Wholistic Therapeutic Services, LLC

Alexia M. Tanner, LCSW
Jessie V. Moreno, LMFT
Joanna Taylor, LMSW
Erin Robinson, MS, MFT
Kayla Purvis, LCSW
P.O. Box 1743 Tifton, GA 31794
229-396-4689 (Main) 229-396-4605 (Fax)
www.wtstifton.com

Welcome to Wholistic Therapeutic Services. We ask for your cooperation in filling out the following forms. This information is confidential and will assist your intake therapist in assessing your needs.

Today's Charges (Self-pay):

Individual Intake Assessment: Average Charge $150	Your Rate:_____	Client's Initial verifies acceptance _____
Couple Intake Assessment: Average Charge $150	Your Rate:_____	Client's Initial verifies acceptance _____

Future Session Charges:

Individual Sessions: Average Charge $110	Your Rate:_____	Client's Initial verifies acceptance _____
Family Sessions: Average Charge $125	Your Rate:_____	Client's Initial verifies acceptance _____
Shorter Session (30 Minutes) Average Charge $75	Your Rate:_____	Client's Initial verifies acceptance _____
Extended Therapy (over 50 minutes) Average $150	Your Rate:_____	Client's Initial verifies acceptance _____
Letters or Affidavits $20-$250	Your Rate:_____	Client's Initial verifies acceptance _____
Copies of Documents: $.10 per page and $25.00 Administrative fee plus postage (if mailed).		Client's Initial verifies acceptance _____

- Rates will only be adjusted at the discretion of Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC. You may speak with your intake provider directly about any concerns you may have.
- If there is a balance on the patient's account, the Client/guardian will be required to pay the Minimum Due Amount prior to meeting with the therapist. This will equal the amount of the co-pay for that day's service **and** either 10% of the balance or $25.00, whichever is greater.
- There may be charges for services that are not covered by insurance, including lengthy phone calls (e.g. to client, family members, teachers, or lawyers) or paperwork. This includes crisis consultation or evaluation. This is a minimal of $25.00 (each 15-minute segment).
- Please note Letters/Affidavits/Copies required within a 48-hour period are an additional $25.00 fee. Payment must be collected before paperwork will be released.
- Please request a Court appearance Schedule (if applicable).
- **No-Show Fees:** Flat Rate of $50.00 (**Must be paid in Full before next session will be scheduled.**)

Insurance:

Please Provide an Insurance Card with Driver's License. We will accept insurances we are currently in network with. However, it is your responsibility to cover all charges your insurance does not cover. If insurance changes, it is your responsibility to update our records. Co-pays and Deductibles are due at the time of service. By signing this you hereby agree to the above payment plan. If we are billing insurance you do hereby give Wholistic Therapeutic Services, LLC permission to bill your insurance you have provided on file and you agree for your insurance to be charged from this date forward, unless notification received by WTS in writing with end date attached. Money is due at time of service. You may pay with cash, credit card (utilizing Square Processing) or money order. Please note services will be suspended if payment or payment agreement has not been reached within 90 days.

Print Name: _____ Date: _____

Signature of Client or Guardian: _____ Therapist: _____

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Court Required Services: Limitations of Confidentiality

I, _____, do herby verify that a court proceeding (whether court ordered or through mediation services) has brought me to this agency. Therefore, I understand that the information being presented during the intake process and through continued sessions is therefore under limitations of confidentiality, as any information Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC deems is in the best interest of the courts to obtain will be discussed prior to and within the court proceedings. _____

I do understand that Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC will make it a priority to protect the interest of **all** involved in the case and therefore will only share what is relevant to the safety needs and recommendations for the case. Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC will remain professionally unbiased and report on professional opinion and recommendations for the entire case not just one individual. _____

I do understand that Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC will discuss recommendations with me prior to court, however, questions may arise in court that have not been discussed with me in session prior to court. Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC must answer all questions with professional and educated opinion. ____

I do hereby agree that Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC has permission to talk with all lawyers and judges associated with the case and that this will be completed in the most professional and confidential manner possible but will occur through in person, cell phone, email and text messaging contact. _____

I do understand that by signing this form that I understand the limitations of confidentiality and have signed this prior to sharing any confidential information with Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC. Therefore, I do understand that I cannot hold Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC liable for information that will be shared prior to and in a court proceeding. _____

_____ _____
Signature of Patient or Personal Representative Date:

_____
Name of Patient or Personal Representative

_____
Witness Date:

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Court Fees & Additional Service Fees

Court Fees:

- Preparation for Court or Preparation for Court Deposition (This does not include Phone calls)
  - $100.00 (First hour)
  - $100.00 (Each additional hour of preparation, per hour)

(Initial Here _____)

- Phone Calls
  - $25.00 per 20-minute phone conversations related to court hearing (to include Lawyers, Judges, Guardian ad Litem, CASA, and any other pertinent members related to Court).

(Initial Here _____)

- In-Court or Court Depositions
  - $250.00 (per hour- starting at time of arrival per subpoena until dismissal from subpoena)

(Initial Here _____)

- Affidavits
  - $100.00 (up to 3 Professional Pages)
  - $125.00 (4-9 Professional Pages)
  - $150.00 (10+ Professional Pages)
  - $25.00 Delivery Fee

(Initial Here _____)

- Copy of notes for Court $0.10 per page + $25.00 Administration Fee

(Initial Here _____)

- Travel Mileage Expense
  - $0.57 per mile if outside of Tift County (starting from Wholistic Therapeutic Services, LLC)
  - $100.00 Hour for Travel Time (Outside of Tift County)

(Initial Here _____)

Please Note: These services are **not** covered by Insurances. These Services **require** a deposit of 50% the **estimated** charges. **These Charges are To Be Paid** 24 hours before services are rendered.

If you have any questions regarding our Court Fee Schedule, please call Wholistic Therapeutic Services, LLC.

I have read and agree to the above terms and conditions.

_____ _____ Client

Signature or Representative/Date Therapist Signature

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Counseling I am seeking: ❒Individual ❒Couple ❒Group Therapy ❒ Family Therapy

CLIENT INFO	EMPLOYER & INSURANCE
Date of Birth: ____/_____/_____ Name: _____ Address: _____ City: _____Zip: _____ Email:_____ _____ Primary#_____ Work#_____ Legal Guardian: _____ Parent whom does **not** have legal rights: _____ Custody Issues? Yes/No? Who has Guardianship?_____ Approved method of contact: *(Please note all reminders will come via Text and Voice mail-confidential manner)* ❒Email ❒Text ❒Voicemail Would you like to exclude any contact method? _____	Please note if you have confirmed this to scheduling personnel you may choose to leave blank. Employment Company or School: _____ Address: _____ City: _____Zip: _____ Insurance Provider: _____ *(Please provide card to therapist)* Insurance Policy Holder: Name:_____ Date of Birth: _____ I am: Single ❒Married ❒Divorced ❒ Preference of Pronouns? _____

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

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Primary Care Physician:_____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

_____

_____

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? ❒**Yes** ❒**No**

Whom were you referred by? _____

Have you obtained therapeutic services in the past? **Yes/ No** If yes, when and name of clinician?

_____

Release of Information

You may provide persons in this area who are allowed contact with this therapist. This would include identification and scheduling of appointments, minimal report given and receipt of messages (I.e. Step Parents, Grandparents, Partners, and Other Parties you are allowing to assist with the support of your care).

Name: _____ Relationship to you: _____

Address: _____ Phone Number: _____

Name: _____ Relationship to you: _____

Address: _____ Phone Number: _____

Name: _____ Relationship to you: _____

Address: _____ Phone Number: _____

By signing this, I hereby give permission for this/these person(s) to receive the information stated above. I hereby understand this can be revoked at any time and must provide a written revoke of this permission.

_____ _____

Print Name Date:

_____

Signature

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Client Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from ___Wholistic Therapeutic Services, LLC____. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Client or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:
Date Received:
Patient Declined Copy ☐
Staff Signature:

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Consent for Treatment/ Limitations of Confidentiality

Please Read Carefully

Psychotherapy is a working cooperative relationship between you and your therapist. Each member of this cooperative relationship has certain responsibilities. Your therapist will contribute his or her knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I. Fees and Appointments

1. Appointments are 50 minutes in length and take place on a regular basis (established between you and your therapist). Your therapist holds your specific hour for you each scheduled appointment. If you are unable to keep an appointment, please cancel as soon as possible. You will be allowed to cancel (with more than 24 hours' notice) four sessions within a one-year period with no charge. The year begins on the date of your Intake Appointment. After four cancelled appointments, you will be responsible for payment of missed sessions. If you can reschedule your appointment within two working days, it will not count as a cancellation. We ask that you pay prior to your session each week. We reserve the right to suspend therapy if services are rendered and not paid for after one session. Please speak with your therapist immediately for payment options.
2. During your initial appointment, you will be assigned a fee for your weekly sessions based on your ability to pay. Please discuss any concerns regarding your financial status with your therapist, especially if your financial situation should change or improve. Additionally, once per year your fee is subject to reevaluation. If it is determined that, based on your circumstances, you can pay more, your fee may be adjusted. All client fees are subject to review on an annual basis.
3. You may pay with Cash, Credit Card (We utilize Square Processing), Money Order.
4. By signing this agreement, you are consenting to the billing of your insurance (provided on file) and/or private pay. You also consent that you will notify WTS immediately of any changes to your insurance or private pay status.

II. Confidentiality

1. Communication between you and your therapist is confidential. This means that your therapist will not discuss your case orally or in writing without your expressed written permission (Please refer to the HIPPA package you received at intake). Please note that you must sign a release for all parties not guardianship (for minors) including parents who do not have parental rights.
2. Your therapist has an ethical and legal obligation to break confidentiality under the following circumstances:

a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
d. If you introduce your emotional condition into a legal proceeding.
e. If your records are subpoenaed by a court of law.

III. Training and Clinical Supervision

Wholistic Therapeutic Services, LLC and Alexia M. Tanner, LCSW & Associates contracted with WTS, reserve the right to host and maintain training relationships with students at the Bachelor and Master's Level in this field. WTS and Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC will ensure all levels of professionalism and confidentiality during which time a trainee is present. Please contact Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC with any concerns.

IV. Child Care Release

WTS does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 12 may not be left without supervision in the waiting room.

V. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your therapy at any time, for whatever reason and without any obligation, apart from payment of fees for services already provided. We request that you end services in writing to ensure closure, however, you are not obligated to do so. You have the right to question any aspect of your treatment with your therapist. You also have the right to expect that your therapist will maintain professional and ethical boundaries by not entering other personal, financial, or professional relationships with you. WTS reserves the right to discontinue therapy at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by WTS of your therapeutic needs, WTS' ability to address those needs, or other circumstances that lead WTS to conclude in its sole and absolute discretion that your therapeutic needs would be better served at another counseling facility. Under such circumstances, WTS will suggest an appropriate therapist(s) or therapeutic agency.

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VI. **This agreement is valid** for provision of services by all associates contracted with WTS and under the Clinical directive and supervision of Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC. I agree to the treatment by these persons if deemed appropriate for my care. I agree to discuss any concerns with Alexia M. Tanner, LCSW and Associates of Wholistic Therapeutic Services, LLC and understand I have the right to treatment by a Licensed Clinician upon request.

VII. Social Media Policy

Our code of Ethics prohibits us as therapists to engage with our clients on personal social media sites. Please know that our decision to deny social medial connection requests is to protect our professional relationship and your confidentiality. If you would like a copy of this code of ethic, please speak with your therapist directly. We do have a professional website and Facebook page that allows engagement. Please note when you respond or message on these sites, we cannot and will not ensure confidentiality and if you choose to do so we consider this an informed consent about your confidentiality. We kindly request you schedule appointments through our office, website or by email as this is considered more secure than social media messengers.

VIII Communication:

We have many different options for contact. However, please understand that if you choose to participate in any type of communication to include but not limited to cell phones, text, email, or other non-encrypted avenues, we cannot ensure the complete confidentiality of these modalities and by **checking** the following boxes you are stating that you understand the risks and agree to wave your rights to Confidentiality as it pertains to these avenues of communication. Please note the therapist will still maintain confidentiality to the extent allowed but cannot ensure complete confidentiality as some may not be a secure network despite the efforts of the therapist.

☐ Cell Phone provided on File ☐ Email Provided on File

☐ Other forms of Non-Encrypted Avenues ☐ Teletherapy

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to Wholistic Therapeutic Services, LLC and Alexia M. Tanner, LCSW and associates contracted with WTS to provide therapeutic services and that this contract is binding for all future sessions you may have with this entity.

Print Name: _____ Date: _____

Signature of client or representative: _____

Relationship of representative: _____Therapist: _____

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Wholistic Therapeutic Services strives to provide a safe and appropriate environment for all clients. The safety of all client's is of foremost concern for us and we want all to feel welcome, safe, and secure.

To ensure this, please note the following policy changes, effective **IMMEDIATELY**:

UNATTENDED CHILDREN POLICY

ALL children under the age of 18 must be accompanied by a parent/guardian over the age of 18, unless they are driving. Children attending therapy must not be left unattended when receiving services due to safety concerns. Wholistic Therapeutic Services is not responsible for the safety or behavior of the child(ren) while in the waiting area. This responsibility lies solely with the parent/guardian of the child(ren). Adults who are receiving services, who are accompanied by a child (ren), must not leave child(ren) alone in the waiting area. If another adult is not present with the child(ren), the appointment will be rescheduled. Wholistic Therapeutic Services is not able to provide babysitting services and cannot monitor individual children to ensure their personal safety. If a child is dropped off or left unattended, the parent or guardian will be called immediately, and the appointment will be rescheduled. Failure to follow this policy will result in termination of services.

Please sign and date below indicting you have read and agree to abide by policy changes.

Client's Name: _____

Client's Signature: _____

Parent/ Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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Missed Appointment and Cancellation Policy

Your therapist is committed to providing excellent care and reserved your scheduled appointment just for you. Failure to show for scheduled appointment and late cancellations prevent other clients from being seen. If you are unable to keep an appointment, please cancel your appointment by 3:00PM prior to your scheduled appointment and by 3:00PM Friday if your appointment is Monday.

You will be allowed to cancel three sessions within a one-year period with no charge. The year begins on the date of your Intake Appointment. After three cancelled or missed appointments, you will be responsible for payment of cancelled or missed sessions. **Cancelled or missed appointment fees must be paid in full before next session will be scheduled.** **Your therapist reserves the right to terminate treatment if cancelled or missed appointments exceed three.** If you can reschedule your appointment within two working days, it will not count as a cancellation.

Please note, any changes or cancellations can be made by calling (229)396-4689 or texting (229)785-8180 and must be completed by 3:00PM prior to your scheduled appointment and by 3:00PM Friday if your appointment is Monday.

Your signature below indicates that you have read and understand this information.

Print Name: _____ Date:_____

Signature of Client or Representative: _____

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CELL PHONE USE POLICY

Wholistic Therapeutic Services makes it a priority to follow best practices in ensuring the privacy and confidentiality of clients. Furthermore, we strive to provide a comfortable and stress-free therapeutic environment that can greatly assist both the therapist and client. Sounds can affect the effectiveness of the therapeutic environment. We appreciate your cooperation in helping protect the confidentiality of clients and maintain a quiet comfortable environment.

Below is a description of cell phone policy changes:

- Please **SILENCE** cell phones. A ringing cell phone is a distraction.
- NO cell phone use in the waiting room or therapist office. ALL phone calls must be taken outside. **NO EXCEPTIONS!**
- **NO PHOTOGRAPHS** or **VIDEOS** with cell phone. Taking photographs or videos with your cell phone can present a risk for unauthorized disclosure of Protected Health Information and could be an invasion of privacy.

Please sign and date below indicting you have read and agree to abide by policy changes.

Client's Name: _____

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor. If Filling out for a minor (0-18 years of age), please answer according the symptoms of the minor within the past 6 months. Note: Some questions will not apply and will be covered in the intake assessment.

(☑ your concerns)

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Issues with Sleep					
Issues with Appetite due to stress					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING/EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Self-Mutilation (not suicidal)					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					

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Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I typically need something (drug/medical) to help calm down					

I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

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I USE THE FOLLOWING….	Never	Seldom	Often	Always	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES…	Never	Seldom	Often	Always	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

I HAVE…	Never	Seldom	Often	Always	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

SCHOOL/EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					
I have been identified with Behavioral issues at school. Plans_____					

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I have been identified with academic issues at school. Plans?_____					

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness? ❒**Yes** ❒**No**

Has a close relative ever been hospitalized for a psychiatric illness? ❒**Yes** ❒**No**

Does anyone in your family have a mental illness? ❒**Yes** ❒**No**

Has anyone in your family every attempted or committed suicide? ❒**Yes** ❒**No**

Previous Diagnosis (es): Please list all and who diagnosed_____

_____

Does anyone in your family have a substance abuse problem? ❒**Yes** ❒**No**

Have you ever been arrested? ❒**Yes** ❒**No**

1) How well you are doing on your job/school: **(☑)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

2) How well you are doing in your parent (for kids)/marital/significant other relationship:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

3) How well you are doing in your family relationships:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

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4) How well you are doing in relationships with people outside your family:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

5) Please rate your current physical health:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

6) Please rate your general happiness and well-being:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

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Informed Consent for Telemental Health Services

I hereby consent to engaging in Telemental Health (herein referred to as "distance therapy") with Alexia M. Tanner, LCSW and parties associated with Wholistic Therapeutic Services, LLC, as part of my psychotherapy. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance therapy:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to distance therapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; 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 telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand that there are risks and consequences from distance therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPPA-compliant service which is encrypted for video Telemental Health communications. Further, the contents of my therapist's computer are encrypted.
- I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services, group therapy), I will be referred to a psychotherapist who can provide such services in my area.
- I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.
- I also understand that I must provide a reliable emergency contact (to remain on file) that would be able to have access to me in the event of an emergency. I understand that in the event the therapist has reasonable and professional concern that I may be a harm to myself or others, emergency services (including provided contact) will be contacted and my last known address will be disclosed. I understand that I have the right to remove the emergency contact at any time in writing but must disclose a new emergency contact for therapeutic services to continue.

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- My Emergency contact is:

_____

_____

Name, Address and Telephone Number must be included.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

Client Signature Date

_____ _____

Parent or Guardian Responsible for Client Date:

_____ _____

Therapist's Signature Date

_____ _____

Therapist Supervisor's Signature Date

_____ _____

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Please Note The Following Changes as of 1/4/2021

- There will be a charge added to all Credit Card Charges
  - $3.00 for Charges $50.00 or below
  - $5.00 for Charges over $50.00

(Initial Here:_____)

- Until Further Notice: **Our Lobby is closed. Absolutely No Exceptions.** Our Lobby does not meet CDC Guidelines for Social Distancing. Please help us maintain CDC guidelines.

(Initial Here:_____)

- Please remember to sign in on the kiosk and then return to your vehicle. If you do not sign in, we will have no way of knowing that you have arrived for your appointment and you may be charged a No-Show fee.

(Initial Here:_____)

- Going forward, a credit card will need to be placed on file (we utilize Square for secure storage). Please see additional form. This credit card will be charged for No-show or late cancellations (within 24 hours) appointments fees. These fees are not covered by insurance and are your responsibility. Please note these fees are outlined in your Intake agreement packet. As a reminder, No-show fees are $50.00 and Late Cancellation Fees are $25.00. This credit card will also be used for payment if Tele-Therapy is conducted.

(Initial Here:_____)

- **You** are responsible for Self-Pay, Co-Pays, and Deductibles on date of service. You are responsible for letting us know immediately if your insurance has changed. You are also responsible for any charges in which insurance does not cover. Once billed, any issues pertaining to insurance are the responsibility of the client or guardian. If not taken care of, Wholistic Therapeutic Services, LLC will bill you for the contracted amount not paid by insurance. Failure to do so may result in a suspension of services.

(Initial Here:_____)

I have read and agree to the above terms and conditions.

_____ _____

Signature of Client or Guardian **Date:**

_____ _____

Witness **Date:**

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Letters and Additional Services

- Letters:
  - $50.00 (up to 3 Professional Pages)
  - $75.00 (4-9 Professional Pages)
  - $150.00 (10+ Professional Pages)
  - $25.00 Delivery Fee (if applicable)
  - Special Letters: (Must pay separate fee for Evaluation prior to Receipt of Letter)
    - $25.00 Emotional Support Letter
    - $25.00 Evaluation Approval to Return to School Letter
  - Letters Needed within 72 Hours' Notice: $50.00 Convenience Fee

(Initial Here _____)

- Phone Communication:
  - First 10 Minutes are Complementary
  - $35.00 per phone calls lasting between 10-20 minutes (this includes client, parent, or collaborative calls).
    - Please note, we will not participate in phone calls lasting more than 20 minutes unless scheduled prior to the phone call. You will be asked to schedule a time to speak if needing more than this allotted time.
  - $65.00 per phone calls lasting between 20-45 minutes (to include client, parent, or collaborative calls).
    - Please note, we will not participate in phone calls lasting between 20-45 minutes unless scheduled prior to the phone call.
  - $100.00 per phone calls lasting between 45-60 minutes (to include client, parent, or collaborative calls).
    - Please note, we will not participate in phone calls lasting more than 60 minutes.

(Initial Here _____)

- Electronic Communication: (This does not include Scheduling or Rescheduling Appointments)

Please note: This includes emails to client, parent(s) or collaborative professionals.

  - First Email or Text Message Complementary (containing therapeutic communication)
  - $25.00- Up to 5 emails or text messages containing therapeutic communication.
  - $50.00- 6-10 emails or text messages containing therapeutic communication.
  - $75.00 – 11-15 emails or text messages containing therapeutic communication.
  - $100.00- 15-20 emails or text messages containing therapeutic communication.
  - $150.00- 21+ emails or text messages containing therapeutic communication.

(Initial Here _____)

- Verification of Appointments:
  - $0.00 Given at time of appointment or Emailed to You

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- $5.00 Faxed or Mailed to School or Work
- $10.00 Notarized Copy

(Initial Here _____)

- Copy of Notes or File:
  - $0.10 per page + $25.00 Administration Fee (no exceptions)

(Initial Here _____)

Please Note: These services are **not** covered by Insurances. These Services **require payment prior to rendering of services or at the next appointment.**

If you have any questions regarding our Fee Schedule, please call Wholistic Therapeutic Services, LLC.

I have read and agree to the above terms and conditions.

_____ _____

Client Signature Date

_____

_____

Professional Therapist Signature Date

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CREDIT CARD AUTHORIZATION

I hearby grant Wholistic Therapeutic Services, LLC permission to process credit/debit charges.

The security of your personal information is extremely important. Wholistic Therapeutic Services, LLC is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the "information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

This form is requested for all clients and required to be on file.

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:

_____ I authorize Wholistic Therapeutic Services LLC to use my credit/debit card number on file that is provided below to process charges/fees assigned for the named individual listed above.

_____ I authorize Wholistic Therapeutic Services LLC to be compensated for missed appointments of which the client/s named above did now show up for session or cancel session less than 24 hours before the time of the appointment. Missed appointment fees and canceled appointment fees.

Please complete all the information below:

Type of card (check one) _____VISA _____Master Card Other:_____

Exact name on card _____

Relationship to client _____

Card number _____

Expiration Date _____

CUV _____ Email_____

Billing address _____Zip Code_____

I have read and agree to these terms and conditions.

Signature _____

Date _____