Spring To Life Counseling, LLC

Client Demographic Form

Today's Date: _____

Name: _____

Address: _____
STREET CITY STATE ZIP CODE

Name (partner/other): _____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Ok to leave voice message? _____

Cell Phone: _____ Ok to leave voice message? _____ Text message? _____

Email Address: _____ Ok to send message through email: _____

Date of Birth: / / Age: _____ Gender: _____ Marital Status: _____

Employment Status: _____ Employer: _____

Occupation: _____

Others living in home:

INSURANCE INFORMATION (IF APPLICABLE)

Name of Insured: _____ Insured date of birth: _____/_____/_____

Insurance Company: _____

Subscriber identification number: _____ Group number: _____

I authorize use of this form with all of my insurance submissions. I authorize the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I authorize direct payment to my service provider. I hereby permit a copy of this to be used in place of an original. If I decide not to use my insurance and self-pay, I understand no information will be given to my insurance company.

EMERGENCY CONTACT (FOR MEDICAL EMERGENCY ONLY)

Name: _____ Phone: _____ Relationship: _____

Do I have permission to contact this person in event of emergency? _____YES _____NO Initial_____

DUTY TO WARN

I designate the following people to be contacted if I am in danger:

_____
NAME RELATIONSHIP TO CLIENT TELEPHONE NIMBER

_____
NAME RELATIONSHIP TO CLIENT TELEPHONE NIMBER

Spring To Life Counseling, LLC

Client Information and Consent

THERAPIST
Claire Martin is a Licensed Professional Counselor engaged in private practice providing mental health services to clients directly and as an independent provider for various managed care companies. Claire has been licensed by the Missouri since 2017. She is Owner and Clinical Director of Spring To Life Counseling, LLC.

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

MENTAL HEALTH SERVICES: BENEFITS & RISKS
While it may not be easy to seek help from a mental health professional, the hope is that this experience will assist you in understanding your situation or problem and moving toward a resolution of this issue. A therapist has professional training and knowledge of human development and behavior and will make observations about your situation and will assist you in finding options for resolution of your issue(s). The therapist may utilize various therapeutic approaches in order to assist you in resolving your problem(s). You should be aware that entering into psychotherapy is a risk. Psychotherapy sessions can be painful at times. Often times, you may learn new information about yourself that you may not like. Often personal growth cannot occur until you are able to confront your issues and experience the associated feelings. These feelings may include pain, sadness, anger or shame. The success of our work depends on quality effort of both therapist and client and the realization that you are ultimately in control of and responsible for the changes that result from psychotherapy.

GOALS, PURPOSES, AND TECHNIQUES OF THERAPY
Psychotherapy may be one way to effectively treat your problem. There may be alternative ways to treat your problem. It is important for you to discuss any concerns you have regarding the therapist's treatment recommendations. The therapist encourages you to provide input into setting your goals for therapy and the therapeutic techniques used for treatment. As therapy progresses, these goals and techniques may change.

RELATIONSHIP
Your relationship with your therapist is a professional relationship. In order to preserve this relationship, the therapist cannot have any other type of relationship with you. Any personal or business relationships with you will undermine the effectiveness of the therapeutic relationship and therefore is strictly prohibited. Your therapist is committed to your mental health but is not in the position to become socially or personally involved with you. Please note that the therapist does not accept any gifts, or barter/trade services.

SESSIONS
Individual Therapy sessions are 50 minutes in length. The number of sessions needed depends on various factors and can be discussed during your session. Some insurance companies may provide a limited number of sessions under your designated plan. If your insurance company requires authorization for mental health services, your therapist will obtain this authorization prior to the initial appointment.

APPOINTMENT CANCELLATIONS and NO-SHOWS
To schedule an appointment, please call the Spring To Life Counseling, LLC telephone number at 347-860-3351. If you think that you will be unable to attend a scheduled appointment, please provide a 24-hour notice. **There may be a fee assessed for less than a 24 hour notice. A fee may be charged for no show appointments.** It is up to the therapist's discretion to determine if fees will be charged. These charges are your responsibility and cannot be billed to the insurance company. If you miss an appointment, it is your responsibility to contact the therapist to reschedule. If you do not show up for an appointment, or do not call to cancel your appointment within 24 hours of the missed appointment, all future scheduled appointments will be canceled. If you

plan to be more than 10 minutes late to your session, please call to determine if your appointment needs to be rescheduled.

CONFIDENTIALITY

All sessions with your therapist are confidential. No information will be released without your written consent. However, there are some exceptions including, but not limited to the following:

1. All insurance companies require that a provider furnish a diagnosis and sometimes a treatment plan on each client in order to justify the necessity of treatment and payment. Your insurance company paying for services may have a right to review all of your treatment records.
2. Missouri State Law demands that all providers report any suspected physical or sexual abuse to the appropriate Child or Elderly Hotline Services, which is then reported to the appropriate agency for investigation.
3. Missouri State Law and Professional Ethics require all providers to report if a client is homicidal or suicidal. This is reported in order to help the client rather than harm the client. Therapist also has a duty to warn any person who is a potential target for harm by a client. Therapist will notify targeted person and law enforcement of any such threats.
4. If a Federal or State Court requests the release of records, the provider has to comply, with certain exceptions.
5. Most insurance companies require that a provider keep a patient's "Primary Care Physician" informed of his/her mental health treatment. By signing the consent, you agree to allow me to keep your physician informed at my discretion.
6. A fee dispute between the therapist and client.
7. A negligence suit brought by the client against the therapist or a complaint filed with a licensing board, or other state or federal regulatory authority.

For further information, please review the Notice of Privacy Practices handout provided to you by the therapist. If you have additional questions, please address them with the therapist. By signing this information and consent form, you are giving consent to the understated therapist to share confidential information with all persons mandated by law and with the managed care company and/or insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

FEES & PAYMENTS

I am requiring a sliding scale fee in exchange for services provided.

- Fee for services range from $75 - $125. Sliding scale is available.
- All fees are appreciated at the end of each session.
- Fees are accepted through check, money order, or cash. Please make checks and money orders payable to Spring To Life Counseling, LLC or to Claire Martin
- Appointments cancelled within 24 hours or missed appointments, may result in a fee.
- If there are questions or concerns about the therapy fee, please discuss this matter with Claire Martin, Owner and Clinical Director of Spring To Life Counseling, LLC.

ADULT/MINOR PATIENTS

Adult patients are responsible for payment of their own accounts. The adult accompanying a minor and the parents/guardians of the minor are responsible for payment of the minor's account.

DOCUMENTATION

Written documentation, summaries or completion of forms requested by you or other agencies (i.e. Social Security Administration, Short-term Disability companies, etc.) will not be provided. However, if any formal request for this service is requested, there will be a charge.

LEGAL PROCEEDINGS

The therapist **DOES NOT** attend court proceedings. If you believe any situation you are involved in will require the therapist being involved in legal matters, a referral to other therapists will be provided to you. If the therapist is subpoenaed on your behalf or if for testimony on behalf of another party which involves you, an additional fee will be charged for the therapist's time, preparation and expense spent in responding to a subpoena.

Spring To Life Counseling, LLC

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, no friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) will be accepted. This could compromise your confidentiality and respective privacy and also blur the boundaries of our therapeutic relationship.

CLIENTS RIGHTS

As a person participating in therapy, you and your child have the right to:

- Be treated with dignity and respect & be emotionally safe
- Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, or disability.
- Understand Health Insurance Portability & Accountability Act (HIPPA) and privacy rules.
- Understand the limits of confidentiality.
- Ask questions and get answers about services.
- Have freedom from abuse, retaliation, humiliation, neglect, and financial or other exploitation.
- Refuse or withdraw from services at any time.
- Be informed about the rules that will result in discharge from services if violated.
- Participate fully in decisions regarding you or your child's discharge from therapy and receive advance notice regarding the proposed discharge.
- Be given help in obtaining another community resource for counseling.
- Make complaints, have them heard, get a prompt response, and not receive any threats, retaliation, or mistreatments as a result. File a grievance if you are not satisfied with the response to a complaint.
- Ask to see or get an electronic or paper copy of your record or file I have about you. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.
- You can ask me to correct health information about you that you think is incorrect or incomplete. I may say "no" to your request, but I will tell you why in writing within 60 days.
- You can ask me to contact you in a specific way (for example, home or office phone).
- You can ask me **not** to use or share certain health information for treatment or payment. If I am required by law not to agree to your request, I may say "no" if it would affect your or another's safety.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment with your health insurer. I will say "yes" unless a law requires me to share that information.
- You can ask for a list (accounting) of the times I've shared your health information for ***six*** years prior to the date you ask, who I shared it with, and why. I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'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.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.
- 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. I will make sure the person has this authority and can act for you before I take any action.
- To be assisted in obtaining an interpreter in cases of communication barriers (for example, language or hearing impairment)

CLIENT RESPONSIBILITIES AND CHOICES

- To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives, and other matters relating to health or care.
- To be respectful of property and personnel in the office.
- To promptly fulfill financial obligations to me.
- To present any significant complaints or concerns about care.
- To help me improve my service and environment by providing feedback about service needs, expectations, and perceptions of care.

- I *never* share your information unless you give me written permission: Not for marketing purposes, sale of your information, and/or sharing of psychotherapy notes

TELEPHONE & EMERGENCY PROCEDURES

- In order for us to provide the best care for our clients, if you believe you are in a life-threatening crisis, please call 911, call your psychiatrist, go to the nearest emergency room, call Life Crisis 314-647-4357, or Behavior Health Response (BHR) at 314-469-6644.
- If you need to contact me for an emergency, please indicate it clearly in your message. Telephone calls are monitored as time allows and I cannot guarantee immediate return calls. I am not responsible for you or your child's behaviors, decisions occurring outside the consultation, whether before or after a telephone call or consultation.
- If there is an emergency whereby I become concerned about you or your child's personal safety, the possibility of injuring someone else, or about receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you or your child from injuring themselves or others; and to ensure that he/she receives the proper medical care.

Spring To Life Counseling, LLC

Consent to Participate in Counseling Services

This signatory sheet is to acknowledge Notice of Privacy Practices document has been read and understood by me and that I voluntarily agree to receive mental health services which include assessment, care, treatment or services through the understated therapist. I agree to participate in the planning of my care, treatment or services and I acknowledge that I may discontinue care, treatment or services at any time. I have been given opportunity to ask questions and seek clarification of this document. I acknowledge that I have been given the choice to receive a copy of this signed Client Information & Consent Form.

Client Name (Print):_____ Date: _____

Client Name (Signature):_____

Parent/Legal Guardian Name (Print): _____ Date: _____

Parent/Legal Guardian Signature (Signature): _____

Relationship to Client: _____

Signature of Professional: _____ Date: _____

ELECTRONIC MESSAGING POLICY

It is understood that any written communication via the Internet, including e-mail, or via texting may be susceptible to unauthorized interception. In the event that you do not wish any communication via e-mail or other means, please notify us in writing.

___ I do NOT want to communicate by any form of electronic messaging

___ I give you permission to communicate with me by electronic messaging. I understand this form of communication may be susceptible to unauthorized interception.

Spring To Life Counseling, LLC

EMDR Acknowledgement & Consent Form

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a treatment approach that has been widely validated by research for use with Post-Traumatic Stress Disorder (PTSD). Research on other applications of EMDR is now in progress.

I have also been specifically advised of the following:
(1) Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion and/or physical sensations.
(2) Subsequent to the treatment session, the processing of incidents and/or material may continue, and other dreams, memories, flashbacks, feelings, etc., may surface.
(3) Before commencing EMDR treatment, I have thoroughly considered all of the above information. I have obtained whatever additional input and/or professional advice I deemed necessary and/or appropriate to making an informed decision concerning my participation in EMDR treatment.

By my signature on the Acknowledgement and Consent form, I acknowledge and consent to receiving EMDR treatment from Common Ground. I understand that I may stop treatment at any time before or during any EMDR session. My signature on this Acknowledgement and Consent Form is free from pressure or influence from any person or entity.

Client Name (Print):_____ Date: _____

Client Name (Signature):_____

Parent/Legal Guardian Name (Print): _____ Date: _____

Parent/Legal Guardian Signature (Signature): _____

Relationship to Client: _____

Signature of Professional: _____ Date: _____

Spring To Life Counseling, LLC

Spring To Life Policies on the Use of Telemental Health

- Definition of Telemental Health: I understand that I have the rights with respect to telemental health. Telemental health involves the use of electronic communications to enable Spring To Life Counseling, LLC to connect with individuals using live interactive video and audio communications. Telemental health includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.
- The laws that protect the confidentiality of my personal information that I have already signed also apply to telemental health. A copy of HIPPA policies and Therapeutic Informed Consent can be provided.
- I understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.
- Spring To Life Counseling, LLC utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telemental health via Zoom. As of 3/18/20 the Department of Health and Human Services (HHS) has created a temporary provision to use non-HIPAA compliant platforms such as Zoom, FaceTime, or Skype. Spring To Life Counseling, LLC will only offer these when and, if the HIPAA compliant platform does not work or is otherwise not available.
- Spring To Life Counseling, LLC follows the State of Missouri Regulations for telemental health: as well as their respective board regulations and ethics.
- By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
- Payment for Telemental health Services: Spring To Life Counseling, LLC will bill insurance for telemental health services when these services have been determined to be covered by an individual's insurance plan. The standard co-pay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of- pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company

Spring To Life Counseling, LLC

Consent to the Use of Telemental Health

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Name (Print):_____ Date: _____

Client Name (Signature):_____

Parent/Legal Guardian Name (Print): _____ Date: _____

Parent/Legal Guardian Signature (Signature): _____

Relationship to Client: _____

Signature of Professional: _____ Date: _____