Welcome to Renewed Hope Counseling Services!

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. Please print and sign ***all*** of the enclosed pages (with the exception of the Authorization to Release Health Care Information form which is optional, unless you are an adolescent or young adult).

The ***Intake Form*** provides me with your basic identifying and contact information as well as information about your symptoms and what you hope to gain from therapy.

The ***Counseling Disclosure Statement*** outlines my therapeutic background and approach, policies regarding financial matters, confidentiality of information, and client rights. Please sign and date at the bottom of the disclosure statement. If you are a minor, please have a parent sign and date the form as well.

The ***Office Policies*** document outlines my policies related to payment, insurance reimbursement, emergency procedures, and other administrative information. Please sign and date at the bottom of the disclosure statement. If you are a minor, please have a parent sign and date the form as well.

Please sign and date the ***Credit Card Authorization*** form.

Please sign and date the ***Consent for Telehealth Consultation*** form.

Optional: If you would like for me to consult with other therapists or providers that you have worked with or if you would like for me to be able to share information with a family member, please complete an ***Authorization to Release Health Care Information*** form for each organization/person.

> ****If you are an adolescent or young adult whose parent/legal guardian or other individual will be covering the cost of therapy, please complete this form to give me permission to communicate with them regarding financial arrangements and scheduling.****

Please sign and date the ***Good Faith Estimate Notice*** form.

Please sign and date the ***Notice of Privacy Practices (HIPAA)*** form. If you would like to read the HIPAA consent form, you can find it on my website.

Please scan these documents back to me upon their completion. I look forward to meeting you!

Sincerely,

S Bickerstaff

Sara Bickerstaff, LMHC

CLIENT INTAKE FORM

Today's Date: _____

Name: _____ Birthday: _____

Social Security Number: _____

Address, City, State, & Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____ Work Phone: _____

What is the preferred way to contact you regarding appointments? _____

Is it okay to leave a message? _____

In order to protect your privacy, I typically will not identify myself as calling about counseling when I contact you.

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone #: _____

Has any member of your family ever been treated in our office? _____

Whom may I thank for referring you to my practice? _____

Relationship Information

□ Single □ Married (1st, 2nd, 3rd) □ Separated □ Widowed □ Living with Significant Other/Roommate

□ Divorced (1st, 2nd, 3rd) Date of Divorce: _____

Spouse/Partner's Name: _____ # of Years Married/Partnered:_____

Sexual Orientation: □ Straight □ Gay □ Lesbian □ Bisexual □ Questioning □ Other Gender: □ M □ F □ Trans □ NB

Names and ages of your children (indicate if stepchildren, adopted, or foster children): _____

_____

Medical History

Personal Physician/Organization: _____ Phone: _____

Address: _____

Current Psychotropic Medications/Dosages: _____

Previous mental health diagnoses: _____

Diagnosed by: _____

Date of last medical exam: _____

Current non-prescription drug use: _____ Frequency of use:_____

Have you been in psychotherapy before? _____ Dates: _____

With whom and where: _____

Have you had any prior ***inpatient*** treatment for psychological, emotional, or substance abuse issues? _____

If yes, how many occasions: _____ How long? _____ Dates: _____

Facility Name: _____ City _____ State _____

Facility Name: _____ City _____ State _____

Has any member of your family had inpatient treatment for psychological, emotional, or substance abuse issues?

If yes, who/why? _____

What would you like to gain from therapy/what are your goals for therapy? _____

_____

Is there anything else you would like me to know? _____

_____

Symptom Checklist

Depression: Check all that apply

□ depressed mood
□ diminished interest or pleasure in all or almost all activities
□ significant weight loss
□ significant weight gain
□ insomnia
□ hypersomnia
□ feelings of restlessness
□ feelings of being slowed down
□ fatigue/loss of energy
□ feelings of worthlessness
□ feelings of guilt
□ poor appetite
□ overeating
□ low self-esteem
□ poor concentration/distractible/difficulty making decisions
□ feelings of hopelessness
□ recurrent thoughts of death, suicidal thoughts, suicide attempt or plan
□ irritability
□ inflated self-esteem
□ decreased need for sleep (i.e. feeling rested after only 3 hours of sleep)
□ racing thoughts
□ increase in goal-directed activity
□ excessive involvement in pleasurable activities that have a high potential for negative/painful consequences

Frequency of these symptoms:

□ occasionally
□ frequently
□ most of the day, nearly every day
□ chronically depressed mood for most of the day, nearly every day for at least 2 years

Anxiety: Check all that apply

□ restlessness
□ easily fatigued
□ difficulty concentrating
□ irritability
□ muscle tension
□ sleep disturbance (difficulty falling or staying asleep, unrefreshing sleep)
□ panic attacks
□ phobias
□ social anxiety
□ obsessions or compulsions

Frequency of these symptoms:

□ occasionally
□ frequently
□ excessive anxiety or worry occurring more days than not for at least 6 months

Trauma: Check all that apply

□ recurrent thoughts or intrusive memories of a traumatic event
    date(s) of traumatic event(s): _____
    nature of traumatic event(s): _____
□ acting or feeling as if the traumatic event were recurring
□ avoidance of situations/stimuli associated with the trauma (avoidance of thoughts, feelings, places, people)
□ past sexual trauma
□ past physical trauma
□ past emotional trauma

Other:

□ divorce from spouse/partner
□ divorce of parents
□ family issues (divorce, domestic violence, alcoholism); please describe: _____
□ cutting/self-injury
□ grief/loss
□ hyperactivity
□ academic issues
□ alcohol/drug issues
□ eating disorder (bingeing, purging, laxative abuse, anorexia); please describe: _____
□ sexual dysfunction
□ hallucinations
□ delusions
□ sexual identity issues
□ spiritual issues
□ relational concerns; with whom: _____
□ physical symptoms; please list: _____
□ other: _____

Substance Abuse History

Family alcohol/drug abuse history:
○ father/stepfather
○ mother/stepmother
○ grandparent(s)
○ sibling(s)
○ spouse/partner
○ children
○ no history of abuse

Personal substance use status:
○ active abuse
○ early full remission
○ early partial remission
○ sustained full remission
○ sustained partial remission
○ no history of abuse

Substances Used (please list all):
_____
_____

Consequences of Use:
_____
_____
_____

Sexual, Cultural, & Spiritual History

Sexual history:
○ currently sexually active
○ currently sexually satisfied
○ currently sexually dissatisfied
○ currently sexually inactive
○ no sexual history

Age of first sexual experience: _____
Age of first pregnancy or fatherhood: _____

Are there any issues regarding sexuality you would like to address together?
_____

Pregnancy history (women):
How many times have you been pregnant? _____
Have you had any miscarriages? _____ How many? _____
Have you had any abortions? _____ How many? _____
Do you have infertility issues? _____
Have you ever experienced the death of a child? _____ How many? _____

Ethnicity: _____ (ex: White, African American, Native American/Alaskan, Pacific Islander, Asian, Native Hawaiian)

Religious/Spiritual Identity: _____

Importance of religion/spirituality: □ High □ Med □ Low

Are there any cultural/ethnic or religious issues that you want me to be aware of that contribute to your current problem? _____

Family of Origin Information

Below are questions regarding your family of origin.

Parents' current marital status (please check):
○ married to each other
○ separated
○ divorced
○ mother deceased; when? _____
○ father deceased; when? _____
Please list immediate family members and their relation to you (mother, father, sister – please include age, brother – please include age): _____
Are any siblings deceased? If so, whom? _____

Overview of Father (for adolescent clients only):

Name: _____ Occupation: _____

Education: _____ General Health: _____

Describe his personality in 5 words or less: _____

Overview of Mother (for adolescent clients only):

Name: _____ Occupation: _____

Education: _____ General Health: _____

Describe her personality in 5 words or less: _____

Describe your family childhood experience:

○ outstanding home environment
○ normal home environment
○ chaotic home environment
○ witnessed physical, verbal, and/or sexual abuse towards others
○ experienced physical, verbal, and/or sexual abuse from others

How would you describe your relationship with your sibling(s)? _____
How would you describe your relationship with your parent(s)? _____

Current Socio-Economic Information

Living Situation:
○ housing adequate
○ housing overcrowded
○ dependent on other(s) for housing
○ housing dangerous/deteriorating
○ living companions dysfunctional

Employment:
○ employed and satisfied
○ employed and dissatisfied
○ unemployed
○ supervisor
○ unstable work history

Financial Situation:
○ no current problem
○ large debt
○ poverty or below-poverty
○ impulsive spending
○ relationship conflict over $$

Social Support:
○ supportive network
○ few friends
○ substance-use-based friends
○ no friends
○ distant from family of origin

Military History:
○ never in military
○ served – no incident
○ served – with incident

Legal History:
○ no legal problems
○ now on parole/probation
○ arrest(s) not substance-related
○ arrest(s) substance-related
○ court-ordered to this treatment
○ jail/prison ____ time(s)
total time served: _____
describe last legal difficulty and dates:
_____
_____

All information shared in session is confidential except in circumstances governed by the laws including the mandatory reporting of alleged harm to self or harm to others, particularly in the case of child, handicapped person, or elder abuse. For more information regarding confidentiality and office policies, please review the Counseling Disclosure Statement and Statement of Client Rights.

Please use the scale below to answer the following questions.

4 = True to a great extent	3 = Mostly true	2 = Somewhat true	1 = Not true at all

My current concerns affect my success in life. _____
My current concerns affect my ability to interact and connect with others. _____
I am optimistic that I will be able to make some positive changes as a result of counseling. _____

Counseling Disclosure Statement and Statement of Client Rights

Please read the following information and ask any questions you might have during the intake session. When you sign this document, it will represent an agreement between us.

Training and Degrees. I hold a master's degree in Counseling Psychology from Northwest University and am a Licensed Mental Health Counselor in the state of Washington (#LH60289638). I regularly consult with other professionals regarding clients with whom I am working. These consultations are obtained in such a way that confidentiality is maintained. I also attend continuing education trainings to ensure that my skills remain up to date.

Past Experience. I have nearly 30 years of experience working with adolescents and families and have a Bachelor's degree in Elementary Education. From October 2008 to June 2009, I completed my counseling internship at West Seattle High School in the Teen Health Center. In my capacity as a counseling intern, I worked with students with mental health concerns including suicidal ideation, physical abuse, post-traumatic stress, acculturation, drug and alcohol use, sexual identity, anxiety, and depression. During my internship, I also gained valuable experience in counseling families of youth. Also, from June 2010 until May 2012, I worked as a Clinical Therapist in Behavioral Rehabilitation Services at Ruth Dykeman Children's Center with severely emotionally and behaviorally disturbed children. I have interests specifically in the areas of depression, anxiety, relational issues, trauma, and family of origin issues.

The Therapy Process. Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and potentially frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve relational issues can also lead to discomfort and may result in changes that were not originally intended.

The specific way I approach therapy is tailored to each individual, considering their presenting concerns, goals, personality, and past experiences. Though I draw from several therapeutic models, I typically utilize Acceptance Commitment Therapy (ACT) and EMDR to help people heal from past experiences, identify unhelpful beliefs about themselves, and step into their core values. My approach is warm, compassionate, relational, and authentic. I strive to create an environment that is non-judgmental and safe for my clients to explore how they got to where they are and what they want for their future. I encourage my clients to embrace change so that they can gain confidence and become more closely aligned with their values.

Client Rights

You have the right to a confidential relationship with me. Other than the limitations to confidentiality listed below, information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you.
3. You have the right to ask questions about any of the procedures used in the course of your therapy.
4. Should you choose not to enter therapy with me, I will provide you with names of other qualified professionals whose services you might prefer.
5. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you have already incurred. I have the right to terminate therapy with you under the following conditions:

    - When I believe that therapy is no longer beneficial to you.
    - When you have an unpaid balance on your account, unless special arrangements have been made with me.
    - When you have failed to show up for your last two therapy sessions without a 24-hour notice.
    - If I determine during the first three sessions that another provider will better serve you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.
    - When you fail to cooperate with the proposed treatment.

As life can bring unexpected circumstances, should I be unable to continue your therapy, one of my trusted colleagues will contact you to discuss what would be best for you at that time.

Confidentiality: Under certain legally-defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally-defined situations include:

- Revealing to me active child abuse or neglect. If an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Active physical or sexual abuse of a dependent adult or an elder is taking place.
- If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
- If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court.
- If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
- If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.
- In the event of a medical emergency, emergency personnel or services may be given necessary information.
- If the client brings a complaint against me with the state of Washington, Department of Health, client information will be released.
- In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
- If you are under the age of 13, your parents have legal rights to information regarding therapy sessions.

Signatures:

By signing below, I acknowledge that I have read, understood, and agree to the terms of this contract.

Client Name (Print)	Date
Client Signature	Date
Parent/Legal Guardian (Print)	Date
Parent/Legal Guardian Signature	Date
 Sara Bickerstaff, MA, LMHC	Date

Office Policies

Payment for Service: You are expected to pay for services at the time they are rendered. Please notify me if any problem arises regarding your ability to make timely payment. Checks returned NSF will be charged $20.00.

At the beginning of the therapy relationship, I will request your credit card information and will hold it on file for session payment, late cancellations, or no-shows. Please be advised that if you miss an appointment without 24 hours' notice, your credit card on file will be charged. If your credit card is declined and your bill remains unpaid, I have the option to discontinue therapy with you until the balance is paid. A late fee of $25.00 each month will be added to your unpaid balance. Fees that remain unpaid after 90 days may be turned over to small-claims court or to a collection service and may still incur the monthly late fee. If you have an unpaid bill, I may withhold your records until your bill is paid in full.

Records preparation will be billed per WAC 246-08-400: $28.00 clerical fee + $1.24 per page for the first 30 pages and $0.94 per page for any additional pages. If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit.

Charges for other services, including but not limited to, consultations with other therapists or professionals are charged at my regular hourly fee, prorated to the nearest quarter hour; this includes any travel time. Because of the increased amount of work involved in providing court-related services (such as consultations with lawyers or parenting evaluators, depositions, etc.), my fee for these services is double my usual hourly fee with a minimum of a one-hour charge ($253). After the first hour, you will be billed in 5-minute increments. If I am required to appear in court (virtually or in-person), I charge a minimum full day fee of $2025 (8 hours x $253/hour), regardless of how much time is actually spent in court. Pre-payment of the full day fee is required in advance. In addition to these fees, an additional 3.5% + $0.15 service fee will be charged. Some other services, such as depositions, may require payment in advance. These rates and policies also apply to those who are sliding-scale fee clients.

*Please note that my rates increase each January. At that time, I will provide a new Office Policies document for your signature.

Insurance Reimbursement: I am an out-of-network provider. Clients who carry insurance can submit superbills to their insurance company for possible reimbursement. I will provide you with a superbill upon request. I do not bill insurance companies nor do I accept payment from them. In some cases, I can submit claims to your insurance company on your behalf. Please be informed that, if you submit a superbill to seek reimbursement from your insurance company or if I submit a claim on your behalf, your insurance company may ask for documentation of therapy sessions. By signing this document, you are acknowledging your understanding and giving your consent for me to comply with their request. If your insurance company, for whatever reason, does not think that the services provided are medically necessary, it will be your responsibility to reimburse them for any payments they have made to you. Please also be advised that I must provide the insurance company with a diagnosis code that will become a part of your permanent medical record.

Cancellations/No Shows: Since an appointment reserves time specifically for you, **a minimum of 24-hours' notice is required** for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification. Insurance companies do not reimburse for missed sessions. If you are late (up to 15 minutes), I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. If you are a sliding scale client, you will be charged my regular rate for a missed appointment or a late cancellation. If you are more than 15 minutes late to the session, it will be considered a no-show, you will not be seen, and you will be charged the full fee for the session.

Telephone Time: Sometimes telephone consultations may be needed at times in our therapy. I will charge you my regular fee, prorated over the time needed. Please be advised that insurance companies do not reimburse for phone time/sessions. There is no charge for calls (less than 10 minutes) about appointments or similar business.

Longer Sessions: Sessions that go beyond the 45 or 90 minutes will be prorated to the nearest quarter hour. Please be advised that insurance does not cover sessions longer than 53 minutes.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency situation arises, please state this when you leave your message and I will return your call as soon as possible. After 10 minutes of telephone time, you will be charged on a prorated basis. If I have not called you back within 60 minutes and the emergency persists or the emergency is such that you cannot wait for me to return your call, please call your physician or admit yourself to a hospital for observation. You can also call 911 or the Crisis Line at 988.

Divorce/Custody or Court-Related Disputes: If you ever become involved in a divorce/custody or other court-related dispute, I want you to be informed about the difference between the clinical and the forensic role. In order to avoid dual relationships and conflicts of interest, I will provide you or your child with clinical services only. I do not intend to become involved in legal disputes such as personal injury lawsuits, divorce proceedings, dependency hearings or custody battles. These proceedings can erode the

client-therapist relationship and compromise you or your child's ability to be honest with me during treatment. In addition, I do not participate in evaluation for adoption home studies or provide evaluations of parental fitness to adoption agencies or state entities.

By signing this document, you agree that:
• My role is limited to providing treatment and that you will not involve me in any legal dispute;
• You will request your attorneys not to subpoena me or refer in any court filings to anything I have said or done;
• You will not ask for my participation or recommendations in an adoption home study or dependency hearing;
• If there is a court-appointed evaluator in your child's custody or dependency dispute, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody, custody arrangements, or visitation;
• If, for any reason, I am required to provide expert testimony or documentation for a legal dispute, adoption proceeding or dependency case, or to appear as a witness, the party responsible for my participation agrees to reimburse me according to the policies noted in the Payment for Service section above.

Social Media and Email Correspondence Policy: Social networking requests (Facebook, LinkedIn, Skype, Twitter) will be denied in an effort to maintain professional boundaries and client confidentiality. In addition, email correspondence should be limited to scheduling purposes only as email is not a secure method of communication. By choosing to communicate with me by email, you assume risks to confidentiality. Also, please do not rely on email for emergency notification as I may not check email on a daily basis.

Termination of Therapy: If you have not been in contact with me for over 90 days, your file will be closed due to legal and ethical reasons. If you decide to re-engage in therapy after termination, you will be asked to sign a new informed consent form and may be charged the initial intake session fee.

Signatures:

I agree to enter therapy with Sara Bickerstaff, MA, LMHC at her current rate of $235.00 per 45-minute intake session and $190.00 per 45-minute session for individuals; $210.00 for 45-minute family sessions (anytime there is more than one person in the room). I will make payment by credit card (including a 3.5% + $0.15 service fee) at the time of the therapy appointment, unless we have made other arrangements prior to the time of service.

I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to continue therapy with Sara Bickerstaff. I am contracting only to pay for completed therapy sessions or sessions I miss without providing 24-hours notice or any other fee charged for services noted in the Office Policies.

I, _____, (client; or guardian if under 13 years old) authorize and request that Sara Bickerstaff, MA, LMHC, CMHS, carry out diagnostic procedures and/or treatment which now or during the course of my care as a patient are advisable. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understood this Office Policies document.

I have read and understand these office policies and have asked any questions I have regarding these policies.

Client Name (Print)	Date
Client Signature	Date
Parent/Legal Guardian (Print)	Date
Parent/Legal Guardian Signature	Date
SBickerstaff, MA, LMHC, CMHS Sara Bickerstaff, MA, LMHC	Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ Security Code (CVV): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Signature of Cardholder Date

CONSENT FOR TELEHEALTH CONSULTATION
(As agreed upon by provider and client)

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

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

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the telehealth service, the telehealth services do not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth platform facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information regarding the telehealth platform or that such information is current, accurate or up-to-date.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. I will also inform my provider if email is not a secure way to provide me access to my telehealth appointment.

By signing this form, I certify:

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

_____

Signature of Client Date

_____

Signature of Parent/Legal Guardian (if client is under the age of 13) Date

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I hereby give my consent for Sara Bickerstaff, LMHC to:

☐ Release Information ☐ Exchange Information ☐ Obtain Information ☐ Other

To/with/from:

Name: _____

Relationship to Client: _____

Address: _____

Phone: _____

Description of information to be released:

☐ Financial arrangements and scheduling ****(must be checked for clients whose parent/legal guardian or other individual is financially responsible for treatment)****

☐ Coordination of care with another professional

☐ Other: (please be specific with information you are giving permission to release) _____

_____

_____

I understand that my records are protected under the Federal and/or State Confidentiality Regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CRF, Parts 160 and 164, and cannot be disclosed without written authorization unless otherwise provided for in the regulations. I also understand that I may revoke my permission in writing at any time except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as described below. I further acknowledge that the information to be released was fully explained to me and permission is given of my own free will. I understand that generally the program may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. I understand that re-disclosure of this information is prohibited by law.

_____

Signature of Client Printed Name of Client Date

_____

Signature of Parent/Legal Guardian (if client is under the age of 13) Date

This authorization will expire 90 days after the termination of therapy or on _____
as specified by the client and may be revoked at any time by providing a written request of revocation of this release.

Mental Health Counselor License: **#LH60289638**
Federal Tax ID/EIN: **272421904**
NPI: **1861937948**

GOOD FAITH ESTIMATE NOTICE

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

I, _____, have received and read this notice and understand my options regarding receiving a Good Faith Estimate and know how to get more information if needed. If I choose to receive a Good Faith Estimate I will contact Sara Bickerstaff prior to my appointment.

_____ _____

Client Signature Date

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

By my signature below I, _____ (client), acknowledge that I received a copy of the Notice of Privacy Practices for Sara Bickerstaff, LMHC.

_____

Signature of Client Date

_____

Signature of Parent/Legal Guardian (if client is under 13*)* Date

If a personal representative signs this acknowledgement on behalf of the client, please complete the following:

Name of Personal Representative: _____

Signature of Personal Representative: _____

Relationship to Client: _____