Partners in Wellness/Calm Tomorrows, LLC
519 E. 141st Suite L
Glenpool, Ok 74033
(539)664-6268
www.partnersinwellnessok.com

CLIENT INFORMATION FORM

Client's Full Name _____ Age:_____

Gender: M / F Preferred Pronouns:_____

Home Address: _____

City, State, Zip: _____

Phone numbers: Home _____ Work _____

Other_____

Date of Birth ___/___/___ S.S.# _____-____-_____

If the above mentioned is a minor child please complete additional contact information below:

Parent/Guardian Full Name:_____ Phone:_____

Address:_____

Email:_____

May we leave a message for you at home? Yes No

May we call you at work? Yes No

May we leave a message for you at work? Yes No

May we send you a text message? Yes No

Insurance and Payment Information

A form of payment is required to be on file for deductibles and any charges not covered by your insurance provider. You will be notified before charges are made to your balance. At the time of payment you have the option to utilize an alternative form of payment. Co-Pays are due at the time services are rendered.

Employer: _____Insurance Provider: _____

ID Number:_____

Group Number:_____

Name of Insured:_____

Relationship to Client:_____

If the insurance is not through your employer or Medicaid, who is the primary insured. _____ His/her date of birth: _____

Employer: _____

Address: _____

Marital status of insured: Married Single Divorced Separated Widowed

Name of person responsible for any deductible, co-pay, or fees: _____

Address: _____

Name on Card: _____ _____ _____

Card Number:_____

Expiration Date:_____ CSV_____ Billing Zip Code:_____

In the event of an emergency or need for immediate transport to a medical facility please complete the information below

Physician: _____ Phone Number: _____

Physician Address: _____

Hospital and Address: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Partners in Wellness
519 E. 141St St Suite L
Glenpool, Ok 74033

Informed Consent

Below are listed some important facts regarding your treatment with Calm Tomorrows, LLC. Please read them carefully. If you have any questions, please raise them with your therapist.

Services Provided: Calm Tomorrows, LLC provides counseling services including intake assessment: $125, and treatment planning, consultations, individual/ family, and group psychotherapy: $100 per 45-50 session. A credit card or debit card will be required to be placed on file in the event that your insurance remits a payment that results in a balance. Your therapist will contact you with an invoice prior to charges being placed on your card.

This payment, in cash or credit card, is required before the service or your session will be rescheduled. No checks will be accepted.

Invoices that are unpaid after 30 days will incur a 15% late charge. Invoices will be sent every 30 days with the 15% adding on to each total. After 90 days unpaid invoices will be sent to collections. Your therapist will provide upon request a monthly receipt for your insurance filing. It is the client's responsibility to file insurance unless the therapist is in network with your insurance company.

It is the responsibility of the client to ensure their insurance is within network and to establish any deductible payments they may incur. Co-pays will be due at the time of service.

Your therapist will discuss with you the treatment choices best suited for your needs. The extent and duration of your evaluation/treatment will depend upon your choice and the recommendation of your therapist/evaluator. The client or therapist can terminate the treatment at any time, for any reason.
Cancellation Policy: If you need to cancel an appointment, please notify this office as soon as possible. After 3 no-shows the case will be administratively closed.
Confidentiality: All information and records will be kept confidential, and will be held in accordance with state laws regarding the confidentiality of such records and information However, records and/or information will be released regardless of consent under the following circumstances:

1) According to state and local laws, therapists must report all cases of physical or sexual abuse or neglect of minors or the elderly to the appropriate agency;
2) According to state and local laws, therapists must report all cases in which there exists a danger to self or others to the appropriate agency;
3) When authorized by the recipient of services in order to process medical insurance claims and to authorize payment of benefits;
4) In the event that a patient is in need of emergency services and other medical personnel need to be contacted;
5) In the event that your records may be court ordered by court.
6) It should be noted if case consultation with a health care provider is necessary in order to provide optimal treatment for a client, this will occur with the utmost care being taken to conceal identifying information.

Right of Access to Records: Adult patients, and legal guardians of minors, including managing and possessory conservators, have the right to access the record of the services provided to them from Calm Tomorrows. Please discuss any questions you have about this with your therapist/evaluator.

Treatment of Minors: Treatment of children under 18 will be provided only with the consent of the legal guardian. By signing this consent form, the person acknowledges that he or she is the legal guardian (as established by the State or by divorce decree) of any minor presented for treatment and is at least 18 years old him or her self.

Phone Numbers: If you need to contact your therapist, please leave a message at . Your therapist will return your call as soon as possible during business hours (8 am—5 pm, Monday—Friday). Although we try to be prompt in responding to messages, due to having a very busy practice, sometimes we return calls on the following business day. Messages will be checked a few times a day, but never during the nighttime. Messages will be checked much less frequently on weekends, and holidays. Messages will be returned from weekend calls on Monday, unless Monday is a holiday.

Emergencies: Due to the nature of the practice, we are often not immediately available by telephone. We do, however, check the phone periodically for messages. Therapeutic calls are billed pro-rated at the regular fee. If you need to talk to someone immediately, please call 911 or go to your nearest hospital emergency room.

Email, Texting, and Online Social Networking Policy: Because it is not possible to guarantee the confidentiality of email communications, please use discretion in deciding whether to communicate with us via email. Calm Tomorrows cannot be held responsible for any information lost in transit or viewed by a third party. Email should only be used for brief, general questions. Hence, emergencies, therapeutic issues, sensitive personal information, and cancellations should all be communicated over the telephone or in person. Calm Tomorrows does not communicate with clients by text messages, and we ask that you do not use this method of communication. Likewise, Calm Tomorrows does not communicate with clients via online social networking sites (e.g., Facebook, Twitter, etc.).

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a sensitive and confidential nature, it is agreed that should you be involved in legal proceedings, neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested. If the therapist is court ordered by the judge to attend a court preceding the client is responsible for the fee of $250 per hour with a 4 hour minimum before the court date.
Any Court Appearance will be billed at the following rate:
$300 – retainer up front
$150 - per hour on stand
$150 - per hour to be on call or waiting to testify

Please read the "Disclosure Statement and Informed Consent" document before signing.

My signature affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a client of Calm Tomorrows,, I was given sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand these office policies and procedures. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time.

Calm Tomorrows

Receipt and Acknowledgement of Notice of Informed Consent

Client Name

Date of Birth

Social Security Number

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Calm Tomorrows at 405-238-0216 or I can submit my questions in writing at 519 E. 141st St. Suite L, Glenpool, Ok 74033.

Signature of Client

Date

Signature of Parent, Guardian or Personal Representative *

Date:

*If you are signing as a personal representative of an individual, please describe your legal authority to act on this individuals behalf.

_____ Client refuses to Acknowledge Receipt

Signature of Witness

Date

Notice Of Privacy Practices for
Calm Tomorrows, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Privacy Practices

- As required by the Privacy Regulations
- Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Effective Date of this Notice: April 14, 2003

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

Our Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered **"Protected Health Information" (PHI)**. We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are **required** to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice from the Clinic you visit or the Compliance Office at 2401 Southwest Boulevard in Tulsa, Oklahoma.

How We May Use and Disclose Your Protected Health Information

We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclosure of your PHI for purposes of:

- treatment
- payment
- our health care operations

For uses beyond that, we must have your **written authorization** unless the law permits or requires us to make the use or disclosure without your authorization.

If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI.

However, the law provides that we are permitted to make some uses/disclosures **without your consent or authorization**. **Oklahoma law requires** that we inform you that the information used or disclosed may include records which indicate the presence of a communicable or venereal disease which may include, but are not limited to:

- hepatitis
- syphilis
- gonorrhea
- Human Immunodeficiency Virus (HIV)
- Acquired Immune Deficiency Syndrome (AIDS)

Any use or disclosure also may include mental health or other sensitive information.

The following offers more description and some examples of our potential uses/disclosures of your PHI.

1. **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**
   Generally, we may use or disclose your PHI as follows:

- **For treatment:** We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment for consultation purposes in provision or coordination of your care.
- **To obtain payment:** We may use/disclose your PHI in order to bill and collect payment for your health care services. We may release information to third parties for collection purposes. For example, we may contact your employer to verify:
    - employment status
    - release portions of your PHI to the Medicaid program
    - a private insurer to get paid for services that we delivered to you.
- **For health care operations:** We may use/disclose your PHI in the course of operating our clinics. For example, we may disclose your PHI to our accountant or attorney for audit purposes.
- **Appointment reminders:** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home, or notify you of appointments by phone.

2. **Uses and Disclosures Requiring Authorization**
   For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.
3. **Uses and Disclosures of PHI not requiring consent or authorization**
   The law provides that we may use/disclose your PHI without consent or authorization in the following circumstances:
    - **When required by law:** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.
    - **For public health activities:** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. Oklahoma law requires us to report, among other things, the following items:
        - Tumors
        - Birth Defects
        - Cases of communicable disease
        - Infant eye infections
        - Infants born exposed to alcohol and other harmful substances
        - Abortions
    - **For health oversight activities:** We may disclose PHI to another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.
    - **Relating to decedents:** We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **For Worker's Compensation purposes:** We may disclose PHI in relation to workers' compensation programs, established by law, that provide benefits for work-related injuries or illnesses.

4. **Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring Consent or Authorization**

   The law provides that we may use/disclose your PHI from alcohol and other drug records without consent or authorization in the following circumstances:
   - **When required by law:** We may use/disclose PHI when a law requires that we report information about suspected child abuse and neglect, or when a crime has been committed on the premises or against personnel, or in response to a court order.
   - **Relating to decedents:** We may disclose PHI relating to an individual's death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.
   - **For research, audit or evaluation purposes:** In certain circumstances, we may disclose PHI for research, audit or evaluation purposes.
   - **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement when a threat is made to commit a crime on the premises or against personnel.
5. **Uses and Disclosures Requiring You to have an Opportunity to Object**

   In the following situations, we may disclose a limited amount of your PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law.
   - **To families, friends or others involved in your care:** We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.
6. **Your Rights Regarding Your Protected Health Information**

   You have the following rights relating to your protected health information:
   - **To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.
   - **To choose how we contact you:** You have the right to ask that we send your information to an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
   - **To inspect and request a copy of your PHI:** Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you

want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is
  - correct and complete
  - not created by us and/or not part of our records
  - not permitted to be disclosed.

  Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in PHI.
- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure for treatment, payment, and operations; to you, your family, or the facility directory; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- **To receive this notice:** You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

7. **How to Complain about Our Privacy Practices**

   If you have questions about this Notice or any complaints about our privacy practices, please contact the Compliance Office listed below. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may request information or file a complaint by contacting:

   Calm Tomorrows, LLC

   519 E. 141st St Suite L

   Glenpool, Ok 74033

   You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775. We will take no retaliatory action against you if you make such complaints.

Calm Tomorrows

Receipt and Acknowledgement of Notice of Privacy Practices

Client Name

_____ _____

Date of Birth Social Security Number

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Calm Tomorrows at 405-238-0216 or I can submit my questions in writing at 519 E. 141st St. Suite L, Glenpool, Ok 74033.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative * Date:

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*If you are signing as a personal representative of an individual, please describe your legal authority to act on this individuals behalf.

_____ Client refuses to Acknowledge Receipt

_____ _____

Signature of Witness Date

Calm Tomorrows

Client and Family Bill of Rights

____ You have the right to be treated with dignity and respect

____ You retain all rights, benefits, and privileges guaranteed by law

____ You have the right to receive accurate information about services.

____ You have the right to know the complaint process.

____ You have the right to terminate services that are not satisfactory.

____ You have the right to choose a counselor that meets your needs.

____ You have the right to know the names and professional credentials of your therapist.

____ You have the right to discuss all components of your treatment with the therapist.

____ You have the right to be informed of the confidentiality practices/laws.

____ Upon written request I will arrange to review your record and progress

____ You have the right to receive services without discrimination. Your ethnic background, race, religion, sexual ethnicity, disability, personal/social creed will not affect any service provided to you.

____ You have the right to receive care with consideration and respect in a safe and humane environment

____ You have the right to privacy in your treatment.

____ You have the right to the confidential treatment of your personal records. This information will not be released without your prior consent, except in a transfer to another health care facility or as required by law, or under third party payments.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date