Number: _____

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Billing Acknowledgement

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Client Name (typed): _____

Client Signature: _____ **Date:** _____

Parent Signature for Minor: _____ **Date:** _____

Thank you for helping us keep our records current.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Standard Intake Questionnaire Template (3.25.25)

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

Have you seen a mental health professional before?

- Yes
- No

If applicable, list ALL medications (including non-psychotropic) you are currently taking, for how long, and for what reason. What is the dosage of each? What time of day do you take it (morning, evening, bedtime)?

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

May we contact your prescribing doctor for coordination of care?

- Yes
- No

Who is your primary care physician? Please include type of MD, name and phone number.

May we contact your primary care provider for coordination of care?

- Yes
- No

Relationship Status

- Single, never married
- Domestic Partner
- Engaged
- Married
- Divorced/Separated
- Widow

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc...

Do you feel safe in your current living situation?

- Yes
- No

Legal Status

- On Probation
- On Parole
- Court-mandated
- Bankruptcy
- Personal Protection Order
- None

What is your highest level of education?

- GED
- High School Diploma
- Some College/Certificate
- Associates Degree
- Bachelors Degree
- Masters Degree
- Trade School
- None of the above

What is your current occupation?

How long have you been employed with current employer?

Do you enjoy your occupation?

- Yes
- No

Do you drink alcohol?

- Yes
- No

Do you have a history of alcohol abuse?

- Yes
- No

Do you use recreational drugs?

- Yes
- No

Do you have a history recreational drug abuse?

- Yes
- No

Do you have suicidal thoughts?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

Do you have thoughts or urges to harm others?

- Yes
- No

Have you ever been hospitalized for a psychiatric issue?

- Yes
- No

Is there a history of mental illness in your family?

- Yes (mothers' side)
- Yes (fathers' side)
- No

Please check any of the following you have experienced in the past six months

- [ ] Increased appetite
- [ ] Decreased appetite
- [ ] Trouble concentrating
- [ ] Difficulty sleeping
- [ ] Excessive sleep
- [ ] Low motivation
- [ ] Isolation from others
- [ ] Fatigue/low energy
- [ ] Low self-esteem
- [ ] Depressed mood
- [ ] Tearful or crying spells
- [ ] Anxiety
- [ ] Fear
- [ ] Hopelessness
- [ ] Panic
- [ ] Other

Please check any of the following that apply

- Headache
- High blood pressure
- Gastritis or esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic pain
- Loss of consciousness
- Heart attack
- Bone or joint problems
- Seizures
- Kidney-related issues
- Chronic fatigue
- Dizziness
- Faintness
- Heart valve problems
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer
- Other

Environmental Stressors - Please check any of the following that apply

- Problems with Peer Group
- Educational Problems
- Family Problem
- Relationship Problems
- Employment Problems
- Legal Problems
- Financial Problems
- Other
- None

What are your goals for counseling?

How often do you want to be seen? (weekly, bi-weekly, monthly)

Do you prefer in person or virtual appointments? Please note this depends on insurance coverage if billing insurance.

- In Person
- Virtual
- Combination of both in person and virtual

What else would you like me to know?

Alcohol Use Disorders Identification Test (AUDIT): Self-Report Version

* *indicates a required field*

Alcohol Use Disorders Identification Test (AUDIT)

Instructions: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Check the option that best describes your answer to each question.

*** 1. How often do you have a drink containing alcohol?**

(0) Never

(1) Monthly or less

(2) 2 to 4 times a month

(3) 2 to 3 times a week

(4) 4 or more times a week

*** 2. How many drinks containing alcohol do you have on a typical day when you are drinking?**

(0) 1 or 2

(1) 3 or 4

(2) 5 or 6

(3) 7, 8, or 9

(4) 10 or more

*** 3. How often do you have six or more drinks on one occasion?**

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

*** 4. How often during the last year have you found that you were not able to stop drinking once you had started?**

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

*** 5. How often during the last year have you failed to do what was normally expected from you because of drinking?**

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

* 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

* 7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

* 8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

* 9. Have you or someone else been injured as a result of your drinking?

(0) No

(2) Yes, but not in the last year

(4) Yes, during the last year

* 10. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested you cut down?

(0) No

(2) Yes, but not in the last year

(4) Yes, during the last year

* Now add up the total for your answers using the number in parentheses next to each answer you selected. Record your total score here:

This is your AUDIT Score

Source: Babor TF ; de la Fuente JR ; Saunders J ; Grant M. AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care. WHO/MNH/DAT 89.4, World Health Organization, Geneva, 1989.

Consent for Telehealth Consultation

Road2Wellness Behavioral Health Services

616 W. Broad Street

Linden MI 48451

810-936-0079

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is **NOT an Emergency Service** and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM **AGREEING** THAT I HAVE READ, UNDERSTOOD AND **AGREE** TO THE ITEMS CONTAINED IN THIS DOCUMENT.

X

Credit Card Authorization

By your electronic signature of this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered. These charges will appear on your bank/credit card statement as Road2Wellness. You have the right to request a paper copy of this document.

I **authorize** Road2Wellness to **charge my credit card** through Stripe within **24hrs after** the session has been completed. I also agree that my credit card can **be charged** for any session that is **not cancelled at least 24 hours prior to the scheduled session.**

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Road2Wellness in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

X 

Notice of Privacy Practices

Road2Wellness Behavioral Health Services

616 W. Broad Street

Linden MI 48451

810-936-0079

This notice went into effect on 01/1/2021

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.
Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

X 

Informed Consent for Psychotherapy

Road2Wellness Behavioral Health Services

616 W. Broad Street

Linden MI 48451

810-936-0079

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are **no miracle cures.** I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

X _____

Practice Policies

Road2Wellness Behavioral Health Services

616 W. Broad Street

Linden MI 48451

810-936-0079

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule **24 hours in advance.** You will be responsible for the full session **fee of $150.00.** If cancellation is less than 24 hours.

The standard meeting time for psychotherapy is **50 minutes.** It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $25.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a **time commitment is made to you and is held exclusively for you.** If you are late for a session, you may lose some of that session time.

BILLING

Road2Wellness completes billing as a courtesy. You will be responsible for any balance not covered by insurance. Road2Wellness will submit a claim twice before requesting you to pay the remaining balance and pursue reimbursement from your insurance. Road2Wellness will also provide necessary documentation to help you obtain reimbursement.

WORKSHOPS

Road2Wellness will collect cost of workshops five days prior to workshop attendance. **No refund will be issued unless 48-hour notice is given by client to reschedule/cancel.** Illness or emergency will be honored upon rescheduling. Please contact our main line to reschedule or cancel if needed 810-936-0079.

TELEPHONE ACCESSIBILITY:

Should you need to reach me between sessions, please call our mainline at 810-936-0079. Messaging via your client portal is encouraged for a faster response. I may not be immediately available, but I will strive to return your call within 48 hours. Note that in-person or virtual sessions are preferred over phone sessions. Nonetheless, phone sessions can be arranged if you are traveling, unwell, or require extra support. **In case of an emergency, please dial 911 or go to the nearest emergency room.**

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain 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 you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

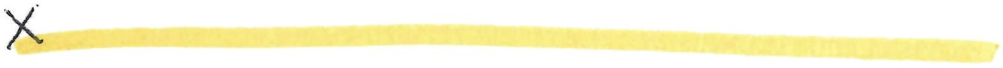
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for **three consecutive weeks,** unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

X 

Client Financial Responsibility Form

Thank you for choosing Road2Wellness, PLLC. We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.

I agree that I am legally responsible and agree to pay to the Provider for all fees, charges and expenses incurred by the below Client or owed to Road2Wellness, PLLC in connection to Provider providing care to Client.

I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.

-

Client name:

Responsible party(ies) name:

Relationship to client:

Responsible party's signature:

I consent to sharing information provided here.

In Case of an Emergency

** indicates a required field*

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following: -Text 988 (National Crisis Line) - Call Lifeline at (800) 273-8255 (National Crisis Line) - Call 911 - Go to the emergency room of your choice

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows: You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

* Name:

* Phone:

You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

* Hospital:

* Phone:

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list this police department and contact number here:

* Police Department:

* Phone:

Release of Information

* indicates a required field

* Client's name:

* I authorize Road2Wellness, PLLC to:

- Send
- Receive
- Both

* The following information:

- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records
- Progress notes, and treatment or closing summary
- Other

* To: (response should be doctor name, group name, or school name that information should be released to)

* Phone:

* Your relationship to client:

- Self
- Parent/legal guardian
- Personal representative
- Other

* The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other