Theravada Mental Health LLC

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Main Office (702) 757-8720 • Fax (702) 974-4677 • Email info@theravadawellness.net • Website www.theravadawellness.com

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapeutic services.

Today's Date: _____

PATIENT INFORMATION

Patient's first name:_____ Last:_____ MI:_____ Marital status:_____

Is this your legal name?_____ If not, what is your legal name?_____ Former name:_____

Birth date:_____ Age:_____ Gender:_____ Sexual Orientation: _____

Address:

_____

Social Security no.:_____ **Cell phone no.:**_____**Email:**_____

Occupation:_____ Employer:_____ Employer phone no.:_____

Income Source if Not Employed:_____

Name of Parent/Legal Guardian:_____ Parent/Legal Guardian Phone no.:_____

Currently a Student?_____ School Name:_____

How did you hear about us (If google search, please indicate what you were searching for:_____

If referred by another clinician, do you give your permission for us to communicate to one another? If so, can you please list his/her contact information:_____

Other family members seen here: _____

PRIMARY INSURANCE INFORMATION (if applicable)

Type of Insurance:_____

Subscriber's name:_____ Subscriber's S.S. no.:_____ Birth date:_____

Group no.:_____ Policy number/Member ID:_____

Patient's relationship to subscriber: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Type of Insurance:_____

Subscriber's name:_____ Subscriber's S.S. no.:_____ Birth date:_____

Group no.:_____ Policy number/Member ID:_____

Patient's relationship to subscriber: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____

Relationship to patient:_____ Home phone no.:_____ Work phone no.:_____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ no ☐ yes

(Therapist/psychiatrist name/agency) _____

Have you had previous psychotherapy? ☐ no ☐ yes

(Previous therapist's name/agency) _____

Have you had previous psychiatric hospitalizations? ☐ no ☐ yes

(Previous hospital(s)/reason for admittance) _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ☐ yes ☐ no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ☐ yes ☐ no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ☐ yes ☐ no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Theravada Mental Health LLC. I understand that I am financially responsible for any balance. I also authorize Theravada Mental Health LLC to release any information required to process my claims.

Patient Signature: _____Date: _____

Printed Name: _____Date: _____

Guardian Signature: _____Date: _____

Printed Name: _____ Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

Informed Consent for Services

Welcome to Theravada Mental Health LLC. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand the presented information. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Description of Service

Mental health therapy services are provided in office or a community setting by a masters-level mental health professional. Theravada Mental Health LLC provides individual, group and family counseling for adults, children and adolescents. The areas may include: Anxiety, phobias, stress reduction, behavioral issues, grief/loss, trauma/abuse, depression, self-esteem, career goals, personal wellness, conflict and anger management, relationship issues, personality disorders, human sexuality and body image and life transitions.

The length of therapy will be agreed upon between your mental health provider and the client with consideration to the given limits by third party payment. Be aware that under managed care programs, termination of therapy is generally a matter decided by the managed care provider. The duration of an intake session involving a comprehensive evaluation may range from one (1) to two (2) hours with subsequent standard sessions running twenty (20) to fifty (50) minutes per session. It is expected that clients will arrive for their appointments on time and no time adjustment will be made for late arrivals.

Following the initial assessment, the frequency and duration of such sessions will be based on the individual needs of each client in addition to possible stipulations set forth by one's managed care program. A comprehensive treatment plan will be developed between you and your mental health provider following the initial assessment. Such treatment plan will be referenced throughout your treatment and will be adjusted accordingly to meet your therapeutic needs.

Contact Information: The mental health provider is often not immediately available by telephone. The mental health provider does not answer their phone when they are with clients or otherwise unavailable. At these times, the client may leave a message on the provider's confidential voice mail and the client's call will be returned as soon as possible, but it may take up to 48 hours for non-urgent matters. For confidentiality protection, the mental health provider also does not use email, chat or text to engage clients (unless authorized electronic appointment reminders and/or enrollment requests are activated). If, for any number of unseen reasons, the client does not hear from the mental health provider or the mental health provider is unable to reach the client, and the client feels they cannot wait for a return call or if the client feels unable to keep themselves safe, 1) contact one of the following crisis hotlines: 24/7 Crisis Call Center/National Suicide Prevention Hotline at 1-800-273-8255 2) go to your Local Hospital Emergency Room or 3) call 911.

In the event that the mental health provider is unable to reach the client via authorized means of communication, the mental health provider will use the client's emergency contact information to locate and contact the client. Provided examples: if the client cannot be contacted within 48 hours by the mental health provider after a no-call, no show appointment, the client's emergency contact information will be utilized to locate and contact the client.

Cancelations: It is requested that to cancel an appointment the client must call at least 24 hours before the time of the appointment. Any appointment cancelled less than 24 hours in advance will be subject to a late cancelation fee of $75.00, unless such cancelation fees are null and void based on your managed care program's regulations or such cancelation was deemed medically necessary or emergency-based. If the client can reschedule the missed or late canceled appointment, it will be up to the discretion of the clinician as to whether the $75.00 late cancellation fee is waived. If the client has two (2) no-call, no show appointments and/or cancels with less than 24 hours' notice within a three (3) month time frame, the client may be limited to having to schedule weekly based on clinician availability for all future appointments. If the client has three (3) no-call, no show appointments and/or late cancellations within a three (3) month time period, the mental health provider will discuss with the client their decision to participate in services and may consider a referral to another provider if deemed necessary.

Interruptions in Therapy: Interruptions may occur due to family or medical emergencies, death, hospitalization, vacations, or professional training. When such interruptions occur, clients will be informed. Please provide your mental health provider with your preferred contact information upon enrollment. As well, if such interruptions such as incapacitation or death of the provider occur, the following individual will be granted limited access to your PHI as to assist you in receiving copies of your PHI. Note that the following individual will only be granted access under such severe circumstances so that you, the client, can access your PHI. Such individual will have no other capacity to access such records prior to such severe circumstances. Upon incapacitation or death of the provider you may contact the following individual to receive your PHI: Piera Carfagno, LMFT; 5715 W Alexander Ste 115, Las Vegas, NV 89115; 702-482-7345.

Self-Pay and Charges: The fee for self-pay counseling services is as follows: Initial assessment: $120.00; 15 to 30-minute session: $80.00; 31 to 45-minute session: $100.00; 45 to 60-minute session: $120.00. Payment is due when the client comes in for the appointment. There will be no bartering of services and gratuity gifts will not be accepted. Payments may be made by cash, check, or credit card. Any returned checks are subject to an additional fee of up to $25.00 to cover the bank's returned check fee.

Insurance Reimbursement: When requested, the mental health provider will file insurance forms for reimbursement and preauthorization. The client is expected to pay their co-payment at the time the service is being rendered. The client must be billed their co-payment amount which will be due at the beginning of appointment. Mental health sessions are often limited with most insurance plans. If deemed necessary, the mental health provider will seek approval for additional sessions prior to the last approved session. If request is denied, clients have the option to pay out of pocket for services. Some managed-care plans will not allow the mental health provider to provide services to you once your benefits end or you may not be able to afford the fee for service. If this is the case, the mental health provider will do their best to find another provider who will help the client continue psychotherapy. We will work together to find the best option for services.

Responsibility for Payment: The client is responsible for all counseling charges unless otherwise stipulated by the client's managed care program. The client has the right to dispute fees charged for services rendered. Any outstanding balance over $50.00 will be charged to the client's credit card on file. The client will be asked to provide credit card information when the client presents themselves for mental health services. Any outstanding unpaid accounts will become delinquent after 60 days and then be turned over to an attorney or collection agency. If the client has outstanding debts, counseling services may be subject to termination. All fees charged in order to recover delinquent fees will be billed to the client (or primary person responsible for payments in the family). If the client is unable to pay, a referral for the continuation of therapy will be provided.

Provider Credentials

Clinical professionals at Theravada Mental Health LLC have credentialed licenses including LMFT, LCSW, LCPC, and CSW-I, and they are experienced in Psychotherapy, Interpersonal Psychotherapy, Psychodynamic Theory, Trauma-Informed Care, CBT, DBT techniques, Group Therapy, Family Therapy, Art and Play Therapy, Exposure Therapy, and Mindfulness practices. Scope of practice focuses on adults, adolescents, children, families and couples who experience symptoms of acute, chronic, or complex trauma, depression, schizophrenia spectrum, body dysmorphia, trauma/PTSD, and anxiety, among other issues. Psycho-education will be provided to assist individuals and families better understand mental health treatment and needs. Establishing a healthy therapeutic relationship with clients is our first priority. It is paramount to our practice to maintain professionalism while engendering a relaxed, calming, safe, non-judgmental environment in which clients are encouraged to be honest and transparent about any and all issues they may be facing.

Consent to Treatment

I do hereby voluntarily seek and consent, myself or my child, to take part in the treatment by the mental health provider named below. I understand that developing a treatment plan with this mental health provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no guarantee can be made to me as to the results of treatment or of any procedures provided by this mental health provider. Therapy outcome is largely influenced by the clients' characteristic such as motivation, severity of symptoms and acceptances of personal responsibility for change.

I understand that there are many benefits to the therapy process, such as; I may experience reduction in feelings of distress in the family or greater awareness of self and issues causing disruption in the marriage/family. However, during the counseling process I may also experience disruptions in life or discomfort due to anxiety or pain related to issues discussed or discovered during the counseling process. Risks may also include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of my life.

I understand that I may stop my treatment with this mental health provider at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court and my provider will have the report such termination to the proper authorities.) In the event that therapy is terminated before the time agreed upon, a referral would be given if needed. Some alternatives to traditional therapy are self-help books, pastoral counseling, support groups, and medication.

I understand that confidentiality of records of information collected in regard to my treatment will be held or released in accordance with state and federal laws regarding confidentiality of such records and information as stated in the Private Notice provided to me. Such state and federal laws include mandatory reporting of all cases related to abuse or neglect of a minor or dependent adult, all cases where there exists a danger to self or others and in which the law requires my mental health provider to disclose confidential information. Such specifics to confidentiality are outlined in the Privacy Notice provided to me.

I understand that my provider may disclose any and all records in relation to my treatment for care management, coordination of treatment, claims processing, reviews and/or quality assurance to the extent necessary to provide services. Such reviewers are held to the same confidentiality laws and regulations as my current provider.

I understand that if I feel my privacy rights have been violated, I have the right to file a complaint. Such procedure to file a complaint is outlined in the Privacy Notice that has been provided. Filing a complaint will not change the healthcare provided to me by Theravada Mental Health LLC in any way.

I understand that if I am court ordered to services at Theravada Mental Health LLC, such agency will file periodic updates with the courts in regard to my treatment progress.

I understand that I have the right to look at my health information (PHI) under the supervision of my mental health provider. I also have a right to a copy of my PHI which such requested information can be found outlined in the Privacy Notice provided to me.

I understand that client's records, clinical notes, counseling contracts, and all financial records will be maintained for a period of seven years. In the case of minors, such records will be kept until the age of 25 or seven years after the last date of services (whichever is longer). Any release of the sessions will be done with the written approval of the clients (parent/legal guardian of minor(s) must first give permission). These documents will be kept in a secure area and on a HIPAA complaint data system. After such timeline has lapsed, client records will be permanently destroyed.

I understand that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnosis, and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the mental health provider may stop my treatment and I will be financially responsible for any unpaid services.

I understand that if my mental health provider is to appear in court or is subpoenaed to appear in court in reference to my treatment, I will be held responsible to pay for the full rate of $500.00 per hour for my mental health provider to be absent from the office per compensation for my mental health provider's time. This same per hour rate, $500.00, also applies to my mental health provider's prep time and consultation for such legal court cases. I am expected to pay any cost even if the request is from a third party on my behalf. I am encouraged to speak with my mental health provider before waiving rights to confidentiality for any legal course cases.

I understand that a fee of $1.00 per page may be applied for copying, mailing and/or faxing of any records or reports in reference to personal requests for PHI, disability reviews, workers compensations, court order, and/or subpoenas (unless otherwise specified by your managed care organization).

I understand that if disputes/complaints arise, I should feel free to address my concerns with my mental health provider. In the event their dispute(s) or complaint(s) are not resolved I have the right at any time to seek the assistance of the: Secretary of the U.S. Department of Health and Human Services and/or the Nevada Board of professional to which your mental health provider belongs.

US Department of Health and Human Services
Bureau of Professional Licensure
PO Box 23489
Washington, DC 20026

Consent to Treatment of Minor

I understand that the parent(s) and/or legal guardian(s) shall have legal right to information in most cases concerning or relating to the minor child unless otherwise ordered by a custody decree or court order. This information may include but not limited to educational, law enforcement and medical records. It is requested that a copy of court orders and/or custody decrees be provided to Theravada Mental Health LLC for documentation purposes.

I understand that the parent(s) and/or legal guardian(s) shall have legal right to information concerning or relating to the minor child with the exception of substance abuse/use information, in most circumstances. Exclusions to this right to information include the limitation of information to a parent or legal guardian if such information may cause harm to the minor child and such restriction of information would be in the best interest of the minor child's safety.

I understand that the parent(s) and/or legal guardian(s) and the minor child will discuss with the mental health provider the definition of confidentially verses privacy. The parent(s) and/or legal guardian(s) and minor child may also be asked to sign a parent/child confidentiality agreement. Note that if the minor child reports high risk intentions or behaviors to the mental health provider, such information will also be discussed with the minor child's parent(s) and/or legal guardian(s).

I understand that if a minor child is receiving services, Theravada Mental Health LLC is not accountable to notify non-custodial and/or legal guardians who were not present at the time of enrollment and/or not present at succeeding sessions in reference to current or following services, unless specifically requested by the custodial parent(s) or legal guardian(s) whom is authorizing the enrollment of the minor child with Theravada Mental Health LLC .

I understand that if I ever become involved in a divorce or custody dispute that Theravada Mental Health LLC will not engage in custody determinations, give opinions concerning visitation or custody arrangements and will not provide evaluations or expert testimony in court. A different mental health professional for any evaluations or testimony should be acquired for these purposes.

I understand that any amount due after the third-party payment is received will be billed to the person signing the enrollment agreement. I understand that it is my obligation, as the consenting adult to services, to collect payment for any amount owed by the other parent.

Consent to Treatment of Family or Couple

I understand that the mental health provider will not provide any services to an individual family member or couple while providing services to the couple and family. If the couple or entire family cannot make it to session, the session needs to be cancelled and rescheduled. The mental health provider has a "No Secrets" policy and that while working with a couple or family, anything disclose individually, whether by phone or in passing, will not be held in confidence. The mental health provider will work with the member with a short period and support the disclosure to the other partner or family members. If not, the mental health provider will disclose after the agreed upon time as passed.

Consent to Treatment with Assisted Animal Therapy (AAT)

Although AAT comes with many benefits, it also comes with inherent risks. When working with therapy animals we *cannot be 100% sure* that their behavior will always be predictable. We will follow the professional Alliance of Therapy Dogs standards of practice as well as their policy and procedures in regard to animal participation. The companion animals participating have been medically screened and registered with American Kennel Club (AKC) Therapy Dog Title.

I understand that I, and anyone who might claim on my behalf, release Theravada Mental Health LLC from liability of any kind arising out of personal injury, and property damage resulting from my participation in AAT at Theravada Mental Health LLC.

I understand that I assume all the foregoing risks and **accept personal responsibility** for all expenses, medical or otherwise, following any such damages or injuries, which may in any way be associated with my participation in AAT at Theravada Mental Health LLC. This may include but is not limited to injuries that the therapy animal or client sustains.

Consumer Rights

I have read and had explained to me the basic rights of individuals who undergo services at Theravada Mental Health LLC. These rights include:

- The right to receive quality of care, free from discrimination based on race, color, creed, sex, age, sexual orientation, social or economic status, political belief, disability or religion.
- The right to have a safe treatment setting, free from sexual, physical, and emotional abuse.

- The right to have a respectful and dignified treatment.
- The right to obtain information about the mental health provider's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- The right to confidential treatment under state and federal laws which is outlined in the Privacy noticed provided to me.
- The right to receive comprehensible information pertaining to my services, diagnosis and expected results of my overall treatment through Theravada Mental Health LLC .
- The right to participate and make decisions in the formation of my evaluation, treatment plan and services provided through Theravada Mental Health LLC .
- The right to refuse any form of treatment or service.
- The right to file a complaint if I believe my privacy rights have been violated. Such procedures are outlined in the Privacy Notice provided to me.
- The right to have an Advanced Psychiatric Directives which will be followed with reasonable care by Theravada Mental Health LLC. Such directives should be provided to Theravada Mental Health LLC for record purposes. More information regarding Advanced Psychiatric Directives can be found at www.nrc-pad.org

Consumer Responsibility

As a consumer of such services, I accept the responsibility for the following:

- To be an honest and active participate in my evaluation, treatment and care while engaged in services with Theravada Mental Health LLC and to ask questions if I do not understand the services that are being provided.
- To inform Theravada Mental Health LLC of my past and current medical and mental health issues in addition to a comprehensive listing of current medications being taken. It is also my responsibility to inform Theravada Mental Health LLC of any changes to these medications.
- To provide Theravada Mental Health LLC of current insurance card(s), if such insurance will be billed for services. I am to also notify Theravada Mental Health LLC of any alterations to this insurance coverage. I will be held financially responsible at the full rate of service until such insurance information is provided.
- To be accountable for my decisions and for the attainment of my treatment plan. Which also includes such results if I refuse to follow my treatment plan or its recommendations and directives.
- To understand my insurance coverage and agree to any and all financial obligations to Theravada Mental Health LLC. I also acknowledge and agree that payment or co-payment is due at the time of the service.
- To contact or communicate with my insurance company if any limitations or necessities are required for service. If such contact is not rendered, I will be financially responsible for unpaid services.
- To contact or communicate with the insurance card holder that the stated insurance will be billed for such services provided by Theravada Mental Health LLC.

Provider Responsibility

The mental health provider of such services accepts the responsibility for the following:

- The mental health provider will endeavor to be present, honest, and emphatic throughout the counseling sessions. The mental health provider will engage the clients verbally and help the clients work toward the agreed upon therapy goals. Progress of therapy will be monitored with the aid of a treatment plan.
- The mental health provider will handle the client's personal information and information shared in the counseling sessions as confidential as stipulated by federal and state laws.
- The mental health provider will uphold the following exceptions to confidential and privileged information:
- When mandated by law, in cases of suspected or proven physical or psychological child abuse, incest, child neglect or abuse of a dependent adult.
- When clients have provided a written waiver of right and confidentiality.
- When clients poses a danger to themselves or others.
- When clients discloses an intention to commit a crime.
- When a judge orders a mental health provider to make records available.
- When the mental health provider is working under supervision.
- When the mental health provider consults with experts or peers.
- When the mental health provider is involved in a lawsuit.
- When reimbursement require disclosure. Third parties may review client records prior to reimbursement of fees.
- When the mental health provider is a defendant in a civil, criminal, or disciplinary action arising from the therapy.
- When family members take confidential information outside the therapy sessions.
- When the mental health provider is trying to collect a debt owed by the client for services.

- The mental health provider may require frequent consultation with other mental health professionals to ensure quality care for clients. Such consultation is standard practice. Every effort will be made to protect the identity of clients.
- The mental health professional will work to maintain the integrity of the counseling process, the mental health professional will refrain from entering into dual and multiple relationships with the client. The mental health provider will maintain a professional relationship with the client at all times. There will be no socializing between the mental health provider and client outside of the counseling setting. The client is not allowed to visit or contact the mental health provider at the mental health provider's primary residential residence. The mental health provider does not engage in any physical contact with clients. In the event that the mental health provider sees the client in a public place, to maintain confidentiality the mental health provider will only acknowledge the client if it is first initiated by the client. The mental health provider will not engage in any conversation with the client. Please take into account that if the client speaks to the mental health provider in public, the client may be self-disclosing you are in session.
- The mental health provider will focus on the client's protection, confidentiality, and to maintain professional boundaries, the mental health provider will not accept any social media requests or communicate with clients via social media. The mental health provider also does not use email, chat or text to engage clients. If the client shares any information about counseling services on a rating site of business or mental health professionals, please be mindful that the client is self-disclosing that they are or have received treatment.

Self-Pay and Charges (found within this document)

The fee for self-pay counseling services is as follows:

Initial assessment: $150
15 to 30 minute session: $80
31 to 45 minute session: $100
45 to 60 minute session: $120
Payment is due when the client comes in for the appointment. There will be no bartering of services and gratuity gifts will not be accepted. Payments may be made by cash, check, or credit card. Any returned checks are subject to an additional fee of up to $25 to cover the bank's returned check fee. Credit card charges will read the following title on the bank statement: "Theravada Mental Health LLC".

Agreement to Enter into a Therapeutic Relationship

By printing your name, signing, and dating this form, you are acknowledging that you have read and understand the INFORMATION CONSENT TO TREATMENT & NOTICE OF PRIVACY PRACTICES in its entirety and that you acknowledge receipt of the Health Insurance Portability and Privacy Act (HIPAA) Notice of Privacy Practices, you agree to the policies of your relationship with your therapist, and you are authorizing Theravada Mental Health LLC to begin treatment with you.

Client Name _____ (Please Print)

Client Signature_____ Date _____

Guardian Name _____(Please Print)

Guardian Signature_____ Date _____

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

Therapist's Signature: _____ Date: _____

Client refuses to acknowledge receipt. _____

Communications Policy

Preference for Confidential Communications:
As per the Notice of Privacy Practice, you have the right to request that this office communicates with you about your health information in a certain way or at a certain location. For example you can request to be contacted by mail or at work. Please indicate where you would like to be contacted:

I prefer to be contacted by: ☐Phone ☐Email ☐Texting ☐Mail ☐Online platform (e.g. Skype)

I prefer to be called and/or texted at the following number:_____

I ☐DO ☐DO NOT want messages to be left at this number.

Please only call at these times: _____

I prefer emails to be sent to: _____
☐Administrative Purposes and/or ☐Treatment purposes.

I prefer texts to be sent to: _____
☐Administrative Purposes and/or ☐Treatment purposes.

I prefer mail to be sent to: _____
☐ Administrative Purposes and/or ☐Treatment purposes.

I prefer to use the application _____
☐Administrative Purposes and/or ☐Treatment purposes.

I prefer to use the online platform: _____with the username: _____
☐Administrative Purposes and/or ☐Treatment purposes.

Other instructions: _____

Email, Texting, Online Platforms, and Applications
Your protected health information must be kept private and secure according to federal and state laws and professional ethics codes. Email, texting, online platforms, and applications are convenient ways to communicate for treatment purposes (such as discussing your current symptoms) and administrative purposes (such as appointment scheduling and billing). Reasonable means to protect the security and confidentiality of communications via email, texting, online platforms, and applications will be taken. **However, it is impossible to guarantee the security and confidentiality of communication via email, texting, online platforms, and applications.** Should confidential information be improperly disclosed, through no fault of this office, this office will not be liable for such disclosures.

Potential risks of communicating by email or text may include:

- Misdelivery of emails or texts to an incorrectly typed address or number.
- Email and online accounts and phones can be hacked.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email, texts, and online platform or application data may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect emails, texts, online communications and application data transmitted through their systems.
- Information sent via emails, texts, online platforms, and applications can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails, online platforms, and applications can be used to introduce viruses into computer systems.
- Emails, texts, and online platform and application data can be used as evidence in court.

All emails and texts to or from patients concerning diagnosis or treatment will be filed as part of the patient record. Since the information will be considered part of the record, other individuals authorized to access the record, such as staff and billing personnel, will also have access to those emails. Note that all email is retained in the record of the system sending the email. Emails and texts may be forwarded internally to workforce members as necessary for diagnosis and treatment.

COMMUNICATION VIA EMAIL, TEXT, ONLINE PLATFORM, OR APPLICATION SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

You have the option of choosing whether to communicate with this office via email, texting, online platforms and/or applications and what information you wish to communicate. **You do not have to consent to communication via email, texting, online platforms, or applications** and communication can be handled in person or via phone call or mail. You may revoke any permission at any time by writing the office.

By consenting to communicate through email, text, online platform or application, you also agree to the following responsibilities:

- If you send a communication that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify the office that the communication was not received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule appointments.
- To the extent possible you should NOT use email, texting, online platforms, or applications to make disclosures about sensitive medical information such as: mental health treatment, drug, alcohol or substance abuse, information related to AIDS and HIV, and genetic information.
- It is your responsibility to inform the office of any changes to your communication preferences including changes in mailing address, phone number, email address, or online account usernames.

Social Media

Requests to connect from current or former clients on social networking sites, such as Facebook, LinkedIn, Twitter, Pinterest, Google+ or other sites or apps, will not be accepted. Adding clients as friends on these sites and/or communicating via such sites is likely to compromise privacy and confidentiality. Please do not communicate with Theravada Mental Health LLC or our providers via any social networking sites. If you choose to "like me" on Facebook or "follow" me on Pinterest or any other social media platform, I assume that you are making an informed decision about how this may compromise your confidentiality. Fan lists on Facebook and follower lists on Pinterest, etc., are public information and easily accessed by anyone on the internet.

Business Review Sites

We have listings on Psychology Today which includes options for users to rate their providers and add reviews. These listings are not requests for testimonials, ratings, or endorsement from you as our client. You have a right to express yourself on any site you wish. But due to confidentiality laws, I cannot respond to any review on any site whether it is positive or negative. And like other online communications, there are privacy risks.

I recognize that technology is ever-evolving and that electronic communications cannot be fully protected from unauthorized interception. Understanding the risks of electronic communication via email or texting, I have indicated my preferences and consent for communications.

Client/Patient Signature _____ Date _____

Guardian/Representative Signature (if applicable) _____ Date _____

HIPAA Disclosure and Consent Form

This form is an agreement between you, and me/us, when we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices and our informed consent for service, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, Theravadawellness.com, or by calling us at 1-702-395-3050. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

By signing below, I agree that I have read the above information with the mental health provider. The mental health provider has clarified any items that were unclear to me. I understand the information that was presented in the Notice of Privacy Practice and Informed Consent for Service. I give consent to the terms of these documents and agree to enter into a counseling relationship with Theravada Mental Health LLC. I agree that a photocopy of this form is acceptable and is to be considered as valid as the original, but it must be individually signed by me, the releaser, and a witness if necessary.

Please circle:

YES NO I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

YES NO I have received a copy of this form, Informed Consent for Service and the Notice of Privacy Practices and agree to their terms.

Signature of client	**Printed name**	**Date**

Signature of parent/guardian/representative	**Printed name**	**Relationship**	**Date**

Signature of professional	**Printed name**	**Date**

No Show, Missed Appointment Policy Form

When your appointment is scheduled, Theravada Mental Health LLC is setting aside a dedicated time slot to ensure you are seen. We only ask that if you must reschedule your appointment, that you please provide us with **AT LEAST 24 HOURS NOTICE**. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. There is a charge of **$75** for not showing up for scheduled appointments or for not cancelling at least 24 hours in advance. Repeated cancellations or missed appointments will result in loss of future appointment privileges leading up to possible discharge and referral. Additionally, this is the card we will keep on file and use for co-payments and session fees **unless the client otherwise specifies** and provides an alternative form of payment.

Credit card appointment reservation form

Please take notice. The card that is provided below will be charged on the day of your scheduled appointment for a cancellation with less than 24 hours' notice, a failure to attend the appointment without notice to Theravada Mental Health LLC or your therapist, and for co-pays unless otherwise specified.

Credit Card # _____

(Circle One) – M/C – Visa – Disc – Amex

Expiration Date-- _____

CC Security Code (3 digits) -- _____

Billing Address: _____

_____

Patient Name _____
(Printed)

Cardholder Name _____ Date _____
(Printed)

Cardholder Signature _____ Date _____