PATIENT REGISTRATION

DATE: ________________

PATIENT NAME: ___________________________________ ___MALE ___FEMALE

SOCIAL SECURITY #: ______________________ DATE OF BIRTH: ______________

DRIVERS LICENSE #: _______________________

ADDRESS:____

CITY: ________________________________ STATE: _____ ZIP: ___________

MARITAL STATUS: ___SINGLE ___MARRIED ___DIVORCED ___WIDOW

WHO REFERRED YOU TO US? ____

CONTACT INFORMATION:

PHONENUMBER (___)_______________ ___HOME ___CELL ___WORK

PHONENUMBER (___)_______________ ___HOME ___CELL ___WORK

PHONENUMBER (___)_______________ ___HOME ___CELL ___WORK

PREFERRED NUMBER TO CONTACT YOU: ___HOME ___CELL ___WORK

MAY WE LEAVE A MESSAGE ON THIS PHONE? ___YES ___NO

EMAIL ADDRESS: ____

MAY WE EMAIL YOU APPOINTMENT REMINDERS? ___YES ___NO

MAY WE EMAIL YOU ABOUT UPCOMING GROUPS? ___YES ___NO

EMERGENCY CONTACT IMFORMATION: (REQUIRED)

NAME: ______________________________ RELATIONSHIP:_________________

PHONENUMBER (___)_____________

RESPONSIBLE PARTY: (Who is ultimately responsible for billing)

NAME: ______________________________ RELATIONSHIP:_________________

SOCIAL SECURITY # : _____________________ DATE OF BIRTH: _____________

ADDRESS:____

CITY: _______________________________ STATE: ____ ZIP: __________

PHONE: (_______)_____________________

NAME OF EMPLOYER:____

ADDRESS OF EMPLOYER:____

CITY: _______________________________ STATE: ____ ZIP: ____________

PAYMENT INFORMATION*:

CREDIT CARD NUMBER: ____

TYPE OF CARD: __CREDIT ___DEBIT EXPIRATION DATE: ____________

SECURITY CODE: ____________ BILLING ZIP CODE: ____________

Some people elect to have a card on file to charge for each session, which makes checking out more efficient. We are happy to do that for you as well, if you authorize us to do this, please initial below:

I authorize Connections Counseling to charge my card after each session. _____________

*To be used for payment of sessions. See information on fees and cancellation policy for more information on payment and fees

CONSENT FOR TREATMENT:

By signing my name below, I show that I have read the attached information and, if needed, the information has been verbally explained to my satisfaction. I have had all my questions about fees, confidentiality, insurance, and/or other matters answered, and I have received a copy of this contract if so requested.

I ____________________________________, hereby consent to evaluation and treatment.

SIGNATURE OF PATIENT/
RESPONSIBLE PARTY:____________________________________DATE: __________

PRINTED NAME OF PATIENT/
RESPONSIBLE PARTY:____________________________________DATE: __________

ADDRESS:____

CONSENT FOR PAYMENT:

I authorize payment to Connections Counseling, LLC for services rendered to my dependents/me. By signing below, I have agreed to all the terms in the attached financial agreement.

SIGNATURE OF PATIENT/
RESPONSIBLE PARTY:____________________________________DATE: __________

FEE SCHEDULE:

- In office session: $115/clinical hr (individual, couple, or family)
- Equine Assisted Psychotherapy: $150/clinical hr (individual, couple, or family)*
- Group therapy: $75 per clinical hr
- Crisis session (scheduled within 24 hours of calling/not previously scheduled): $150/clinical hr
- Collaborative emails/texts/phone correspondence with patient, support person or care provider $25/15 minutes, $25 minimum
- Report Preparation: $150/clinical hr, 2 hr minimum
- Requirement to appear in court/attend collaborative meetings: $150/clinical hr
- No Show/Late Cancellation: $75/session.

Release of Information

A release of information is important in order for us to be able to collaborate with your other care providers or support people. You are able to limit the information shared as long as it is not an emergency. By law, if we feel you are a danger to yourself, to others, or are actively psychotic, or if you report someone else is being hurt as in the case of suspected child or elder abuse, We do not need a release in order to speak to someone about you or the situation. With those exceptions, we need to have people and agencies on a release of information in order to confirm We know who you are or collaborate with them. If you wish to revoke your release, you must give me this in writing when we see you or by USPS mail. A text message or email will NOT revoke the release of information. Please let me know if you have any questions.

____ Emergency Contact Person ____________________________ Phone _________________

____ Family or Peer Support Person _________________________ Phone _________________

____ Primary Care Physician _______________________________ Phone _________________

____ Psychiatrist ____ Phone _________________

____ School ____ Phone _________________

____ Employer ____ Phone _________________

____ Past Provider(s) _______________________________________ Phone _________________

____ Pastor/Clergy ____ Phone _________________

I, the undersigned client, hereby authorize Connections Counseling, LLC, to release and/or obtain information with respect to any physical, psychiatric, or substance abuse related condition obtained during the course of diagnosis and treatment. We understand that the purpose of the form is to exchange information pertinent to my treatment. This information which is being disclosed is confidential and is protected by Federal Law.

SIGNATURE OF PATIENT:__________________________________DATE: _________

SIGNATURE OF
PARENT/GUARDIAN:______________________________________DATE: __________

POLICIES and CONSENT TO TREATMENT

We have developed this policy statement for your information, in order to answer questions that are frequently asked by clients regarding services, confidentiality, fees and more. We are happy to discuss these policies with you at any given time. Your privacy is of utmost concern to us and to our practice. All records are kept in a confidential manner keeping with the ethics of the profession. We are honored to be the therapeutic team you have chosen to begin the process of psychotherapy with and we do not take our responsibility to you lightly.

BENEFITS AND RISKS OF THERAPY

People contemplating counseling should realize that they might make significant changes in their lives once they've begun psychotherapy. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriage or significant relationships. They may begin to feel differently about themselves and may change other aspects of their lives. While we may assist clients in making changes, we cannot guarantee outcomes nor advise you of decisions. Patients are ultimately responsible for their growth and changes.

PATIENT RIGHTS AND RESPONSIBILITIES

RIGHTS:

- The right to participate in planning your treatment program.
- The right, to the extent permitted by the law, to refuse specific treatment, procedures, unless there is danger of harm.
- The right to file a grievance, should you feel you are treated unfairly.
- The right to confidentiality.
- The right to be free from discrimination including discrimination because of race, religion, sexual preference, age or disability.
- The right to privacy as appropriate to your treatment setting.

RESPONSIBILITIES:

Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following responsibilities:

- The responsibility to provide accurate and complete information as needed for your treatment planning.
- The responsibility to update any changes in information needed for your treatment planning.
- The responsibility to make it known whether or not you understand your treatment plan.
- The responsibility to actively participate in your treatment.
- The responsibility to indicate when you are unwilling and/or unable to comply with your treatment plan.
- The responsibility for your actions if you refuse to comply with treatment plan recommendations.
- The responsibility to follow all rules and regulations established to maintain a safe treatment environment.
- The responsibility to respect the rights and confidentiality of others.

SCOPE OF PRACTICE/SERVICES OFFERED/CREDENTIALS:

There are guidelines in place to protect a consumer/patient. One of those is the limitation of scope of practice. Scope of Practice refers to what different practitioners are licensed to do or advise on. As a patient, you have a right to decline any type of treatment that is offered, as well as have the right to ask questions about the therapy. It can be confusing to know which provider can provide what service, as we have different types of providers. Therapists, nutritionists, yoga instructors and psychiatrists all have different scopes of practice. We ensure that your treatment team is well rounded and that none of us are providing a service outside of our scope. Please let us know if you have any specific questions about these roles. If you would like information about your provider's experience and credentials, we can provide that to you. There is a short biography for each practitioner on our website as well. Although within our scope of practice, it is our policy to refer out for any custody evaluations or recommendations. We will not be willing to complete custody evaluations, nor make recommendations. The therapeutic relationship is the primary concern and making such recommendations often damages that relationship. We are happy to give you the name of someone who does this kind of work.

Several of us supervise pre licensed individuals who are working towards licensure as therapists and we do have several pre licensed therapists working at Connections. They are registered with the state and they have a clinical supervisor. If you are seeing a supervisee, you will be informed of that and will be informed of who his/her supervisor is. We consult about all cases under supervision. If you ever have questions or concerns when working with one of our staff, feel free to contact Britt, Owner of Connections Counseling, LLC, at any time.

CONFIDENTIALITY:

Professional ethics and state law indicated that the client has the privilege of controlling confidential information. There are exceptions to the laws of confidentiality:

1) in the case of an emergency if the therapist believes that a client is at risk of hurting himself/herself

2)if a child or elder is being abused either physically, emotionally, financially, or by neglect a therapist is required to report this to the Department of Children's Services/Department of Adult Protective Services.

3) if the patient signs a waiver to release information to a third party and

4) if the patient files suit against the service provider

5)if a patient allows his/her mental health diagnosis or treatment history to be admissible in court, or If the patient is involved in legal actions of any kind (including custody issues)and inform the court of services that he/she receives counseling from a therapist, you will be making your mental health an issue before the court. you may be waiving your right to having your record kept confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received mental health treatment.

6) Most insurance companies, other payers, or manage care companies require the provider to release information regarding diagnosis, type and place of service, date of service, treatment plan, or other confidential information. More on insurance below.

INSURANCE:

Britt, Owner of Connections Counseling, LLC, accepted insurance for several years and has made the decision to no longer participate in insurance panels. We, as a team, feel

strongly that managed care should not dictate what type of treatment nor the duration of treatment that someone should receive. If you should choose to submit a receipt to your insurance provider to file for out of network benefits, we are happy to provide you with that form. It is against our policy to release your record to insurance and will decline to do so if requested. Because we do not contract with insurance, we are under no obligation to provide this to your company. Again, the intent is to keep your best interest in mind, make your treatment the number one priority and to protect your confidentiality.

CANCELLATION POLICY:

Because of the nature of our work, a missed appointment or no show to an appointment often means that we cannot fill your time slot with someone else who is needing an appointment. Please extend the courtesy of a 24 hour notice for cancellations so that we can try to offer your time slot to someone else. We take a low number of new patients and carry a small caseload intentionally, so that we can be able to provide comprehensive, attentive services to you while you are our patient. This means that people are waitlisted often. It isn't fair to keep someone who is motivated for treatment waiting, if you cannot commit to the time you have scheduled.

Please note that cancellations after 24 hour notice will be billed at $75 per hour. We will take into consideration extenuating circumstances. In addition, if you have a recurring appointment on our schedule and you cancel more than 2 times, we will no longer hold the recurring time for you. If you no show to an appointment more than 2 times, we will need to discontinue seeing you as a patient. Sessions are typically for 1 clinical hour, which is 45-50 minutes- including time to reschedule the next session. If you are less than 15 minutes late, we can move forward with the session; however, if you are more than 15 minutes late, we will have to reschedule, and this will be considered a "no show". It is difficult to get into a therapeutic process with less than 45 minutes. We will always give your full session time when you have an appointment scheduled and will never start more than 15 minutes later than your scheduled appointment, as we know your time is valuable as well.

EMERGENCIES:

We will often be in session and cannot guarantee we will be available in the event of a crisis. Even if you have our cell phone number(s), this does not mean you have access to us at all times. Additionally, it is not always appropriate for us to intervene, and you may require a higher level of care in the event of a crisis. In the event of an emergency, please do not wait for

us to call you back. Please call 911 or go to your closest emergency room. You may also elect to call Lakeside Behavioral Health Services at 1(800)232-LAKE (5253) or (901)377-4700 or go to their Needs Assessment and Referral Center (2911 Brunswick Road Memphis TN 38133) for an emergency assessment 24 hours a day. If you do choose to go to Lakeside, please let them know we are your therapist and have your therapist added to your release of information. If you require an emergency/crisis session with us and we are able to schedule it, the fee will be $150 as indicated in the fees section.

LENGTH OF TREATMENT:

There is no set length of therapy. Each client or family comes with a unique set of issues and we address people as individuals rather than a preset number of sessions.

TERMINATION OF THERAPY:

The patient has a right to terminate therapy at any given time during the treatment process. If you chose to terminate therapy, we will encourage you to have a session to discuss and process the feelings about termination of treatment. In addition, people do reach completion of treatment, at which time, therapy will also terminate. Again, it is beneficial to discuss and process feelings around the completion of treatment, as it is normal to have mixed emotions around this.

CURRENT PATIENT OF RECORD:

Once you have terminated therapy either as scheduled or by not coming to appointments for 3 months or longer, you are no longer a "current patient of record" and you may be placed on a waiting list with other new patients if you should choose to return.

FEES:

Payment is due at the time services are rendered. We must emphasize that as providers of service, our relationship is with you, but we do need to be able to discuss payments openly.

The fee policy is in place so that all parties are aware of what to expect regarding billing. We do require that the financial agreement form be kept on file for all patients. Some sessions require 1.5-2 hours and will be billed as such.

We request that clients submit a credit/debit card number and/or a pre-filled/signed check to keep on file. You can provide your credit card information on your Patient Registration form. If you cancel with less than 24 hours notice, your card will be debited for $75 or check

filled in for that amount, and you will be notified of this charge. If you have a need to cancel your appointment for emergency purposes, the nature of the emergency will be considered before exacting a cancellation fee. Additionally, if a check is returned by your bank for insufficient funds, there will be a charge of $25. Note that a credit card transaction with incur a 2.0% fee to your charge. (for example, a $115 session fee will require $2.30 additional). You may also make a credit card payment on the website, The website is www.connectionscounselingtherapy.com. We ask that you add the 2.0% (two percent) fee to that transaction.

FEE SCHEDULE:

- In office session: $115 per clinical hour (individual, couple, or family)
- Equine Assisted Psychotherapy: $150 per clinical hour (individual, couple, or family)*
- Group therapy: $75 per clinical hour
- Crisis sessions (scheduled within 24 hours of calling/not previously scheduled): $150 per clinical hour
- Collaborative emails/texts/phone correspondence with patient, support person or care provider $25 per 15 minutes, $25 minimum
- Report Preparation: $150 per clinical hour, 2 hour minimum
- Requirement to appear in court/attend collaborative meetings: $150 per clinical hour
- No Show/Late Cancellation: $75 per session.

We are committed to providing you with best possible care. In order to achieve these goals, we need your assistance and your understanding of your payment policy.

In the event that you do not maintain a $100 balance or less, we will have to pause therapy until you can bring your account current. IT IS UNETHICAL of us to continue allowing you to build up a balance you may not be able to manage. In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees that might occur. The account will become delinquent after it has matured to 121 days from the date of service. If the account goes to collections, there will be an added 33% to the account balance. The office of Connections will determine the collection agency.

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU MAY CHOOSE NOT TO PRINT THIS PORTION OUT - THIS IS FOR YOUR INFORMATION

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. You will find your provider will do all she can to protect the privacy of your mental health records.

As required by "HIPAA", this explanation was prepared to explain how therapists are required to maintain the privacy of your health information and how Connections Counseling, LLC may use and disclose your health information.

The mental health licensing law provides extremely strong privileged communication protections for conversations between your mental health provider and you. There is a difference between privileged conversations and documentation in your mental health records. Records are kept, documenting your care, as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible without your authorization to insurance companies and other third party reviewers.

HIPAA provides privacy protections about your personal health information. We may use and disclose your medical and mental health records without authorization for each of the following: treatment, payment and health care. These functions require release of "protected health information" (PHI). Below, we have defined these three (3) functions: treatment, payment, and health care operations.

1. Treatment Purposes refers to Connections coordinating or managing your mental health care treatment. Examples of this would a counseling session in which the healthcare provider

records information in the health record. Or during the course of your treatment, the treating provider determines she/he will need to consult with another specialist in the area. She may share the information with such specialist to obtain his/her input. Also, this includes communication between Connections and any other treating provider for the purpose of providing health care to you. While this is permitted by HIPAA, Connections' standard practice is to require written releases for this information in many situations.

2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Examples of this would be sending a bill for your visit to your insurance company for payment or the health insurance company or a business associate helping us obtain payment, and them requesting information from us regarding your medical care. We may provide information to them about you and the care given.

3. Health care operations include the business aspects of running her practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. We will share information about you only if it is necessary to obtain and continue your services.

Routine Uses and Disclosures

The use of your protected health information is necessary to perform routine activities at our office such as filing insurance claims, scheduling appointments, keeping records and other tasks. You will not need a written authorization to allow us to perform these duties for you.

We may contact you via telephone (a message may be left) or mail to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We will not require your authorization.

We may also create and distribute deidentified health information by removing all references to individually identifiable information for marketing or research. We will not require your authorization.

Unless required by law, most other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing, except to the extent that we

have already taken actions relying on your authorization; we refer to this as "Authorized Non-Routine Disclosures".

Uses and Disclosures of Protected Health Information Requiring Authorization, Authorized Non-Routine Disclosures

Tennessee requires the provider to get authorization and consent for treatment, a release of payment and to conduct healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. We may disclose Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations without your consent.

Additionally, if you ever want our office office to send any of your protected health information of any sort to anyone outside our office, you will always first sign a specific authorization to release information to this outside party unless stated otherwise in this notice. The release is available upon request.

There is a third, special authorization provision potentially relevant to the privacy of your records: Psychotherapy Notes. In recognition of the importance of the confidentiality of conversation between mental health providers and patients in treatment setting, HIPAA permits keeping separate "Psychotherapy Notes" separate from the overall "designated medical record". Insurance companies cannot secure "Psychotherapy Notes" without your written authorization. "Psychotherapy Notes" are the notes" recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's "designated medical record." A patient's authorization is required for the use and disclosure of psychotherapy notes except for use by the originator of the notes for treatment, or for use of disclosure by the covered entity for its own mental health training programs, or use or disclosure by the covered entity to defend itself in a legal action or other proceedings brought by the patient or guarantor; and/or when required by law.

"Psychotherapy Notes" are necessarily more private and contain much more personal information about you, hence the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency

of treatment furnished, results of clinical test, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, the following protected health information may be released without your consent or authorization:

● Child abuse ● Suspected sexual abuse of a child ● Adult and Domestic Abuse ● Health Oversight Activities (i.e., licensing boards for mental health providers in Tennessee) ● Judicial or administrative proceedings (i.e., if you are ordered here by the court for an independent child custody evaluation in a divorce) ● Serious Threat to Health or Safety (i.e., our "Duty to Warn" Law, national security threats) ● Workers Compensation Claims (if you seek to have your care reimbursed under workers compensation, all of your care is automatically subject to review by your employer and/or insurer(s), except Psychotherapy Notes. If requested, we will obtain your written authorization before releasing any Psychotherapy Notes, unless required by law. ● Disclosures to coroners, medical examiners, and funeral directors ● Disclosures to organ procurement organizations

Your Health Information Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: 1.Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to your therapist– She is not required to grant the request but she will respond to any request; 2.Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice");

3.Right to inspect and copy your records in the designated mental health record set and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; or you have the right to appeal a denial of access to your protected health information except in certain
circumstances;

4.Right to request that your health care record be amended to correct incomplete or incorrect information by
delivering a written request to our office using the form we provide to you upon request.

(The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5.Right to receive an accounting of nonauthorized disclosures of your health information as required to be maintained by law by delivering a written request to her office using the form she provide to you upon request. An accounting will not include internal uses of information from treatment, payment, or operations, disclosures made to you or made at your request, or nonmedical records (clinical information) disclosures made to family members or friends in the course of providing care;
6.Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to her office using the form she gives you upon request; Example would be you may not want your bills sent to your home address so you may request them to be sent to another location of your choosing;
7. Right to revoke your authorization of your protected health information except to the extent that action has already been taken; and, If you want to exercise any of the above rights, please contact Connections Counseling, LLC in person or in writing. We will provide you with assistance on the steps to take to exercise your rights. Mailing address for written requests is: 4937 William Arnold Road Memphis TN 38117.

The office is required to: ● Maintain the privacy of your health information as required by the state and federal law; ● Provide you with a notice of her duties and privacy practices; ● Abide by the terms of this Notice; ● Notify you if we cannot accommodate a requested restriction or request;
● Accommodate your reasonable requests regarding methods to communicate health information with you; and ● Accommodate your request for an accounting of nonauthorized disclosures
Britt Palmer has appointed herself as a "Privacy Officer" for her practice per HIPAA regulations. If you have any concerns of any sort that our office may have somehow compromised your privacy rights, please do not hesitate to contact Britt Palmer, the "Privacy Complaint Officer" immediately about this matter. You will find she is always willing to talk to you about preserving the privacy of your protected mental health information.
Connections reserves the right to amend, change, or eliminate provisions in our privacy

practices and access practices and to enact new provisions regarding the protected health information she maintains. If her information practices change, she will amend her Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting her office and picking up a copy.

Please contact us for more information by asking to speak to our Privacy Officer or for written enquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health and Human Services Office of Civil Rights