ANCHORED IN HEALING
COUNSELING & COACHING

We are so happy that you have decided to take the first step in the healing process. We look forward to working with you to help you become the best version of yourself. Please read the following information and return prior to your first appointment. If you have any questions, please follow-up with your therapist. Let the healing begin!

Intake Information

Personal Information

Full Name: _____
Preferred Name: _____
Date of Birth: _____Age: _____
Gender: _____
Email: _____
Address: _____
City, State and Zip: _____
Occupation: _____
Employer: _____
(Please Circle) I am fulltime/part time/unemployed/other
Are you a student? Yes or No
School: _____
Grade: _____
Area of Study: _____

Relationship Status: Single/ Engaged/ Married/ Divorced/ Widowed

Contact Information

When you are contacted, we want to insure your confidentiality and privacy. Please indicate whether a detailed message may be left.

Primary Phone _____ **Message** Yes / No

Secondary Phone _____ **Message** Yes / No

Emergency Contact Name _____ **Relationship to Client**

Emergency Contact Phone _____ **Emergency Contact Email**

If the client is under 18 years of age, or if the parent(s) will be responsible for payment, complete this section:

Parents' Marital Status Single / Engaged / Married / Widowed Separated / Divorced

Mother's Name _____ **Primary Phone** _____

Work Phone _____ **Message** Yes / No

Address _____ **City, State ZIP** _____

Employment _____

Father's Name _____ **Primary Phone** _____

Work Phone _____ **Message** Yes / No

Address _____ **City, State ZIP** _____

Employment _____

FEES:

Individual Therapy 45-50 min: $100
Family Therapy 45-50 min: $150
Couples Therapy 45-50min: $125
Group Therapy 60 min: $50
Group Therapy 90 min: $75
Existing Patient Check In 30 min: $60
Extended Individual / Family Therapy 75-90 min: $150
Missed Appointment: $75
FMLA paperwork: $50

Health Information

Please describe your reason for seeking help.

_____

_____

_____

_____

_____

Current and Past Medication

Medication	Dose/Freq	Start	Stop	Response	MD Prescribing

Please list any major illnesses or hospitalizations _____

Physician's Name _____ **Address** _____

City, State ZIP _____ **Phone** _____

Psychiatrist Name _____ **Address** _____

Other Physicians _____

Last physical exam _____ **Findings** _____

Please check all that apply to you:

- ☐ Anxiety
- ☐ Obsessive/Compulsive Behavior
- ☐ Paranoid Thoughts
- ☐ Hearing Voices
- ☐ Depression
- ☐ Irritability
- ☐ Fatigue/Low Energy
- ☐ Difficulty Concentrating
- ☐ Isolation from Others
- ☐ Aggressive Behavior
- ☐ Thoughts of Self-Harm
- ☐ Thoughts of Harming Others
- ☐ History of Self-Harm and/or Suicidal Thoughts
- ☐ History of Harming Others
- ☐ Trauma
- ☐ Problems at Work
- ☐ Problems at School
- ☐ Problems in Relationships
- ☐ Problems in Parenting
- ☐ Financial Concerns
- ☐ Family of Origin Issues
- ☐ Faith Concerns
- ☐ Chronic Pain
- ☐ Chronic Illness
- ☐ Difficulty Sleeping
- ☐ Poor Hygiene
- ☐ Alcohol and/or Drug Use
- ☐ Unwanted Sexual Behavior
- ☐ Patterns of Disordered Eating
- ☐ Other: _____

Referral Information

We appreciate referrals and like to send a note of thanks.

Referral Name _____ Email _____

Phone number _____

Can we share your name with the person who referred you?

_____

Client Notification of Privacy Rights

Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how your mental health records may be used and disclosed and how you can get access to this information.

Preamble

The Licensing Laws of the State of Tennessee provide privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes," which is not accessible to insurance companies and other third-party reviewers, and in some cases, not to the patient himself/herself. HIPAA provides privacy protections regarding your personal health information, which is called "protected health information," which could personally identify you. PHI consists of three (3) components: *treatment, payment, and health care operations.*

Treatment refers to activities in which your therapist provides, coordinates, or manages your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when Anchored in Healing Counseling and Coaching obtains reimbursement for your mental health care. Please see patient policies for more information about payment and insurance/third party billing.

Health care operations are activities related to the performance of Anchored in Healing Counseling and Coaching such as quality assurance.

The *use* of your protected health information refers to activities the office conducts in scheduling appointments, keeping records, and other tasks within the office related to your care.

Disclosures refer to activities you authorize which occur outside the office, such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

Uses and Disclosures of Protected Health Information (PHI) Requiring Authorization

The State of Tennessee requires authorization and consent for treatment, payment, and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. We may disclose PHI for the purposes of treatment, payment, and healthcare operations with your consent. You have signed this general consent to conduct payment and health care operations, to authorize me to provide treatment, and to conduct administrative steps associated with your care.

Additionally, if you ever want us to send any of your PHI of any sort to anyone outside our office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help ensure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that we speak with your physician about your treatment and/or medications. Before I talk to that physician, you will first have signed the proper authorization for us to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: our psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-client in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" cannot be secured by insurance companies, nor can they insist upon their release for payment of services. "Psychotherapy notes" are our notes and are defined as follows: notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a counseling session and that are separated from the rest of the individual's medical record. "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: assessment/ treatment starts and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If we are forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time we will be able to limit reviews of your PHI to only your "designated record set" which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of

psychological testing, and any authorizations you have signed. Please note that the actual test questions or raw data of psychological tests are not part of your designated mental health record set.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed, or an authorization that was obtained as a condition for obtaining insurance in cases where Tennessee law provides the insurer the right to contest the claim under the policy.

Business Associates Disclosures

HIPAA requires that we train and monitor the conduct of those performing ancillary administrative services for our practice and refers to these people as 'Business Associates'. These business associates need to receive some of your PHI in order to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information in accordance with state and federal standards.

Uses and Disclosures Not Requiring Consent nor Authorizations

By law, PHI may be released without your consent or authorization in the following instances:

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

No information will ever be released for any sort of marketing purposes.

Square Inc

If you and your therapist choose to utilize the Customers feature of square the other team members of Anchored in Healing Counseling and Coaching may have access to a limited amount of your PHI (name, fee, email, last four digits of credit card & dates of service). All team members have signed confidentiality agreements on PHI.

Client's Rights and My Duties

You have a right to the following: the right to request restrictions on certain uses and disclosures of your PHI. We may or may not agree to these restrictions, but if we do, they shall apply unless our agreement is changed in writing. The right to receive confidential communications by alternative means and at alternative locations. The right to inspect and receive a copy of your PHI in the designated mental health record set for as long as PHI is maintained in the record. The right to amend material in your PHI, although we may deny an improper request and/or respond to any amendment(s) you make to your record of care.

The Right to an Accounting of Non-Authorized Disclosures of Your PHI

The right to a paper copy of notices/information even if you have previously requested electronic transmission of same. The right to revoke any authorization of your PHI except to the extent that action has already been taken.

For more information on how to exercise each of the rights, please do not hesitate to ask for further assistance. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed. Current practices are applicable unless you receive a revision of our policies at a future time. Our duties as therapists include maintaining the privacy of your PHI, providing you with this notice of your rights and our privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed, and you are so notified.

Complaints

The appointed "Privacy Officer" for Anchored in Healing Counseling and Coaching per HIPAA regulations is listed below. If you have any concerns that your privacy rights have been compromised, please let us know immediately. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Jamil Matthews and Lauren Hudson is the appointed "Privacy Officer" for this practice.

This notice is effective as of Jan 15, 2022.

Confidentiality

Our therapists are obligated by their respective ethical boards to keep all information confidential. We take this obligation very seriously and will only violate this standard under circumstances outlined in the section titled Patient Notification of Privacy Rights

Client Policies

Scheduling

Appointments are made directly with your therapist. Please discuss scheduling with your therapist during your session(s).

Missed Appointments/Cancellations

You will be charged $75 for a missed appointment if you do not notify your therapist at least 24 hours in advance. If you are more than 15 minutes late for a scheduled appointment, the appointment may be considered as “no show” and will need to be rescheduled at the discretion of the therapist. “No shows” for appointments are subject to being charged $75 for the session.

In Person sessions

In person sessions are at a premium due to the current condition of the world. We have limited availability for all in person sessions. All in person sessions which are scheduled, payment will have to be processed 48 hours prior to your appointment. We want to ensure that those limited slots are best used by those that can commit to in person on Saturday.

Payments

Payments are to be made at the session(s), unless other arrangements have been made. The fee is based on a clinical hour of 50 min. Checks are to be made payable to Anchored in Healing Counseling and Coaching. Anchored in Healing Counseling and Coaching requires a credit card on file to be used only for missed appointments and late cancellation fees. Because there is an additional banking fee associated with using a credit or debit card, a $5.00 per transaction fee.

Fees: Anchored in Healing Counseling & Coaching reserves the right to change fees. Your therapist is required to give you 30days notice of any fee changes

Insurance/Third Party Billing

We will gladly create a superbill with the information needed to file an insurance claim. Coverage for therapy varies according to a person's plan and the insurance company. Full payment for the session is due at the time of the session. We do not file insurance claims, and we are not on insurance panels.

Communication

Please discuss communication with your therapist during your session(s). If you are in an emergency and cannot reach your therapist, please call one of the following numbers for help; General Emergencies, 911; or Crisis Hotline: 901-274-7477.

Credit/Debit Card Information

Name on Card _____ **Card Number** _____

Expiration Date _____ **CVV Number** _____

Billing ZIP Code _____ **Email Address** _____

Recurring Charge Authorization

The undersigned card member consents and permits Anchored in Healing Counseling and Coaching to automatically charge the standard rate for counseling sessions that I attend. I understand there will be an additional $5.00 fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service.

_____ _____

Signature of Client or Parent/Guardian Date

Authorization

By signing below, I acknowledge I have read, agree to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties, including organizations or individuals who are being invoiced for the client's services, for billing purposes and payment of medical benefits to the therapist.

_____ _____

Signature of Client or Parent/Guardian Date

Agreement in Policies

I acknowledge that I have read, understand, and agree to the following procedures and policies:

_____ Client Notification of Privacy Rights

_____ Client Policies

_____ Fee Payment Policy and Authorization Form

By signing,

Print Name of Client

_____

Signature of Client or Parent/Guardian

_____

Date

_____

Signature of Therapist

_____

Date

_____

ANCHORED IN HEALING
COUNSELING & COACHING

Authorization to Release Information

(Valid until revoked in writing by patient or guardian)

Patient Name: _____

Address: _____

Date of Birth: _____

Initial all the options below to which you agree:

_____I hereby authorize Lauren Hudson, LCSW to release and/or obtain medical records from any physician, mental health provider, healthcare facility, insurance carrier, or school that has assisted, or will assist in the future, with the above patient, but not limited to, the following individual providers and agencies:
_____
_____
_____
_____
_____

_____ I give Lauren Hudson, LCSW permission for to communicate via face-to-face, phone, email, fax, etc., with the following family members:
_____
_____
_____
_____

The above consents, initialed by me, are subject to revocation or change at any time except to the extent that Lauren Hudson, LCSW has acted in reliance thereon. If not previously revoked, the consents will terminate in two (2) calendar years from the date of initial session. I understand that, if health insurance is being utilized to cover the cost of treatment, that certain clinical information must be released in order to file claims and I consent to that release. This information, which is being disclosed is confidential and is protected by Federal Law.

_____ _____
Signature of Patient or Guardian Date

ANCHORED IN HEALING
COUNSELING & COACHING