Empowered Harmony Counseling, Psychiatry & Wellness Center

"REAL SOLUTIONS FOR REAL LIFE."

Patient Registration Form

Patient Information

First Name:_____ Last Name: _____ MI:_____

Preferred Name:_____ Date of Birth:____/____/____ Sex: _____

Street Address:_____

City:_____ State:_____ Zip: _____

Best Contact Number: _____ Email:_____

Primary Care Physician:_____ Psychiatrist:_____

Insurance Information

Primary Insurance:_____

Member/Enrollee ID Number: _____ Group Number:_____

Insured Party Name (If different from patient): -_____

Relationship to Patient:_____ Date of Birth:____/____/____ Sex:_____

Insured Party Street Address:_____

City:_____ State:_____ Zip: _____

Secondary Insurance (if applicable):_____

Member/Enrollee ID Number: _____ Group Number:_____

Responsible Party for Billing

(The person responsible for any out of pocket costs including copays, late cancellation fees, etc.)
The responsible party will receive phone calls, email, and mail if there is a balance on the account.

*If the client is above 18 and someone else is the responsible party for billing, the client must sign a release.

Patient is the responsible party for billing o

Responsible Party Name:_____ Sex:_____ Relationship:_____

Date of Birth: ____/____/____ SSN:_____-_____-_____ Employer:_____

Street Address (If different from patient):_____

City: -_____ State:_____ Zip:_____

Best Contact Number: _____ Email:_____

Emergency Contact

Contact Name:_____ Best Contact Number:_____ Relationship:_____

How did you hear about us?_____

Signature:_____ Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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Please understand that to protect your privacy, we cannot share any information or confirm that you are receiving services without vour written consent. If you would like to allow anyone, including your spouse, a co-parent, or your physician to receive information about your treatment, schedule, billing, etc. this form must be completed and on file with our office.

Name of Patient:_____ DOB:_____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize Empowered Harmony Counseling, to use and/or disclose and/or request my protected health information as checked below:

- Name of therapist/doctor
- Scheduled appointments
- Treatment plan/summary
- Psychological evaluation/test results
- Diagnosis
- Progress notes
- Compliance with treatment
- Medications
- Treatment plan
- Billing/Account related information
- Discharge/Termination plans
- Other: _____

I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524). I may revoke this authorization at any time by notifying Empowered Harmony Counseling in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy. Empowered Harmony Counseling agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name	Relationship	Phone	Fax

Client Name:_____ Client Signature:_____ Date: _____

Witness Name:_____ Witness Signature:_____ Date:_____

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Adult Intake Form

To help your clinician understand your concerns, please answer the following questions on this form.

Client's Legal Name:_____ Date of Birth:_____

What is your reason for seeking therapy today? _____

_____

Gender Identity (optional): • Male • Female • Transgender • Cisgender • Non-binary

Pronouns (optional):_____

Sexual Identity (optional): • Heterosexual • Gay • Lesbian • Bisexual • Pansexual • Undecided

Race/Ethnicity Please check all that apply (optional): • African American • Arab American • Asian or Pacific Islander • Caucasian • Hispanic • Multi-racial • Native American • Other:_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure - Adult

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (Clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting a lot more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	

VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affect your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, pipe, using snuff, or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is without a doctor's prescription, in greater amounts or longer than prescribed [e.g, painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Are there other concerns not listed above that you want to discuss?

PREVIOUS COUNSELING

Outpatient (place and year): _____

Inpatient (place and year):- _____

Intensive Outpatient Program/Partial (place and year): _____

FAMILY & SUPPORTIVE RELATIONSHIPS

Marital Status: • Single Married • Divorced o Widowed • Committed partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, etc.)	Quality of Relationship	Living with you?
			• Good • Fair • Poor	
			• Good • Fair • Poor	
			• Good • Fair • Poor	
			• Good • Fair • Poor	
			• Good • Fair • Poor	
			• Good o Fair • Poor	
			• Good • Fair • Poor	

EDUCATION

Highest level completed:

• High School o Attended College or Technical School • College Degree • Graduate Degree • Other: _____

EMPLOYMENT/CAREER

• Employed • Unemployed • Disabled • Retired • Stay-at-Home Parent

FINANCES

Overall stress level: • High • Medium • Low

SPIRITUALITY/RELIGIOUS BACKGROUND AND PRACTICE

Religious upbringing: • Nonexistent • Attending church • Belief in God • Other: _____

Present practice: • Inactive • Active o Searching • Other: _____

TRAUMA HISTORY

Have you had a history of trauma, abuse, or neglect?

If yes, what type of abuse or trauma occurred? • Physical • Sexual • Emotional • Neglect • Verbal

MEDICATION

Please list all current medications and supplements you are taking: (attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)? o Yes oNo

Name of medication:_____ Explain reaction:_____

Name of medication:_____ Explain reaction:_____

MEDICAL INFORMATION (Optional)

Please check all medical issues for which you have had treatment:

- Allergies
  (e.g., allergic reactions, seasonal allergies, etc)
- Bone disease
  (e.g., osteoporosis, arthritis, broken bones, etc)
- Endocrine disease
  (e.g., diabetes, hypothyroid, low testosterone, etc)
- Head and brain illness or injury
  (e.g., fainting, concussion, seizures, dementia, etc)
- Immune disease
  (e.g., serious infections, Rheumatoid Arthritis, etc)
- Mouth and teeth disease
  (e.g., gum disease, cold sores, canker sores, etc)
- Poisoning & chemical exposure
  (e.g., overdose, lead exposure, work fumes, etc)
- Blood disease
  (e.g., anemia, bleeding disorders, etc)
- Digestive system disease
  (e.g., ulcers, heartburn, Celiac Disease, IBS, etc)
- Genetic disease
  (e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)
- Heart/cardiovascular disease
  (e.g., heart arrhythmia, heart attack, high blood pressure)
- Lungs and breathing disease
  (e.g., asthma, COPD, emphysema, etc)
- Muscle and movement disease
  (e.g., tremors, tics, Restless Legs, Parkinson's, etc)
- Serious injuries and wounds
  (e.g., burns, cuts, stabs, crushed limbs, etc)
- Other:_____

Check all areas where you have had past surgeries:

- Cancer
  (e.g., procedures for cancer treatment)
- Ear, Nose, Throat
  (e.g., tonsillectomy, thyroidectomy, etc)
- Obstetrics & Gynecology
  (e.g., hysterectomy, c-section, abortion, etc)
- Plastic surgery
  (e.g., reduction, implant, reconstruction, etc)
- Urology
  (e.g., kidney stones, hypospadias, etc)
- Weight loss
  (e.g., gastric bypass, band, sleeve, etc)
- Cardiac / Vascular
  (e.g., procedures for heart, blood clot, stroke)
- Gastroenterology (digestive system)
  (e.g., stomach, gallbladder, liver, etc)
- Orthopedic
  (e.g., joint replacement, bones, spinal fusion, etc)
- Neurosurgery
  (e.g., brain surgery, spinal fusion, etc)
- Vision
  (e.g., LASIK, eye muscle correction, etc)
- Other:_____

Do you have any current or ongoing medical concerns?_____

Do you have problems with pain? • Yes ›No

Severity of your pain? (low) 1 23 4 5 6 7 8 9 10 (high)

Location of your pain? _____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home? • Yes No

If yes, please explain: _____

SUBSTANCE USE

Do you use alcohol? Yes No (If yes, number of drinks and frequency: - _____)

Do you use recreational/illicit drugs? • Yes No (If yes, drug(s) of choice and frequency: _____)

Have others viewed your use as a problem? • Yes No

Have you ever tried to cut down on your alcohol or drug use or quit using? • Yes NO

If yes, please explain: _____

Has alcohol/drug use interfered with family, work, or interpersonal life? • Yes ›No

If yes, please explain: _____

Have you had any prior substance abuse treatment? • Yes No

When?	Where?
_____	_____
_____	_____

LEGAL HISTORY

Are you involved with the legal system, Friend of the Court or Child Protective Services? • Yes • No

If yes, explain: _____

Do you currently have a probation or parole officer? • Yes No

If yes, name: _____

Have you been involved with the legal system in the past? • Yes No

If yes, explain: _____

Client Signature: _____ Date _____

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Portability and Accountability Act of 1996. (HIPAA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (AS A CLIENT IN THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Commitment to Your Privacy

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

II. Uses and Disclosures

Treatment. Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health care provider, such as your family physician or another professional counselor.

Payment. Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the clinical condition being treated.

Health care operations. Your PHI may be used as necessary to support the day-to-day activities and management of Empowered Harmony Counseling for example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your PHI may be disclosed to federal, state or local law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointments. Your PHI will be used by our staff to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. The contact may be made by phone, U.S. mail, email or texting.

Informative Information. Your PHI may be used to send you information on the treatment and management of your psychological/medical condition that you may find to be of interest. We may also send you information describing their psychological/health-related goods and services that we believe may interest you.

**If there is ever a breach of your healthcare information and it comes to our attention, we will inform you as soon as possible.

III. Personal Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to a restriction you request.
- The right to receive confidential communications concerning your psychological/medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.

- The right to inspect and/or copy your PHI that may be used to make decisions about you, including client psychological/medical records and billing records, but not including psychotherapy notes. The client's provider can provide a summary of the client's PHI if in the professional judgment of the client's provider, providing the client with unlimited access to his/her PHI would cause emotional/mental distress or endanger the life or physical safety of the client or another person. A client does not have the right to access Psychotherapy Notes relating to him/her except (i) to the extent the client's treating professional approves such access in writing; or (ii) the client obtains a court order authorizing such access. A provider has 30 days to reply.

IV. Requests to Inspect PHI

- As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office staff at Empowered Harmony Counseling. We may deny your access to PHI under certain circumstances, but in many cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

V. Revise Privacy Practices

- As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. We will post a copy of our current Notice in a visible location in our office at all times, and you may request a copy of our most current at any time.

VI. Complaints

- If you are concerned that your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your concerns to:

HR@empoweredharmony.com

Or contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Spiritual History & Psychotherapy Integration

Would you like spirituality to be integrated into therapy? Please initial _____ Yes _____ No

Religious Affiliation (if any): _____

Do you currently attend a place of worship? _____ Yes _____ No

List a few words to describe your personal faith: _____, _____, _____

Do you have any sleep problems? _____ Yes - _____ No

If yes, please describe: _____

Have you experienced any spiritual trauma or religious abuse? _____ Yes _____ No

If yes, please explain: _____

_____

How does your faith or spiritual practice support your mental health?

_____

Are there any spiritual beliefs or practices that you would like to explore or strengthen through therapy?

_____

Are there any spiritual or religious topics you prefer not to discuss in therapy?

_____

Do you use prayer, meditation, or rituals for emotional support? _____ Yes _____ No

If yes, please describe: _____

Would you like your therapist to be aware of any specific spiritual or cultural values important to you? _____ Yes _____ No

If yes, please describe: _____

BCBA: Board Certified Behavior Analyst.

CADC: Certified Alcohol and Drug Counselor.

CMH: Clinical Mental Health Counselor.

DO: Doctor of Osteopathy (Psychiatrist).

Health Coach: A professional who helps clients make lifestyle changes to improve physical and mental health.

LCADC: Licensed Clinical Alcohol and Drug Counselor.

LCP: Licensed Clinical Psychologist.

LCPC: Licensed Clinical Professional Counselor.

LCSW: Licensed Clinical Social Worker.

LICSW: Licensed Independent Clinical Social Worker.

LMFT: Licensed Marriage and Family Therapist.

LMHC: Licensed Mental Health Counselor.

LMSW: Licensed Master Social Worker.

LPC: Licensed Professional Counselor.

LPCC: Licensed Professional Clinical Counselor.

Life Coach: A professional who helps individuals achieve personal or professional goals.

MD: Doctor of Medicine (Psychiatrist).

PA-C: Physician Assistant - Certified (can specialize in psychiatry).

PMHNP: Psychiatric Mental Health Nurse Practitioner.

PhD: Doctor of Philosophy (Psychology or related field).

PsyD: Doctor of Psychology.

RDN: Registered Dietitian Nutritionist (can provide mental health-related support).

Wellness Coach: A professional who supports clients in achieving overall well-being, including mental and physical health.

Empowered Harmony Counseling, Psychiatry & Wellness Center

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INFORMED CONSENT FOR TELEHEALTH SERVICES

Overview

Telehealth includes the practice of behavioral mental health care assessment, diagnosis, consultation, treatment, and psychoeducation using virtual, video, audio, or data communications.

Expected Benefits

- Increased access to behavioral health care, particularly beneficial to patients in medically underserved communities and rural geographical locations with clinician shortages.
- Flexibility and convenience to stay active and engaged in behavioral health if patients are ill or unable to commute, resulting in fewer missed appointments or late cancellation fees.
- Telehealth offers increased access to specialists. Patients can be referred to specifically skilled clinicians, regardless of location.
- Increased access to privacy.

Possible Risks

As with any medical/health service, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of internet access and/or technology;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

By signing this form, I understand:

- That the laws that protect privacy and confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed without my consent.
- That I may need to download an application/software to use this virtual platform. I also may need to have an internet connection or a smartphone device with good cellular connection at the location used for services.
- The transmission of an appointment could be disrupted or distorted by technical failures.
- That I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care and authorize Empowered Counseling Counseling and any clinicians/administrators assigned by said organization, to use telehealth in the course of my diagnosis and treatment.

Patient Printed Name:_____ DOB: ____/____/____

Signature of Patient/Patient Representative:_____ Date: _____

Signature of Office Staff/Witness:_____ Date:_____

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CONSENT FOR SERVICES

Welcome to Empowered Harmony Counseling. Below you will find important information about the procedures and policies of our practice. Please do not hesitate to reach out to one of our dedicated staff members with any questions that should arise as you review this information.

Practice: We are a group of providers and masters-level therapists with various areas of specialty to meet your needs. We work with individuals, families, couples, and organizations. Our desire is to meet you where you are and walk alongside you in your unique personal journey. Our goal is for every client to feel heard, respected, and supported by our highly trained clinicians.

Office Hours: Our administrative staff provides receptionist and intake scheduling services Monday through Friday from 7am - 5pm and Saturdays from 8am - 12pm. If you reach out to us by email or voicemail, you can expect a 24 hour business day response. As always, if you are experiencing a true emergency, either physical or mental health related, we urge you to call 9-1-1.

Appointments/Missed Appointments: Services are by appointment only. Scheduling appointments is done by calling our office for an intake. If the need arises for you to change your appointment time, or cancel an appointment, please contact your provider as soon as possible. Appointments cancelled with less than 24 hour notice will be billed as a missed at the discretion of EHC. Please note that insurance companies do not cover missed appointments. There is a $100 fee for missed appointments.

Confidentiality: Your trust is extremely important to us. Maintaining your privacy is continually our collective commitment. Our office maintains a "shred all" policy. This means that any paper, despite its contents, is shredded. Your client records are our personal property and shall be treated as confidential. Please note that all client charts are kept for seven years following your closing date from counseling here at Empowered Harmony Counseling. Once seven years has elapsed, since your last appointment, your records are destroyed. All information shared in session with your therapist is confidential except in circumstances governed by laws, including the mandatory reporting of alleged harm to self or others. If we believe a consultation with another professional is important for your care, your confidentiality is protected under the "Privacy Practices" mandated by HIPAA (Health Insurance Portability and Accountability Act of 1996) which you have been provided.

Emergencies: In case of a true emergency/crisis situation, please call 9-1-1 and/or go to the nearest emergency department.

Cost of Therapy: Therapy is a financial investment - an investment in you. In order to meet the needs of clients with a variety of financial abilities, we offer therapy from 3 tiers of professionals: advanced level therapists, mid level therapists, and interns. Rates vary depending on who you see. Please contact our office for more information on specific rates.

Advanced Level Therapists - Advanced level therapists are those who hold either a doctoral or masters degree in either psychology, counseling, social work, or marriage and family therapy and have been in practice for a minimum of One year. These therapists have met all of the post educational requirements set forth by the licensing board and are fully licensed to practice independently. Advanced level therapists often participate with several insurance providers.

Mid-Level Therapists- Mid-level therapists are those who either have a doctoral or masters degree in either psychology, counseling, social work, or marriage and family therapy but are still working on meeting all of the post educational requirements for the advanced level. These therapists may have recently graduated, or be several years into their careers. These therapists hold associate or limited licenses. Mid-level therapists are supervised by advanced level therapists. Mid-level therapists can participate with some insurance providers.

*Interns- Interns are therapists-in-training who have completed the educational portion of their degree but are in the process of completing the internship portion of their degree. Interns can be completing a psychology, counseling, social work, or marriage and family therapy degree. Interns are directly supervised by an advanced level clinician. Interns cannot yet participate with insurance providers.

If we participate with your insurance company, then insurance rates apply. If you are a cash paying (self-pay) client we will discuss our self pay rates with you. You are fully responsible for payment of all services rendered to you. We will bill your insurance company if we can verify your benefits. Full payment is expected at the time of service, unless we are a contracted provider for your insurance company. In the event that your insurance company denies coverage, you will be responsible for the full charge. We accept Zelle, Cashapp, Venmo, debit card, credit card payments (Visa, Discover, MasterCard, etc.) and HSA accounts. A service charge of $25.00 per month may be added to all unpaid balances over 15 days.

We will be happy to answer any questions you may have concerning our policies. We are happy you chose Empowered Harmony Counseling. We look forward to working with you.

Please sign below, indicating your acceptance of the above policies:

Client Printed Name _____

Signature _____ Date_____

Signature of Therapist_____ Date _____

Consent to Use and Disclosure of Protected Health Information

Uses and Disclosure of Your Protected Health Information

Your protected health information will be used by Empowered Harmony Counseling or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the "Notice of Privacy Practices" for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of your Information

You may request a restriction on the use or disclosure of your protected health information at any time. Empowered Harmony Counseling may or may not agree to restrict the use or disclosure of your protected health information. If Empowered Harmony Counseling agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Empowered Harmony Counseling reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and received a copy of the Empowered Harmony Counseling "Notice of Privacy Practices" and give my permission to Empowered Harmony Counseling to use and disclose my health information in accordance with it.

Client Printed Name_____

Client Signature_____. Date_____

At Empowered Harmony Counseling, we recognize that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and will be able to move toward growth in the challenging areas of life. Our therapists work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

Therapist

The therapist is a licensed professional engaged in providing mental health care services to clients. Your therapist will discuss with you the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment will be described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

Number and Length of Sessions

The number and length of sessions needed depends on many factors and will be determined by you and the therapist.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist does not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purposes, and Techniques of Therapy

There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, lawsuits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between therapist and the client; a negligence lawsuit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

Duty to Warn

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing this form, you acknowledge that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

Risks of Therapy

Therapy is the Greek word for change. Change can often be difficult. Often growth cannot occur until past issues are experienced and confronted, this can potentially cause distressing feelings such as sadness or anxiety. The success of therapy

Payment for Services
Payment is expected at the time of service.

Court
In the event your therapist is compelled by law to disclose your records as part of a lawsuit you are party to, or the therapist's testimony is requested by you or required by law, you will be responsible for and shall be expected to pay the costs involved. Insurance will not cover the following costs.
Rates for court/lawsuit requests are as follows:
Record Requests: $5 per page requested
Report Writing, Deposition, Mediation, Testifying: $250 per hour, plus travel, lodging, transportation, food, and waiting time.

After-Hour Urgent Needs
Urgent needs are issues that cannot wait until regular business hours and require immediate action. If you are experiencing, or believe you are experiencing a life threatening medical emergency please call 9-1-1. If you are experiencing a mental health emergency, please contact 9-1-1 or 988.

Therapist's Incapacity or Death
In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing this form, you give your consent to another licensed mental health professional at Empowered Harmony Counseling to take possession of your files and records and provide you with copies upon request.

Consent to Treatment
By signing this form, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time.

Contact Information
By signing this form, you are consenting for EHC to communicate with you by mail, e-mail, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise EHC in the event of any change.
You agree to notify the Center if you need to opt out of any form of communication.

I, _____, acknowledge that I have read and agreed to the Informed Consent on _____.
(Date) (Client's Name)

Client Signature _____ Date: _____

As witnessed by: _____ Date: _____
(Therapist)

The Holmes-Rahe Life Stress Inventory

The Social Readjustment Rating Scale

INSTRUCTIONS: *Mark down the point value of each of these life events that has happened to your during the previous year. Total these associated points.*

LIFE EVENT	MEAN VALUE
1. Death of spouse	100
2. Divorce	73
3. Marital Separation from mate	65
4. Detention in jail or other institution	63
5. Death of a close family member	63
6. Major personal injury or illness	53
7. Marriage	50
8. Being fired at work	47
9. Marital reconciliation with mate	45
10. Retirement from work	45
11. Major change in the health or behavior of a family member	44
12. Pregnancy	40
13. Sexual Difficulties	39
14. Gaining a new family member (i.e. ... birth, adoption, older adult moving in, etc.)	39
15. Major business readjustment	39
16. Major change in financial state (i.e. ... a lot worse or better off than usual)	38
17. Death of a close friend	37
18. Changing to a different line of work	36
19. Major change in the number of arguments w/spouse (i.e. ... either a lot more or a lot less than usual regarding child rearing, personal habits, etc.)	35
20. Taking on a mortgage (for home, business, etc. ...)	31
21. Foreclosure on a mortgage or loan	30
22. Major change in responsibilities at work (i.e. promotion, demotion, etc.)	29
23. Son or daughter leaving home (marriage, attending college, joined mil.)	29
24. In-law troubles	29
25. Outstanding personal achievement	28
26. Spouse beginning or ceasing work outside the home	26
27. Beginning or ceasing formal schooling	26
28. Major change in living condition (new home, remodeling, deterioration of neighborhood or home etc.)	25
29. Revision of personal habits (dress manners, associations, quitting smoking)	24
30. Troubles with the boss	23
31. Major changes in working hours or conditions	20
32. Changes in residence	20
33. Changing to a new school	20
34. Major change in usual type and/or amount of recreation	19
35. Major change in church activity (i.e. ... a lot more or less than usual)	19
36. Major change in social activities (clubs, movies, visiting, etc.)	18
37. Taking on a loan (car, tv, freezer, etc.)	17
38. Major change in sleeping habits (a lot more or a lot less than usual)	16
39. Major change in number of family get-togethers ("")	15
40. Major change in eating habits (a lot more or less food intake, or very different meal hours or surroundings)	15
41. Vacation	13
42. Major holidays	12
43. Minor violations of the law (traffic tickets, jaywalking, disturbing the peace, etc.)	11

Now, add up all the points you have to find your score **TOTAL** ☐

150pts or less means a relatively low amount of life change and a low susceptibility to stress-induced health breakdown.
150 to 300 pts implies about a 50% chance of a major health breakdown in the next 2 years.
300pts or more raises the odds to about 80%, according to the Holmes-Rahe statistical prediction model.

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ Not Much ◯ Some ◯ A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Empowered Harmony Counseling, Psychiatry & Wellness Center

"REAL SOLUTIONS FOR REAL LIFE."

No-Show & Late Cancellation Policy

We value your time and reserve your session exclusively for you. In order to provide the highest level of care and fairness to all clients, we have a firm policy regarding missed appointments and late cancellations.

Missed Appointments (No-Show)

If you miss a scheduled session without providing notice, it will be considered a no-show, and a $100 no-show fee will be charged to the card on file. This fee is not covered by insurance and is the clients responsibility.

Late Cancellations

If you cancel your appointment less than 24 hours before your scheduled time, you will be charged a $100 late cancellation fee. This fee is nonrefundable. While we understand that emergencies and unexpected events happen, we offer a one-time courtesy waiver at the sole discretion of your provider. This courtesy may only be used once during the entirety of your time with our practice, regardless of how long you remain a client. No additional courtesies will be granted.

Reminders and Communication

We send appointment reminders via email and/or text 24/48 hours in advance. However, it is ultimately the client's responsibility to remember their appointment time. If you need to cancel or reschedule, please do so via our client portal or by contacting our office. Clients with two or more no-shows may be subject to termination of services. It is imperative that clients communicate with their provider or the office regarding needing to cancel or reschedule an appointment.

Payment of Fees

No-show and late cancellation fees must be paid prior to scheduling your next session. These fees are nonrefundable. Repeated missed appointments may result in discontinuation of services.

The clients card on file will be charged for any applicable no-show or late cancellation fees. It is a requirement that all clients maintain an active card on file at all times.

By signing our informed consent form, you acknowledge and agree to this no-show and late cancellation policy.

Client Signature: -_____

Date:_____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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TELEPSYCHIATRY PATIENT CONSENT FORM

TELEPSYCHIATRY PATIENT CONSENT FORM

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:
- Reduced wait time to receive psychiatric care.
- Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:
- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session.
- EHC utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions.

Alternatives to the use of telepsychiatry:
- Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:
(1) The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is 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 telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

(2) I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility 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.

- In addition, I understand that telepsychiatry-based services and care may not be as complete as face-to-face services.

I also understand that if my provider believes I would be better served by another form of psychiatric services (e.g. face-to-face), I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry.

(4) I understand that I have a right to access my medical information and copies of medical records in accordance with the law for my state, for a $5.00 a page fee and shipping cost.

Patient's Responsibilities:
- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that my provider determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.
- I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow-up face-to-face visit or a second telepsychiatry visit.
- I understand that post COVID-19 it is my responsibility to contact my insurance company to verify telepsychiatry coverage.

By signing below, I confirm that I have verified my behavioral health benefits with my insurance company and that telehealth is a covered benefit under my insurance plan. If not, I understand that I am responsible for the cost of any telehealth visit not covered by my insurance company.

Patient Consent to The Use of Telepsychiatry:
I hereby consent to engaging in telepsychiatry with EHC as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Patient Name (please print): _____

Signature (patient, parent, guardian): _____

Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

"REAL SOLUTIONS FOR REAL LIFE."

Intern Intake & Therapy Consent Form

Intern Intake & Therapy Consent Form (Self-Pay Patients)
Empowered Harmony Counseling, Psychiatry & Wellness Center
"Real Solutions for Real Life."

Welcome
You are receiving counseling services from an intern under the supervision of a fully licensed therapist. Interns are in training and may be working towards a graduate degree in counseling, psychology, or social work. All sessions are confidential and supervised to ensure you receive quality care.

1. Nature of Services
You will receive counseling services from a student intern who has completed all required clinical education and training to begin seeing clients under supervision. Interns can provide therapy, psychoeducation, and supportive counseling under guidance from a qualified clinical supervisor.

2. Fees and Payment Agreement
You are receiving services as a self-pay patient. Our current rate for intern sessions is:

- $80 per intake session
- $50 per ongoing therapy session

Payment is due at the time of service. We do not bill insurance for intern sessions. Please note: No-show and late cancellation fees without a 24-hour notice will be charged at the full appointment rate.

3. Confidentiality and Supervision
All sessions are confidential. However, interns are required to review session notes and case details with a licensed supervisor. This supervision is essential for training and ensures ethical, high-quality care.

Exceptions to confidentiality include:

- Threats of harm to self or others

- Suspected abuse of children, elders, or dependent adults
- Court orders or legal requirements

4. Rights and Responsibilities

As a client, you have the right to:

- Ask questions about your treatment
- Refuse or stop services at any time
- Request a different provider
- Receive culturally competent and respectful care

You also agree to:

- Attend scheduled appointments or cancel 24 hours in advance
- Communicate honestly and respectfully with your provider
- Notify us if you experience a crisis or safety concern

5. Informed Consent

By signing this form, you acknowledge and agree that:

- You understand that your therapist is an intern and not yet fully licensed
- You understand that your sessions will be reviewed in supervision
- You are receiving services on a self-pay basis and will not seek reimbursement from insurance
- You consent to participate in therapy and understand the risks and benefits

Patient Name (please print): _____

Signature (patient, parent, guardian): _____

Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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WELLNESS & COACHING CONSENT FORM

WELLNESS & COACHING CONSENT FORM

Welcome to Empowered Harmony Counseling, Psychiatry & Wellness Center. This consent form outlines the nature of wellness and coaching services provided. Please review the information below carefully.

1. Nature of Services:
Wellness and coaching services are designed to support personal growth, wellness goals, and life transitions. These services are not a substitute for psychotherapy, medical care, or mental health treatment.

2. Scope of Practice:
Our wellness providers and coaches do not diagnose mental health conditions or prescribe medications. Coaching may include goal setting, skill development, mindfulness, stress reduction, and holistic wellness strategies.

3. Confidentiality:
Your privacy is important to us. Information shared in coaching sessions is kept confidential to the extent permitted by law. However, coaching services are not governed by HIPAA and may not have the same confidentiality protections as therapy.

4. Limits of Confidentiality:
Confidentiality may be broken if there is reasonable concern of harm to self or others, suspicion of abuse, or legal obligation to disclose information.

5. Fees & Payment:
Coaching and wellness services may not be covered by insurance and are billed directly to the patient. Payment is due at the time of service unless otherwise arranged.

6. Communication:
Phone, email, and messaging may be used for scheduling and brief check-ins. These are not to be used for

emergency communication or crisis support.

7. Termination:
You have the right to discontinue coaching at any time. Your provider may also refer you to another professional if your needs are outside the scope of their expertise.

By signing below, you acknowledge that you understand and agree to the terms outlined above and consent to receive coaching and/or wellness services.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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Electronic Communication Consent Form

Electronic Communication

Use of email/electronic communication (text messaging) between patients and their therapist has risks regarding protection of your private health care information. Some examples include:

* Email/electronic communication can be intercepted by someone who is not the intended recipient.
* Intercepted email/text/electronic communication can be stored and printed by unauthorized recipient.
* Your identity can be determined from knowing your emails/electronic communication address/text messages.
* Emails/electronic communications/texts are easily, and sometimes, accidentally, forwarded to unintended recipients.
* Email/electronic communication can transport computer viruses and other malicious software.
* Receipt of email/electronic communication sometimes is not noticed, not responded to, in a timely manner.
* Detailed identifying information, diagnoses and treatment information about you or your child should not be put in the subject line or body of an email/text/electronic communication, nor be transmitted as an attachment to an email.
* Email/electronic communication/texts should NEVER be used to communicate emergency, urgent or other time-sensitive information.

If you choose to use non-encrypted email, text, or electronic communication as a way of communicating with your therapist or the agency, please read below:

* I have read and understand the information provided regarding email/electronic communication/texts messaging. I have had my questions regarding this answered to my satisfaction.
* I understand that Empowered Harmony Counseling, Psychiatry & Wellness Center is required by HIPAA to try to protect my private health care information, which is the reason I am being informed of the risks involved with email/electronic communication/text messaging.
* I understand that I am not required to participate in email and electronic communication, but if I do consent, I may withdraw this consent at any time by notifying my therapist.

Consent for Electronic Communication

I give my informed consent to participate in unencrypted email/electronic communication/text messaging with

Empowered Harmony Counseling, Psychiatry & Wellness Center by signing below:

Patient Name (please print): _____

Signature (patient, parent, guardian): _____

Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

"REAL SOLUTIONS FOR REAL LIFE."

Nondiscrimination Policy

Nondiscrimination Policy

POLICY STATEMENT

Empowered Harmony Counseling, Psychiatry & Wellness Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Empowered Harmony Counseling, Psychiatry & Wellness Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Empowered Harmony Counseling, Psychiatry & Wellness Center provides communication aids to people with disabilities for a fee, with some free services available when possible, to help them communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Empowered Harmony Counseling, Psychiatry & Wellness Center also provides language services for a fee to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact our Civil Rights Coordinator at support@empoweredharmony.com.

If you believe that Empowered Harmony Counseling, Psychiatry & Wellness Center has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by emailing: support@empoweredharmony.com. We are available to help you with filing and resolving grievances regarding civil rights or accessibility accommodations.

Empowered Harmony Counseling, Psychiatry & Wellness Center

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INDEPENDENT CONTRACTOR ACKNOWLEDGEMENT & PATIENT FEES AGREEMENT

NOTICE OF PROVIDER INDEPENDENT CONTRACTOR STATUS

All providers working with Empowered Harmony Counseling, Psychiatry & Wellness Center ("EHC") are independent contractors and are not employees of the company. Each provider is solely responsible for their own clinical services, decisions, and professional conduct. By signing below, you acknowledge and agree that any concerns, disputes, or issues arising during your care are to be addressed directly between you (the patient) and your individual provider. EHC is not liable for actions or omissions of independent providers.

PATIENT FEES AND PAYMENT AGREEMENT

Empowered Harmony Counseling, Psychiatry & Wellness Center bills usual and customary fees for standard clinical services rendered. The following additional services are not covered by insurance and will be charged to the patient directly:

- Completion of FMLA, Long-Term Medical Leave, or other similar forms: $50
- Completion of Short-Term Medical Leave Forms (less than 7 days): $35
- Late Cancellation or No-Show Fee (without 24-hour notice): $100
- Medication Refill Requests without a Scheduled Appointment: $25
- ESA (Emotional Support Animal) Letter: $35
- Medical Record Copying: $5 per page, plus the cost of USPS Priority Mail, FedEx, or UPS.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Empowered Harmony Counseling
SAFETY PLAN & EMERGENCY CONTACT FORM

Client Name: _____ DOB: _____

Primary Therapist: _____ Date Completed: _____

Emergency Contact Person: _____
Relationship to Client: _____ Phone Number: _____

Address of Emergency Contact: _____
_____

Local Crisis Line: _____ National Suicide Prevention Lifeline: 988

Supportive People I Can Call:
1. _____
2. _____
3. _____

Coping Strategies I Can Use When I'm in Crisis:
1. _____
2. _____
3. _____

Places I Can Go to Feel Safe:
1. _____
2. _____

My Warning Signs of Crisis (thoughts, feelings, behaviors):
_____
_____

Steps I Will Take to Keep Myself Safe:
_____
_____

If I am not able to keep myself safe:
I will contact my therapist, a crisis hotline, or go to the nearest emergency room.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

NO SURPRISES ACT: FEE DISCLOSURE, RIGHTS & RESPONSIBILITIES

Empowered Harmony Counseling
NO SURPRISES ACT: FEE DISCLOSURE, RIGHTS & RESPONSIBILITIES

Effective January 1, 2022, under federal law (Section 2799B-6 of the Public Health Service Act), health care providers must give clients who do not have insurance or who are not using insurance an estimate of the expected charges for medical services, including mental health care. This is called a "Good Faith Estimate."

YOUR RIGHTS UNDER THE LAW:
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.
- You can ask your provider or any other provider you choose for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- You are not required to receive services and can decline or withdraw at any time.

For questions or to dispute a bill, visit www.cms.gov/nosurprises or call 1-800-985-3059.

ESTIMATED SERVICE FEES:

- Psychotherapy Intake ..... $250 (53 minutes)
- Psychotherapy ..... $185 (53 minutes)
- Intensive Outpatient Program ..... $550 (3 hours)
- Behavioral Nutritional Therapy ..... $75 (30 minutes)
- Couples Counseling ..... $250 (53 minutes)
- Premarital Counseling ..... $150 (55 minutes)
- EAP Counseling Services ..... Covered by Employer
- Psychiatric Evaluation ..... $450 (45 minutes)
- Psychiatry ..... $150 (15 minutes)
- Holistic Nutritional Psychiatry ..... $140 (30 minutes)
- Adult Testing & Assessments ..... Starts at $950+ (90 minutes minimum)
- Life Coaching ..... $50 (40 minutes)
- Virtual Reiki Therapy ..... $90 (45 minutes)
- Virtual Hypnotherapy ..... $175 (60 minutes)
- Wellness Coaching ..... $75 (60 minutes)

PACKAGES & SUBSCRIPTIONS:

- Psychotherapy Subscription $400/month
- Six Premarital Sessions $750

CLIENT RESPONSIBILITIES:
- Arrive on time and participate actively in services.
- Notify us at least 24 hours in advance for cancellations.
- Maintain updated payment information on file.
- Contact your provider with questions about your services or fees.

PROVIDER RESPONSIBILITIES:
- Deliver high-quality, ethical, and culturally competent care.
- Provide transparent, timely communication regarding fees.
- Offer a Good Faith Estimate upon request.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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IMPORTANT INSURANCE NOTICE

It is your responsibility to know your individual insurance policy. Many insurance policies have exclusions. Most have deductibles, co-payments, and co-insurance. Some insurance policies may not cover our services. Most services at Empowered Harmony Counseling should be covered by your insurance.

It is important for you to check with your insurance carrier to determine if the provider you are seeing is listed as an "in-network" provider. If they are not listed as an "in-network" provider you may have a higher deductible and/or co-pay.

Regardless of insurance coverage, YOU ARE RESPONSIBLE for all bills not covered by your insurance policy.

The practitioners at EHC are independent of each other in their practice or professional service. Claims, either implied or expressed, against the Center or the practitioners will not be addressed other than those between the patient and his/her psychotherapist or provider MHNP, PA-C, or psychiatrist.

I consent to full responsibility for payment of these services and agree to pay them in full at the time of service, unless other arrangements have been made with my insurance or provider.

I also consent to full responsibility for a $100 charge for payment of missed appointments when no notice of cancellation is made 24 hours in advance, including new patient appointments.

I also consent to payment for a fee of $50 if collection action is necessary to collect on any unpaid balances on my account and the necessary release of information for collections.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

PSYCHIATRY OR MEDICATION SERVICES ACKNOWLEDGMENT

Empowered Harmony Counseling
PSYCHIATRY OR MEDICATION SERVICES ACKNOWLEDGMENT

In order to receive medication management services through Empowered Harmony Counseling (EHC), each client is required to attend therapy sessions on a weekly or bi-weekly basis with one of our EHC therapists.

This policy ensures integrative, collaborative care for your mental and emotional wellness and aligns with our holistic treatment model. Medication is not a standalone service at EHC.

By signing below, you acknowledge and agree that:

- You will engage in consistent therapy at EHC while receiving medication management.
- If therapy sessions are missed repeatedly or discontinued, your medication management services may be paused or discontinued.
- You understand that psychiatry and therapy are most effective when integrated as a unified care plan.
- You agree to communicate any concerns with your provider about therapy frequency or challenges attending sessions.

This policy is designed to support your long-term wellbeing and optimize treatment outcomes.

Client Name: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

SPECIALTY SERVICES CONSENT FORM

Empowered Harmony Counseling
SPECIALTY SERVICES CONSENT FORM

Empowered Harmony Counseling (EHC) offers a range of specialty services that support holistic wellness and complement traditional therapy. These services may include, but are not limited to:

- Reiki Energy Healing
- Hypnotherapy
- Wellness Coaching
- Nutritional Psychiatry Support
- Virtual Spiritual Therapy and Meditation Practices

These services are offered by trained and qualified practitioners. Participation in these services is entirely voluntary and NOT required to receive psychotherapy, medication management, or other clinical services at EHC.

BENEFITS & LIMITATIONS:
Specialty services are not a substitute for medical or mental health treatment. They may serve as supportive interventions and are intended to enhance personal growth, relaxation, healing, and overall well-being.

By signing this form, you acknowledge that:

- You understand these services are optional and not medically necessary.
- You have the right to decline or discontinue participation at any time.
- You understand that outcomes vary and are not guaranteed.
- You may discuss any concerns or questions about these services with your provider at any time.

Client Name: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

COURT-ORDERED THERAPY & CHILD WELFARE DISCLOSURE POLICY

Empowered Harmony Counseling
COURT-ORDERED THERAPY & CHILD WELFARE DISCLOSURE POLICY

Empowered Harmony Counseling (EHC) provides therapy services that may be court-ordered or related to cases involving child welfare systems, such as DFAS (Department of Family and Adult Services), CPS (Child Protective Services), or other legal agencies.

IMPORTANT NOTICE TO CLIENTS:

Under federal law (HIPAA - 45 CFR § 164.512(e)), your therapist is not permitted to speak to the court, CPS, DFAS, or any other third party without:

1. A valid court order signed by a judge, OR
2. A properly executed Release of Information (ROI) form signed by the client or legal guardian.

Your therapist cannot:
- Submit clinical evaluations, progress updates, or testify in court without proper authorization.
- Speak to CPS or DFAS regarding your case without one of the two conditions above being met.

These limitations are designed to protect your privacy and ensure legal compliance with HIPAA regulations and professional ethics.

CLIENT ACKNOWLEDGEMENT:
By signing this form, you acknowledge and understand that:

- Your provider cannot release your records or speak with legal or protective services unless a court order or signed ROI is provided.
- All disclosures must comply with state and federal privacy laws.
- If a court appearance is requested or ordered, additional fees may apply.

Client Name: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

RELEASE OF INFORMATION (ROI) AUTHORIZATION FORM

Empowered Harmony Counseling
RELEASE OF INFORMATION (ROI) AUTHORIZATION FORM

Client Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

I hereby authorize Empowered Harmony Counseling to:
[ ] Release information to [ ] Obtain information from [ ] Exchange information with

Name/Organization: _____

Address: _____

Phone: _____ Fax (if applicable): _____

INFORMATION TO BE RELEASED:
[ ] Intake & Assessment Summary [ ] Diagnosis [ ] Treatment Plan
[ ] Progress Notes [ ] Medication Records [ ] Entire Record
[ ] Other (please specify): _____

PURPOSE OF DISCLOSURE:
[ ] Continuity of Care [ ] Legal [ ] Insurance [ ] School/Employer
[ ] Other: _____

EXPIRATION:
This authorization expires (select one):
[ ] One year from the date of signature
[ ] On this date: _____

YOUR RIGHTS:
- You may revoke this authorization at any time in writing.
- Revocation does not apply to information already disclosed under this authorization.
- EHC cannot ensure the confidentiality of records once released to a third party.
- You are not required to sign this form to receive services.

SIGNATURES:

Client Signature: _____ Date: _____

Parent/Guardian (if applicable): _____ Date: _____

Witness/Provider Signature: _____ Date: _____

Federal law (HIPAA - 45 CFR § 164.508) requires written authorization before disclosing protected health information.