Client Information

Name: _____

(Full Legal name: First Middle Last)

Preferred Name:_____ **Birth Date:** _____
(Month Day Year)

*If Minor, Name of Parent(s)/Guardian: _____

Address: _____
(Street and Number) (City,State,Zip)

Phone: _____ May we leave a message? ☐Yes ☐No
May we text you? ☐Yes ☐No
Email: _____ May we email you? ☐Yes ☐No
*Please be aware that email might not be confidential.

Client Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

_____ _____
Partner's Full Name Date of Birth

Client Occupation and Employer: _____ ☐Student

Emergency Contact:

Name: _____ Relationship: _____

Address: _____
(Street and Number)

_____ Phone: _____
(City) (State) (Zip)

Referred By: ☐Self ☐Other Way Ministries Staff ☐Other

If referred by Other, please list who this is:_____

Have you been involved in Other Way Ministries in the past? ☐Yes ☐No

If no, would you like more information on the services offered through Other Way Ministries?

☐Yes ☐No

Primary Health Insurance & Payer Information

Subscriber Name:_____Subscriber's DOB: _____

Relationship to client: ☐Self ☐Parent/Guardian ☐Spouse ☐Other

Insurance Company: _____ Employer Name:_____

Member ID#: _____Policy Group #: _____

Deductible Remaining: _____ Co-Payment: _____

Subscriber's address (if different from above):

_____

(Street and Number)

_____ Phone: _____

(City) (State) (Zip)

Patient Signature Record

Client Name: _____Therapist Name:_____

After Reading The Client Contract, Please Answer The Following Statements. Place your initials after each statement.

Acknowledgement of HIPAA: Your signature below indicates that you have read the HIPAA notice of confidentiality agreement and agree to its terms, and also serves as an acknowledgement that you have been offered and declined or offered and furnished with the HIPAA notice of privacy practices. _____**(initial)**

Therapeutic services contract: _____**(initial)**

Select one of the following:

___As billed to insurance (if Michigan Medicaid)

___Paying by Cash/Credit ⇒ If so, our agreed upon session fee is: $_____*

**ask your therapist if you aren't sure*

Insurance, billing and consent for services: _____**(initial)**

Teletherapy Informed Consent: I hereby consent to engage in online counseling services with _____(therapist) through Alliance Counseling Group._____**(initial)**

I have read and agreed to the terms and conditions of this document. I acknowledge that I am the client or the legal representative of the client, and I agree that my signature is a legally binding agreement.

Client Signature:_____ Date:_____

Parent/Guardian Signature (if client is under 18 years)

Acknowledgment of Review of the HIPAA Notice of Confidentiality

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. I am required by law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

The *HIPAA Notice of Privacy Practices* and the *Patient's Rights and Responsibilities* documents can be printed for you upon your request and is also posted and available for download at www.alliancecounselinggroup.com/forms/

YOUR SIGNATURE ON THE PATIENT SIGNATURE RECORD INDICATES THAT YOU HAVE READ THE HIPAA NOTICE OF CONFIDENTIALITY AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED AND DECLINED OR OFFERED AND FURNISHED WITH THE HIPAA NOTICE OF PRIVACY PRACTICES.

THERAPEUTIC SERVICES CONTRACT

This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

COUNSELING SERVICES: The counseling services are being rendered by a counseling intern. It is my aim to provide counseling services that lead to better relationships, solutions to specific problems and better emotional health.

PROFESSIONAL DISCLOSURE I am a counseling intern at the Alliance Cares internship program. I am a student completing an advanced degree in counseling. Part of my educational requirements is an internship program. I am supervised by the faculty at my school and the therapists at Alliance Counseling Group. I meet with them regularly to ensure clinical excellence. As an intern, I will share details of our counseling sessions with my supervisors for my clinical and

academic development. Including audio and video recordings.

LENGTH OF SERVICE Sessions last approximately 50 minutes each. The duration of counseling varies widely among clients depending on their needs and preferences. You may choose to terminate therapy at any time, but I strongly suggest that we have a final session together once you decide to terminate, so that I am able to help you prepare and end our time together in a way that is most beneficial to you.

INSURANCE, BILLING AND CONSENT FOR SERVICES

BILLING AND PAYMENTS You will be asked to pay for each session at the time of service. Cash, checks, and credit cards are accepted. Payment methods include check, cash, or the following charge cards: Visa, Mastercard, American Express. A receipt is available upon request. Checks can be written to the Burke Group.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS We may use or disclose information in your records for treatment, payment, and health care operations purposes with your consent. Personal health information (PHI) refers to information in a client's record that could identify that client. *Use* of this information refers only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* of information refers to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client.

In providing for your treatment, we may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care through consultation with other treatment providers, outside clinical supervisors, and/or supervisors within the Alliance Counseling Group office. For example, we might consult with another health care provider, such as your child's pediatrician or another therapist.

In order to obtain *payment* for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business---related matters such as audits and administrative services, and case management and care coordination).

MISSED APPOINTMENTS Once an appointment is scheduled, you will be expected to arrive on time for your appointment. If you are unable to keep your scheduled appointment or need to reschedule, please contact me at

CONTACTING ME I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available and alternative numbers to call. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact **911** (24 hours/day) or proceed to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. As a counseling intern, my participation in the Alliance Cares internship program is time bound, I will provide relevant information to ensure your care is not affected.

EMAIL If agreeing above to being contacted by email, please be aware of the following: 1) The use of email is limited to *setting up* or *canceling appointments*, *for sending appointment reminders,* and for *sharing resources or homework assignments*. 2) Due to security, details of your treatment cannot be discussed via email. 3) Email may also not be used as a means of providing services. 4) You also agree to not use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as we cannot guarantee rapid response via email. 5) By consenting to email, you are aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold Alliance Counseling Group or your therapist responsible for any breach of confidentiality that results from the use of the email address listed above.

MINORS If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request that your parents agree to waive access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss

CONFIDENTIALITY In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- If I believe that a child, psychologically or physically compromised adult, or an elderly person is being abused, I must file a report with the appropriate state agency.

- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If I believe that a client is threatening serious bodily harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- To address therapeutic understanding with my intern supervisors.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I have read the information in this document and agree to abide by its terms during our professional relationship.

QUESTIONS AND COMPLAINTS If you have questions about our privacy practices or are concerned your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your questions or concerns to:

David Burke LPC -Clinical Director
Alliance Counseling Group
PO Box 283
Grandville, MI 49418

You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You will not be penalized or otherwise retaliated against for filing a complaint.

TELETHERAPY INFORMED CONSENT

I understand that online counseling services include, but are not limited to, consultation, treatment, and using interactive audio, video, or data communications. I understand that online counseling services involve the communication of my medical/mental information, both orally and visually, to health care practitioners that may be located outside my local area or state.

I understand that I have the following rights and responsibilities with respect to online counseling services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. I need to be physically present, at the time of service, in a state in which my therapist holds a professional license

3. The laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed intent to harm myself, and where I make my mental or emotional state an issue in a legal proceeding.

4. I also understand that the dissemination of any personally identifiable images or information from the online counseling services to researchers or other entities shall not occur without my written consent.

5. I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

6. In addition, I understand that online counseling services may not be as complete as face-to-face services. I also understand that if the counselor believes I would be better served by another form of counseling services (e.g. face-to-face services) I

may be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling services, and that despite my efforts and the efforts of the counselor, my condition may not improve, and in some cases may even get worse.

7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

9. I understand that I may benefit from online counseling services, but that results cannot be guaranteed or assured.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.