Parent/Guardian Information

Today's date _____

Parent/Guardian's Name _____ DOB_____ Age _____

Parent/Guardian's Name _____ DOB_____ Age _____

Address_____

street city state zip

Phone (cell) _____ (work/home) _____ best time to call _____

Email address _____ _____

May I have permission to contact you and leave a message through

☐ Cell VM ☐ Cell Text ☐ Home/Work VM ☐ Email Preferred method of communication _____

Marital Status

☐ single

☐ engaged

☐ married (how long) _____ number of times married _____

☐ separated (how long) _____

☐ divorced (how long) _____

Education _____ Occupation _____

Second Parent/Guardian Education_____ Occupation _____

List those in your family: name, birth date, sex, and relationship to you (biological, step-children, foster or adoptive children, etc.). Indicate if they are living in your home.

First and last name	Birth date	Sex	Relationship	At home
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client Information

Adolescent/Child's name _____ Age _____ DOB _____

Address: _____

Grade/Education level _____ Attending school? ☐ Yes ☐ No School Name: _____

Do you share custody of your child? ☐ Yes ☐ No Do you have primary custody? ☐ Yes ☐ No

(If you share custody and have primary custody of your child, please make a copy of the legal document stating such.)

Please fill out the following information as it applies to the CLIENT.

Please state why you are seeking out counseling. _____

_____

What is the intensity of this problem and the impact on your quality of life? _____

_____

Have you struggled with this same issue before? If so, when? How did you handle it before? _____

_____

Describe the first time you felt this way. What were you doing? _____

_____

What does a typical day look like for you? _____

_____

_____

What is your most difficult relationship right now?_____

_____

What is your most difficult emotion right now? _____

_____

Have you had any prior counseling? ☐ Yes ☐ No

If yes, When? _____ Where? _____With whom? _____

For what purpose? _____

_____

Please tell me about your previous counseling experience. _____

_____

_____

Are you, or another family member, currently seeing a psychiatrist or another counselor? ☐ Yes ☐ No

If so, which family member? _____ Name of helper _____

For what purpose? _____

CRISIS INFORMATION

Do you have any current suicidal thoughts, feelings, or actions?

☐ Yes ☐ No If yes, explain: _____

_____

On a scale of 1-10 (1 being minimal and 10 being severe), how intense are these feelings? _____

Have you acted on any part of these thoughts? _____ If so, tell me about that. _____

_____

_____

Have you had you had any suicidal acts or attempts before? ☐ Yes ☐ No If yes, how many previous attempts? _____ Describe the method used _____

_____

Did anyone know of the attempts? _____

Any current homicidal or assaultive thoughts or feelings, or anger-control problems?

☐ Yes ☐ No If yes, explain _____

_____

_____

Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior?

☐ Yes ☐ No If yes, explain _____

_____

_____

Do you have a history of or are presently self harming?

☐ Yes ☐ No If yes, explain _____

_____

Any current threats of financial hardship or legal issues?

☐ Yes ☐ No If yes, explain _____

Any current threats of significant loss or harm (family relationships, illness, divorce, custody, job loss, etc.)?

☐ Yes ☐ No If yes, explain _____

_____

Would you or others describe you as impulsive?

☐ Yes ☐ No If yes, explain _____

_____

_____

Would you consider yourself a "burden" to others?

☐ Yes ☐ No If yes, explain _____

_____

_____

Do you or someone in your home own a firearm? ☐ Yes ☐ No

FAMILY BACKGROUND

Father's name _____Age _____ Occupation _____

State of health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that best describe your father (e.g. loving, mean, etc.) _____

_____

_____

How do/did you get along? _____

Mother's name _____ Age _____ Occupation _____

State of health _____ Resides in _____

If deceased, how long ago was the loss?_____

List three words that best describe your mother (e.g., loving, mean, etc.) _____

_____

How do/did you get along? _____

Step-Father's name _____Age _____ Occupation _____

State of health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that best describe your step-father (e.g. loving, mean, etc.) _____

_____

How do/did you get along? _____

Step- Mother's name _____Age _____ Occupation _____

State of health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that best describe your step-mother (e.g. loving, mean, etc.) _____

_____

How do/did you get along? _____

Brothers and sisters: Please list in birth order.

First name	Age	Resides In	Relationship Now		
			Close	Distant	In between
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐

Your happiest memories of you and your family as a child are_____

_____

_____

Your most unpleasant memories of you and your family as a child are _____

_____

_____

Have you ever experienced any of the following?

- ☐ Harsh physical punishment or abuse
- ☐ Sexual advances made toward you by an adult, family member, or older peer
- ☐ Sexual abuse
- ☐ Incest
- ☐ Rape
- ☐ Verbal or emotional abuse

(Please be reminded of my limits of confidentiality as it pertains to protecting you. I am ethically and legally required to inform your parent or guardian as well as the authorities if you have been sexually or physically abused by an adult, family member, and/or older peer.)

If so, please explain: _____

_____

_____

_____

SUBSTANCE USE/ABUSE HISTORY

Are you presently, or have you in the past used alcohol on a regular basis? ☐ Yes ☐ No

If yes, please list type of drink (e.g. beer, wine, whiskey, etc.), frequency of use, when you began use, and approximate date of last use _____

_____

Are you currently, or have you in the past, used any non-prescription drug(s)? ☐ Yes ☐ No

If yes, please list name of drug(s), frequency of use, when you began use, and approximate date of last use

_____

_____

MEDICAL INFORMATION

Please list any current medical problems or symptoms you are concerned about.

1. _____
2. _____
3. _____

Please give information concerning <u>all</u> prescription or over the counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

Name	Dosage/How often	Reason Taken	Taken how long	Reaction

Resiliency and Strengths: Check any areas that apply and add what is unique about you.

- [ ] Supportive social network (friend(s), family, etc.)
- [ ] Responsible to family and others
- [ ] Engaged in school
- [ ] Ability to overcome difficult circumstances/events in the past
- [ ] Hobbies/Interests:_____
- [ ] Frustration tolerance
- [ ] Ability to manage stress
- [ ] Strong desire to live life
- [ ] Pet(s)

Check any of the following that you have experienced or identify with·

- [ ] Anger
- [ ] Detachment/numbness
- [ ] Nightmares
- [ ] Anxiety disorder
- [ ] Panic attacks
- [ ] Phobias or severe fears
- [ ] Mood swings
- [ ] Racing thoughts
- [ ] Lack of concentration
- [ ] Memory loss
- [ ] Fainting spells, feeling light headed or dizzy
- [ ] Loneliness
- [ ] Difficulty managing time
- [ ] Difficulty making decisions
- [ ] Low energy
- [ ] Lack of appetite
- [ ] Shyness
- [ ] Premenstrual syndrome
- [ ] Empty nest
- [ ] Low self-esteem
- [ ] Bullying
- [ ] Feeling of being outside oneself
- [ ] Disorganized thoughts
- [ ] Pornography
- [ ] Peer pressure

Check any of the following that you have experienced and indicate how recently.

- [ ] Relationship issues _____
- [ ] Separation/divorce of parents/guardians _____
- [ ] Family conflict _____
- [ ] Obsessive/compulsive thoughts _____
- [ ] Digestive problems _____
- [ ] Depression _____
- [ ] Sleep difficulties _____
- [ ] Hallucinations _____
- [ ] Violence in the home _____
- [ ] Anxiety _____
- [ ] Blacking out _____
- [ ] Hearing voices _____
- [ ] Sexual addiction _____
- [ ] Weight gain/or loss _____
- [ ] Self Harm _____
- [ ] Sexual issues _____
- [ ] Pregnancy _____
- [ ] Abortion _____
- [ ] Manic Depression/Bipolar Disorder _____
- [ ] Alcohol abuse/chemical substance use _____
- [ ] Suicidal ideation _____
- [ ] Homicidal ideation _____

Have you experienced a psychiatric hospitalization (when, how long, reason for admission) _____

_____

_____

_____

Have you experienced other mental or emotional problems (please specify) _____

_____

_____

_____

Prescribing Physician's name _____ Date last seen _____

Physician's address _____ Phone number_____

Coordinating medical treatment is effective for your overall benefit. Please indicate if I may contact your prescribing physician to coordinate your treatment? ☐ Yes ☐ No

Consenting signature: _____ Date: _____

Spirituality

Do you consider spirituality meaningful to you? _____

Level of meaningfulness of religious affiliation now ☐ high ☐ medium ☐ low

Additional information regarding your spiritual beliefs _____

_____

Emergency Contact

Name_____ Contact telephone number_____

Relationship to you_____

Referred by (if applicable)? _____

Please check the e-signature consent box and sign below:

☐ Esignature consent: Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Delivery of a copy of this Agreement or any other document contemplated hereby bearing an original or electronic signature by facsimile transmission (whether directly from one facsimile device to another by means of a dial-up connection or whether mediated by the worldwide web), by electronic mail in "portable document format" (".pdf") form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing an original or electronic signature.

Client Signature: _____ Date:_____

Parent/Guardian Signature _____ Date _____

Statement of practices and procedures

Katherine Arnold, MAMFC, LMFT-S, LPC-S
30665 Walker North Road
Walker, La. 70785
(225) 287-5714

Qualifications: I earned a Masters of Arts in Marriage and Family Counseling from New Orleans Baptist Theological Seminary in 2013. I am a Licensed Professional Counselor-Supervisor LPC-S #5845 and a Licensed Marriage and Family Therapist – Supervisor LMFT-S #1259 registered with the Louisiana LPC Board of Examiners, 11410 Lake Sherwood Avenue North Suite A, Baton Rouge, LA 70816, (225) 295-8444.

Counseling Relationship: Counseling is a partnership built on trust and commitment. The therapeutic process requires the openness and willingness of the client in consistent effort and practice. Goals will be established in collaboration with the client and often require assignments between sessions. The overall goal of therapy and treatment is always resolution of the issues considered most important to the client through the collaborative process.

Areas of Focus: I focus on clients with marriage and family issues, anger, stress, depression, anxiety, and life issues. I also focus on personal growth and career counseling. I am a member of the American Association of Marriage and Family Therapist (AAMFT), Louisiana Marriage and Family Therapist (LAMFT), and American Association of Christian Counseling (AACC).

Fees and Office Procedures: The fee for each 45-50 minute session is $120.00. Checks can be made to Present Hope Counseling. Should a session be planned for 90-minutes, the fee will be in accordance to 2 sessions. Payment for services is due at the close of each session.

Appointments are typically set at the close of each session. Should you need to reschedule or cancel, please call or text my business phone at (225) 287-5714. A 24-hour notice is required for reschedules or cancelations. You will be charged for appointments missed or sessions rescheduled/cancelled within 24-hours of scheduled appointment time.

Services Offered and Clients Served: One approach to counseling is from an emotional focused interaction. Another cognitive-behavioral perspective; patterns of thoughts and actions are explored in order to understand the clients' problems and develop solutions. Yet, another approach is a systems strategy where the interactional patterns and dynamics within the family systems are explored. I consider the clients' immediate family relationships and larger social context as being important resources in solving life's problems. I approach therapy from an eclectic approach based on the client's goals and needs. Specific therapy models used, but not limited to, Cognitive Behavior Therapy, Family Systems Therapy, Emotional Focused Therapy, EMDR, and play therapy. I work with clients in a variety of formats, including individually, as couples, and as families of various ethnic backgrounds. I also conduct group therapy. I see clients eight years or older.

With the client's informed consent, I may engage in coordination of care and specific consults with other professionals to ensure that a high-level, integrated and personalized treatment plan, if believed in the best interest of the client(s). I may also engage in general consults with other professionals. In a general consult, no HIPAA Protected Health Information (PHI) about the client is released, a client consent is not required. The counselor and the client will discuss and agree upon the necessity of referrals to community resources and/or other professionals for coordination of care.

The client has the option of selecting in-person services delivered in an office (with both the counselor and the client present) or teletherapy services (services provided using interactive HIPAA secure technology-assisted media that enables the counselor and the client, separated by distance to interact via synchronous video and audio transmission) within and across Louisiana. For these purposes, I utilize Google Meet services. A client may utilize either mode of delivery as they choose, unless it is determined that the client may not be properly diagnosed and/or treated by teletherapy. A client who cannot be properly diagnoses and/or treated via teletherapy shall be restricted to in-person services and/or properly terminated with appropriate referrals. Teletherapy requires verification of client's identity and location at the start of each session. Please see and sign the attached addendum to consent to engaging in teletherapy services.

Teletherapy concerns: Please note, as I am only licensed in the state of Louisiana, I can only provide teletherapy services to clients currently within the state of Louisiana. Should we become disconnected or experience technical failure, I will call you and troubleshoot issues. At the beginning of each teletherapy session, I will ask client(s) to provide the address to their location and the location of the nearest emergency room. In the event of an emergency during a teletherapy session, I will refer client to the stabilization plan (if applicable) and/or the nearest emergency room. At the end of session, we will schedule our next session. Please refer to general communication section regarding communication between session.

Code of Conduct: As a LPC-S and LMFT-S, I am required by law to adhere to Code of Conduct that has been adopted by my licensing board, the Louisiana LPC Board of Examiners. A copy of the Code of Conduct is available to you upon request.

Confidentiality: Client confidentiality is an essential part of the counseling process. Materials revealed in counseling will remain strictly confidential except for material shared with my Supervisor and under the following circumstances, in accordance with State law:

1. The client signs a written release of information indicating informed consent of such release.
2. The client expresses intent to harm him/herself or someone else.
3. There is a reasonable suspicious of abuse/neglect against a minor child, an elderly person (60 or older), or a dependent or disabled adult.
4. A court order is received directing the disclosure of information.

In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members with the client's written permission. Clients may refuse to provide written permission to waive confidentiality rights between or

among each other. Please be advised that withholding information from each other during couple or family therapy could impede or even prevent a positive outcome to therapy. Any material obtain from a minor client may be shared with the client's parent or guardian.

Medical Records: In accordance with State and Federal requirements, medical records for adult clients are maintained for six (6) years after the client's last visit and seven (7) years past the 18th birthday of minor clients. Request for medical records will be made available within 10-14 days following a signed authorization of Consent to Release Information by the client or parent/legal guardian of a minor client. The client will be responsible for the cost to obtain the copies of their records.

Privileged Communication: It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

Please note: We live in a society that is connected by cell phones, email, and many social media platforms available; client communication can not be one-hundred percent guaranteed to be private. I want you to be aware of the risks of such methods of communication. If you communicate confidential or private information via SMS (text), by phone, or through e-mail, I will assume that you have made an informed decision, having been made aware of the risk.

Texting: Text messaging is unsecure and I will only text you for the purpose of scheduling or if there is an urgent matter that we must discuss, and I can't reach you another way. If appointment information or general business matters need to be communicated to me, text messaging is fine, but no official counseling will take place via messaging.

Social Media: I do not accept "friend" requests or similar connections with clients, their family members or friends on social media. This is to protect your confidentiality and privacy. If you choose to "like" the business's professional Facebook page or comment on posts/blogs, please know this will connect you to our business and we will assume you have made an informed decision to do so. Online relationships can create security risks as well as therapeutic risks. Please note that any social media apps you use may seek to connect you with me or with other visitors to this office through a "people you may know" or similar feature. I have no control over apps that may intrude on the privacy of your treatment in this way. If you would like to minimize the risk of others becoming aware of your connection to me or this office, please make use of the privacy controls available on your phone/device. Turning off a social media app's ability to know your location and refusing it access to your email account, contacts, and history in your phone, protects your privacy and confidentiality.

Emergency Situations: Please note, I do not guarantee immediate accessibility or response. I do not answer email, text, or phone calls/messages when I am with other clients, afterhours, weekends, vacations, or holidays. When I am unavailable, you may choose to leave a message, email, or text and I will respond as soon as possible. In an emergency situation when an immediate response is necessary, you may call the Baton Rouge Intervention Center (225) 924-3900 or 1-800-437-0303, your primary care physician, the local emergency room, or call 911. The Livingston OLOL emergency room located at 5000 O'Donovan Blvd., Walker, Louisiana. The telephone number is (225) 271-6000.

Client Responsibilities: You, the client, are full partner in counseling. Your honesty and effort are essential to success. As we work together, if you have suggestions or concerns about your counseling, goals, treatment, etc., I expect you to share these with me so that we can make the necessary adjustments. If homework is warranted to aid in the therapeutic treatment plan, you are responsible to complete the assignments between sessions. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you. In the event, that I am unable to therapeutically treat you and determine that another mental health provider would better serve you, I will help you with the referral process.

Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of the medications that you are current taking and a history of any pre-existing mental or physical diagnosis.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which you were not initially aware. Marital therapy involving only one spouse may lead to adverse responses from the other spouse. Changes in relationship patterns that may result from family therapy may produce unpredicted and/or possibility adverse responses from other people in the clients' social system. If this occurs, you should feel free to share these concerns with me.

I have read the Statement of Practices and Procedures of Katherine Arnold, MAMFC, LPC-S, LMFT-S and my signature below indicates my full informed consent to services provided by Katherine Arnold, MAMFC, LPC-S, LMFT-S. I am aware that Mrs. Katherine Arnold may share information with other MFT and LPCs for the sole purpose of peer consultation and/or supervision toward certifications, education, or training purposes. I am also aware that my sessions with Katherine Arnold, MAMFC, LPC-S, LMFT-S may be audio or videotaped for the purpose of supervision.

Client Signature **Date**

Katherine Arnold, MAMFC, LPC-S, LMFT-S **Date**

Statement of practices and procedures

Parent/Guardian Consent for Treatment of a Minor:

If the client is a minor, parental authorization provides informed consent for all the above:

I _____ give permission for Katherine Arnold, MAMFC, LMFT, LPC to
(name of parent or legal guardian)

conduct therapy with my _____, _____.
(relationship) **(name of minor)**

Signature of Parent or Legal Guardian **Date**

Present Hope Counseling, LLC.
Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable the mental health professionals of Present Hope Counseling, LLC. to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions 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 toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, 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. Present Hope Counseling, LLC. utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with delivery psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, services will resume as “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. 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.
11. I understand that different states have different regulations for the use of telehealth. The Louisiana Professional Counselors Board of Examiners has authorized, with Board approval, the use of telehealth services to provide continuity of care to clients by their therapists.

Payment for Telehealth Services
Present Hope Counseling will follow standard practices of receiving payment at the time of service or the session rate will be charged during the same calendar week (if a credit card authorization form is on file). We will provide you with a statement of services for your records if you wish.

Patient Consent to the Use of Telehealth 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 agreed to the terms of this document.

_____
Client's Print Name

_____ _____
Client's Signature (if 18 or older) Date

_____ _____
Parent or Guardian Signature (if client is a minor) Date

Financial and Termination Policy

Fees and Payments

The full session fee is $120 for 50 minutes. Payments must be made prior to the start of each session and may be made in cash, credit card, or by personal check. If a parent or third party is paying for the session, the client is still responsible for making payment prior to the start of each session.

All payments made with checks or cash will be at the standard rate listed above. For any transactions utilizing a credit/debit card where the card is present and swiped, a service fee of 3.5% will be added. For payments made with a card on file or requiring manual entry, there will be a 4% service fee added.

Being more than 5 minutes late for an appointment will result in a treatment time that is shortened and will end at the original scheduled time. The full amount of scheduled time will be charged. Arrivals of 15 minutes or later to an appointment will be considered canceled with no treatment provided. The full amount of the original time scheduled will be charged to the client with the need to prepay for future appointments.

Cancellations

Present Hope Counseling, LLC requires 24-hour notification for cancellations. You may contact Katherine Arnold at 225-243-5363 or Katherine@presenthopecounseling.com. Cancellations made without this notice will be charged the full fee of$100. By checking the box below and electronically signing, I agree to comply with this policy for services rendered at Present Hope Counseling, LLC.

A credit card authorization form is attached, however it is not required. This form and credit card information will allow for session fees or cancellation fees to be processed. In the case of a missed appointment and your card is not on file, you will be contacted for payment. A completion of payment is required in order to schedule your next session.

We understand that life's challenges often interfere with scheduled plans. For that reason, we will offer the following exemptions to our cancellation fee:

- Each client will be given one "grace" session per calendar year, regardless of circumstances
- Clients will not be charged for emergent situations such as sudden illness or car accidents.

Please make every effort to communicate with your therapist prior to your scheduled session time.

It is our priority as your therapists to behave in a trustworthy manner. We ask that you approach our cancellation policy with honesty and integrity as well.

Termination Policy Changes

As therapists, we adhere to the ethical principle of autonomy. More specifically, we value the rights of our clients to control the direction of their lives. At any point, our clients can choose to refuse services, with or without explanation. Current professional standards require that services be formally terminated when the client's goals of treatment have been satisfied, when the client requires referrals for other professionals, or when services are no longer being provided.

Throughout the course of therapy, your counselor will make the effort to re-evaluate goals and determine necessity of discharge. As treatment goals are met, frequency of services will decrease. After 90 days without contact between client and therapist, a formal note of termination will be added to the client's file. Should a client no-show/no-call for two sessions, the client will automatically be discharged from services.

Therapists will typically make efforts to prioritize returning clients, even after discharge. However, after formal termination of services, clients will no longer hold a reserved spot on the therapist's schedule.

☐ Esignature consent: Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Delivery of a copy of this Agreement or any other document contemplated hereby bearing anoriginal or electronic signature by facsimile transmission (whether directly from one facsimile device to another by means of a dial-up connection or whether mediated by the worldwide web), by electronic mail in "portable document format" (".pdf") form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing an original or electronic signature.

_____ Client's Signature

_____ Date of Signature

Credit Card on File Authorization

I _____ authorize Katherine S. Arnold, LMFT, LPC at *Present Hope Counseling*, LLC to charge my credit card for psychotherapy sessions at tthe session rate of $120.00 or based on my copay cost in accordance with my insurance plan. In addition, I authorize Katherine S. Arnold, LMFT, LPC at *Present Hope Counseling*, LLC to charge my credit card for cancellation of sessions not honoring the 24-hour cancellation policy as well as missed sessions at a full rate of $120.00 which is an out of pocket cost. Missed/canceled sessions cannot be billed to insurance. I guarantee payment for any services rendered made with my credit card, including renewed cards.

_____

Authorized signature of cardholder Date

_____

Printed name of cardholder

Card Type:

American Express ☐
Mastercard ☐
Visa ☐

Please fill out the 16 digit card number in person with your therapist so sensitive financial data is not sent via email.

Card Number:_____

Expiration Date:_____

Security Code:_____

Name as it appears on Card:_____

Billing Address:_____

Dear Client,

We look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company. However, we do not verify coverage or call to get the information concerning your coverage for you. You must call the phone number(s) on your health insurance card to get the following information PRIOR to your first session. Without ALL questions on this form answered by your Insurance Company, you will be responsible for the full session fee.

Name: _____ Date of Birth: _____
Insured's Name: _____ SS#: _____
Name of Insurance Company: _____ Effective date: _____
Insured's ID number: _____ Group Numbers: _____
Insured's DOB: _____ Plan Name: _____
Employer/School (Indicated on Insurance Card)? _____

You must call the number on your insurance card and ASK THESE QUESTIONS: Ask for a reference number regarding your phone call. Ref. # _____

Do I have outpatient mental health benefits? Yes☐ No☐

Is Katherine S. Arnold, LPC, LMFT (Present Hope Counseling, LLC) on my provider list?
Yes☐ No☐
If no, do I have any "out of network" benefits? Yes☐ No☐
(Write what those benefits are on the back of this form)
Do I have a deductible to meet prior to benefit coverage? Yes☐ No☐
What is the amount of my deductible? $_____
How much of that deductible have I met? $_____
Do I have a co-payment for mental health benefits? Yes ☐ No☐
If so, what is my co-payment amount per session? $_____
How many sessions are allowed per calendar year? _____
Is prior authorization needed for counseling? Yes☐ No☐
If so, authorization number? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: _____ DATE: _____

PRESENT hope COUNSELING

Present Hope Counseling, LLC

HIPAA Acknowledgement Form

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the Present Hope Counseling, LLC HIPAA Notice of Privacy Practice.

Print Name: _____ Date:_____ Signature: _____

Print Name: _____ Date:_____ Signature: _____

Print Name: _____ Date:_____ Signature: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

Other (Please provide specific details)_____

_____

_____

_____

_____ _____

Counselor Signature Date

Present Hope Counseling, LLC
HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU:

A. MAY BE USED AND DISCLOSED AND

B. HOW YOU CAN GET ACCESS TO THIS INFORMATION SHOULD YOU SO DESIRE.

PLEASE REVIEW IT CAREFULLY.

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR "PROTECTED HEALTH INFORMATION" ("PHI").

A. By law we are required to insure that your PHI is kept private.
B. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health (including mental health) or condition, the provision of health care (including counseling) services to you, or the payment for such health care.
C. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI.

1. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice;
2. PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

III. HOW WE WILL USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that *Do Not* **Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:**

1. For treatment. We can use your PHI ***within*** our practice (Present Hope Counseling, LLC) to provide you with mental health treatment, including discussing or sharing your PHI with Present Hope Counseling, LLC therapists, staff and supervisors, trainees and interns. Example: We may discuss your treatment with a supervisor or consult with another Present Hope Counseling, LLC therapist in order to facilitate your care.

2. For health care operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice. Example: We may provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

3. To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies or collection companies.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

B. Certain Other Uses and Disclosures that *Do Not* **Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.

2. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

3. If disclosure is mandated by the Louisiana Child Abuse and Neglect Reporting law. For example, if we have a reasonable suspicion of child abuse or neglect.

4. If disclosure is mandated by the Louisiana Elder/Dependent Adult Abuse Reporting law. For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.

5. To avoid harm. We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (e.g., adverse reaction to meds).

6. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: We may make a disclosure to the appropriate officials when a law requires us to report information to judicial court officials, government

agencies, law enforcement personnel and/or in an administrative proceeding, of if disclosure is required by a lawful search warrant**.** (Mississippi law generally indicates that certain counseling information will not be disclosed in court proceedings, for example testimony by or written records of licensed Marriage and Family Therapists as they pertain to divorce-child-custody issues. However, in some instances courts may order the disclosure of such information.)

7. For health oversight activities. Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

8. For specific government functions. Examples: We may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

9. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.

10. Appointment reminders and health related benefits or services. Examples: We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer.

11. For Workers' Compensation purposes. We may provide PHI in order to comply with Workers' Compensation laws.

12. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

13. If disclosure is otherwise specifically required by law. Example: If compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations, or compelled to comply with a lawful subpoena.

C. Other Uses and Disclosures of your PHI Require Your Prior Written Authorization.
In any other situation not described in Sections IIIA and IIIB above, we will request and must obtain your written authorization before using or disclosing any of your PHI.
Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by us.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask t that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

B. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. (We are not obligated to delete any information, only add corrections or additions.) Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

C. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years (if applicable) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

D. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may decide that we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have our denial reviewed. If you ask for copies of your PHI, we will charge you not more than $.50 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

E. The Right to Choose How We Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint. You may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you. You may also send a written complaint to the Louisiana Department of Health and Hospitals at Post Office Box 629, Baton Rouge, LA 70821-0629.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on June 01, 2017.