Counseling Appointment Agreement

I consider your (or your child's) treatment plan important to providing the best possible service. In respect to that principle, and also to my time that will be designated to your needs, I expect that all appointments will be kept. ***Please note that a $70 fee may be charged for late cancellations.*** There will be no fee charged if you provide at least one business day's (no less than 24 hours) notice for a cancellation and/or rescheduling of an appointment. *(For example, an appointment on Monday or following a holiday must be cancelled on the previous business day with consideration of the one business day / NLT 24 hours' notice requirement.)* As there are a limited number of appointment slots available, this policy allows us to offer the appointment time to someone else who needs to be seen.

Payment of fees is expected at the time of each appointment unless the session is covered by an insurance plan. Your credit card will be processed at the start of the session, should you need to pay the deductible up front with a credit card. Employee Assistance Program benefits may cover our services, however, we will need to contact the representative at your place of employment first to verify the coverage, deductibles, and any other criteria that must be met.

We use a Medical Billing Service to invoice clients of their co-share payment requirements and expect payment of the full amount due within the following 25 days. The subsequent month's invoice may include a $10 service fee when payment has not been rendered at the end of the billing cycle to cover the administrative costs and postage. Accounts which are more than 90 days overdue may be referred to a collection agency for action.

Please note that your therapy appointments will last for 50 minutes to one hour in length unless told otherwise. The initial session, however, may last longer on a case-by-case basis.

Your signature below indicates that you have read, understand and agree to the terms stated above and will continue to force throughout the time that provision of services continue.

Client/Parent/Guardian Signature _____ **Date**_____

Witness Signature _____ **Date**_____

(Note: The witness above may be your clinician or one of our administrative staff.)

CLIENT INFORMATION & RELEASE FORM

DX Code(s):

Description:

Therapist's Name: _____

Referral Source: _____

Client's Name: _____
Last First Middle

Address: _____
Street Number & Name (Apt #) City State Zip

Home Phone (____)____-_____DOB: ___/___/____ SSN----------_____

Work Phone (____)____-_____Cell Phone (____) _____

Client's Employer:_____ Emergency

Contact Person: _____ Address:

_____Home Phone (____) _____

Work Phone (____) _____

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single

Client's Gender: ❑ Male ❑ Female

Responsible Party's Name: _____
Last First MI

Address: _____
Street Number & Name (Apt #) City State Zip

Home Phone (____)____-_____DOB: ___/___/___

Relationship to the client: _____ Responsible

Party's Employer: _____ Responsible Party's

Employer's Office Phone: (____) _____

(Note: Although insurance does not typically cover e-Counseling, some Employee Assistance Programs may cover the support, If you have EAP coverage, let us know.)

I give permission for my therapist to collect monies from and communicate directly with my Insurance Company about me.

Signature: _____ Date: _____

Client's Physician's Name: _____Phone (____) ------- _____

Have you ever been treated by a Counselor/Therapist before? ❑ Yes ❑ No

HOUSEHOLD MEMBERS (Including the client)

Name	Birth Date/ Age	Employer/ School	Occupation/ Grade	Religious Affiliation	Education Level

RESPONSIBLE PARTY: I understand that I am financially responsible for payment of all charges made during the course of treatment and agree to pay as treatment progresses. Should I default on payment, I understand my balance is subject to collections and I am also responsible for the collections charges.

Signature: _____ Date: _____

Revised: 05/2014

YOUR RIGHTS AND RESPONSIBILITIES

- You have the right to good treatment - to be treated nicely, no matter what your state of mind or condition.
- You have the right to be cared for and not be neglected, abused, have your feelings hurt or be yelled at.
- You have the right to privacy.
- You have the right not to be exploited: That is, your provider cannot use you or your case for her or his own personal gain.
- You have the right to treatment no matter your age, race, sex, religion, ethnic background or handicap. If this provider cannot treat you for any reason, you have the right to be referred to a provider who can and will treat you.
- You have the right to know your diagnosis, how your problems will be treated and what you can expect during the term of treatment.
- You have the right to make choices about your care. If a particular treatment is known to be dangerous, you will be given all the information you need to make a good decision about your treatment.
- You have the right to refuse treatment. If you say, "No", to a particular treatment, you have the right to know what might happen with and without the treatment.
- You have the right to see your records. You have the right to have your records treated confidentially, in accordance with the laws.
- You have the right to plan and help decide the kinds of future mental health care you receive if you get sick and cannot tell someone (for example, living wills, power of attorney, guardianship).
- You have the right to file a complaint/grievance with your provider or the Health Related Boards about your services or care given to you. You cannot get in trouble if you file a truthful complaint/grievance.
- You have the right to treatment in the proper place. You won't be sent to a hospital for inpatient treatment if all you need is a therapist. The best location and level of care will be discussed.
- If you have questions or do not agree with your treatment plan, you should discuss it with your provider.
- You have the responsibility to be on time for all appointments with your provider.
- You have the responsibility to give information to your provider if it's needed for your care.
- You have the responsibility to give your opinions, concerns or complaints about your health care and these rights and responsibilities to your provider.

Signature: _____ Date: _____

Counseling Connection, Inc.

Clinician's Name: _____

Before you arrive for your first session with your clinician at the Counseling Connection, Inc., you need to read the Privacy page on our website. Also, visit the U.S. Department of Health and Human Services webpage regarding privacy: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html Please take time to read the information presented therein. We also will need acknowledgement of understanding your privacy protection for your record that we maintain here.

Privacy Protection Acknowledgment Form

I hereby acknowledge reading the Counseling Connection, Inc.'s Privacy page at www.knoxcounseling.com, as well as federal government's web page regarding privacy protection.

Client's Name: _____
Last First Middle

Client's Date of Birth: ___/___/____ Today's Date: ____/___/____

Client's Signature: _____*(See the exception below)

* Exception to the client signature above: If the client is under 18, the parent or legal guardian must be the one to sign this form.

Parent/Legal Guardian's Name:: _____
Last First Middle

Parent/Legal Guardian's Signature:: _____

In case of an emergency, change of appointment, or other important information, how may we contact you?

	May we leave a message?	Client or parent/ legal guardian's initials for each:
Home Phone: (_) _-_____	❑Yes ❑No	_____
Cell Phone: (_) _-_____	❑Yes ❑No	_____
Work Phone: (_) _-_____	❑Yes ❑No	_____
Other Phone**: (_____) _____-_____	❑Yes ❑No	_____

** For this phone, please write detailed instructions below (e.g. explain if this is the phone of a friend, neighbor, or relative and other specific information we may need to know when contacting you through them):

Counseling Connection, Inc.
Permission to Treat Client

Check here if the client is an adult ❑ Check here if the client is a minor child ❑

Client's Name: _____ Date of Birth: : ____/___/____
Last First MI

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Address: _____
Number & Street City State Zip

If the above-named is a minor child (age under 18), complete this section and sign below.

PERMISSION TO TREAT MINOR CHILD (Under age 18): My signature below indicates that I give full permission to treat my minor child.

Parent/Legal Guardian's Name:: _____
Last First Middle

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Address: _____
Number & Street City State Zip

Parent/Legal Guardian's Signature:: _____Date: ___/___/___

PERMISSION TO TREAT ADULT CLIENT: My signature below indicates that I give full legal permission to be treated.

Adult Client Signature: _____Date: ____/___/____

Witness' Name: _____

Witness' Signature: _____Date: ____/___/____

Clinician's Name: _____

Counseling Connection, Inc.

RELEASE FROM / NOTIFICATION TO PRIMARY CARE PHYSICIAN OR OTHER MEDICAL PROFESSIONAL

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

To: _____ Phone: (____) _____-_____
Primary Care Physician or Other Medical Professional's Name

Fax: (____) _____-_____ Today's Date: _____/___/_____

Address: _____
Number & Street City State Zip

Re: _____ Date of Birth: ___/___/___
Client's Name

From: _____ at Counseling Connection, Inc.
Counseling Connection, Inc. Psychologist/Counselor/Therapist's Name

Location: 100 Dalton Place Way, Suite 105, Knoxville, TN 37912 • 865-686-8347 voice • 865-249-7151 fax

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. For more information, please visit the U.S. Department of Health and Human Services website: http://mchb.hrsa.gov/epsdt/

(Counseling Connection, Inc. requests the results of EPSDT screening on minor patients, when available.)

If you have any pertinent information regarding this person, please forward it to the Psychologist, Counselor, or Therapist at the location listed above. If requested information is more than five (5) pages, please mail rather than fax. Thank you.

Initial the following, as appropriate:

_____I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician indicated above to release the information contained on the form to the clinician/facility identified above. I also consent to other necessary communication between the be behavioral health provider indicated above and the clinician/facility identified above. The purpose for exchanging information is to provide continuity and coordination of care. This agreement is valid for one year. I understand that I may revoke my consent at any time.

I do not wish to have information shared with: _____My Primary Care Physician/Medical Provider
_____My other behavioral health clinicians/facilities
_____I am not currently receiving services from a Primary Care Physician/ other medical practitioner
_____I am not currently receiving services from any other behavioral health clinician/facility

Signature (If child, legal guardian signature): _____ **Date:**_____/___/_____

Clinician Signature: _____ **Date:**_____/___/_____

NOTICE TO PERSON RECEIVING THIS INFORMATION: The information disclosed as a result of this authorization is released to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR OFFICE USE ONLY:

The patient is being treated for the following diagnoses:

Date Treatment Began: _____/___/_____

INDEMNIFICATION AND RELEASE OF LIABILITY

At Counseling Connection, Inc., we use Ziva as our Therapy Dog. The American Kennel Club (AKC) describes the Great Dane as such: "The easygoing Great Dane, the mighty "Apollo of Dogs" is a total joy to live with… As tall as 32 inches at the shoulder, Danes tower over most other dogs and when standing on their hind legs, they are taller than most people. Patient with kids, Danes are people pleasers who make friends easily." They received a five-star rating on being affectionate – considered as "lovey-dovey." Great Danes ranked by the AKC as 19 of 284 in popularity of all breeds. As for openness to strangers, the AKC lists them as "everyone is my best friend" in personality traits. They are "eager to please" and "highly adaptable." Britannica says, "While 'gentle giant' may be an overused phrase, it aptly describes the Great Dane. Though large, it is generally friendly and affectionate to both family and strangers."

Trained for several weeks by a professional in Knoxville, Ziva ranked top in her class (which even included another Great Dane). Ziva has been used as a Therapy Dog, registered with the U.S. Service Animal Association, since the Summer of 2017 and we have never encountered an incident with her.

Why, then, is there a need for an indemnification agreement? Great Danes are known to be clumsy at times and may unintentionally step on the feet of clients. For those with low cut shoes, this may result in a scratch or may cause a run in someone's panty hose. They rank 4 out of 5 in "drooling level" – for which the AKC recommends to always have a towel (which we keep on site). After drinking water, they may shake their heads side to side which may result in slobber being hurled across a room. If something nearby frightens a Great Dane, they may bark and the decibel level is considerably louder than most dogs.

You may elect to opt out of K9-assisted therapy, as indicated below. In order to participate in services provided by Counseling Connection, Inc. in which K9-assisted therapy is an integral part, select the option below and agree to the following terms:

1. **AGREEMENT TO FOLLOW DIRECTIONS.** I agree to observe and follow any oral instructions given by Dr. Sabine Scoggins or other employees or representatives of Counseling Connection, Inc. when in contact or close proximity to the Therapy Dog;

2. **ASSUMPTION OF THE RISKS AND RELEASE.** I recognize that there are certain inherent risks associated with K9-assisted therapy including but not limited to those described above and I assume full responsibility for personal injury or damage to clothing or personal property for myself and (if applicable) my family members and further release and discharge Counseling Connection, Inc. from loss or damage arising, whether cause by the fault of myself, my family, Counseling Connection, Inc., or the therapy dog used by Dr. Scoggins.

3. **VIDEO CAMERAS MAY BE IN USE.** Closed circuit cameras are in place in the office. These not only help protect the records locked in our file cabinets after business hours, but also prevent false claims of aggressive behavior by therapy dog(s) in a clinical environment. Of course, your privacy is protected, as the video file is secure and complies with the requirements of the federal health information portability and privacy act, Public Law 104-191.

4. **INDEMNIFICATION.** I agree to indemnify Counseling Connection, Inc. against all claims, causes of action, damages, judgements, costs or expenses, including attorney fees or other litigation costs which may arise from my or my family's presence at the facilities of Counseling Connection, Inc., and the therapy dog used therein, as allowed under Tennessee law.

_____
Initials

5. **NO DURESS.** I agree and acknowledge that I am under no pressure or duress to sign this Agreement and that I can either accept or decline to participate in the opportunity to have K9-assisted therapy at Counseling Connection, Inc. Should I elect to decline, the therapy dog shall be always kept at arm's length before, during, and after each session.

6. **DISPUTE RESOLUTION.** The parties will attempt to resolve any dispute arising out of or relating to this Agreement through friendly negotiations amongst the parties. If the matter is not resolved by negotiation, the parties will resolve the dispute using Alternative Dispute Resolution procedures using a third-party mediator recognized by the state of Tennessee.

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS, I EITHER AGREE OR DECLINE TO PARTICIPATE IN K9-ASSISTED THERAPY. I ALSO UNDERSTAND THAT, SHOULD I CHANGE MY MIND IN THE FUTURE, I MAY SIGN A SUBSEQUENT AGREEMENT TO REVERSE MY DECISION.
CHECK ONE:

☐ I hereby agree to participate in K9-assisted therapy and accept the terms described above.

☐ I hereby decline to participate in K9-assisted therapy and desire to be kept at arms-length or more from the therapy dog.

_____	_____	_____
Printed Name of the Client	Signature of the Client	Date

1.