CHART NO. _____

Intake Date: _____

Clinician: _____

Phone 1(907) 290-3603
Fax 1(907) 931-6379

634 S Bailey Street Ste 103
Palmer, AK 99645

CLIENT INFORMATION

Date: _____

Patient Name: _____ DOB: _____ SSN: _____

Ethnicity: _____

Parent/Legal Guardian: _____ DOB: _____ SSN: _____

Phone Number (Home): _____ Phone Number (Cell): _____

Address: _____

City: _____ ZIP Code: _____

E-mail Address: _____

Parent/Legal Guardian: _____ DOB: _____ SSN: _____

Phone Number (Home): _____ Phone Number (Cell): _____

Address: _____

City: _____ ZIP Code: _____

E-mail Address: _____

Referred By: _____

INSURANCE INFORMATION:

Insurance Co. Name: _____ ID Number: _____

Group Number: _____Claims Address: _____

Policy Holder Name: _____ DOB _____ SSN# _____

Policy Holder Address: _____

Employer: _____ Phone Number: _____

What is your relationship to the insured? _____

(If there is another health plan, please fill out another intake form and write "Secondary Insurer" on top of this form)

Have you had counseling previously? Yes ☐ No ☐ When? With whom? What purpose?

_____

_____

Have you been hospitalized for psychiatric care? Yes ☐ No ☐ When? Where? What purpose?

_____

_____

Are you currently taking medication? Yes ☐ No ☐ Please list with amounts taken.

_____

_____

Spiritual Practices (optional): past/current: _____

_____

Who is your health care provider: _____ Last date seen: _____

Reason you are seeking counseling at this time: _____

_____

_____

_____

Goals you hope to achieve for you or your child: _____

_____

_____

_____

In Case of Emergency:

Name: _____ Relationship: _____

Address: _____ Phone Numbers:_____

Playful Journeys Counseling Center

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Agreement for Parents with Shared Custody

Therapy can be a very important resource for children of separation and divorce. The goals of therapy would include but are not limited to:

- Facilitate open and appropriate expression of the strong feelings which routinely accompany family transitions including guilt, grief, sadness and anger.
- Provide an objective and emotionally neutral setting in which children can explore these feelings.
- Help children understand and accept the new family composition and the plans for contact with each member of the family.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental stage.

Therapy is most successful when parents are able to put aside their differences for the child(ren) and focus on the therapeutic goals which will be collaboratively determined by the parents, child(ren), and the therapist.

Limits of Confidentiality:

- **Records are kept within the professional and ethical guidelines.**
- **Any matter brought to our clinicians' attention may be revealed to the other caregiver(s). Matters which are brought to the attention of our clinical staff and concern the child's welfare may be kept confidential.**
- **Our clinicians are legally obligated to bring any concern regarding the health and safety to the attention of relevant authorities.**
- **Therapy is a place of healing and for your child to develop healthy coping strategies. We ask that you agree to keep their mental health record private and confidential, and to not be a part of litigation. This includes any contacts with a custody investigator as their report becomes a part of the court process.**
- **We are here to support your child and will not align with either parent. Our philosophy is that children need both healthy parents in their life in order to attain better understanding and perspective.**

Limits of Therapy:

This treatment will not yield recommendations about custody. In general, we recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation

and conflict resolution, including mediation, custody evaluation, and collaborative divorce proceedings.

Financial Responsibility:

Our office will assign one caregiver as the responsible party for the financial portion of the child's therapy. The caregiver that agrees to the terms and conditions of the Financial Policy and Agreement will have primary financial responsibility. Any correspondence regarding the financial status of the account will be sent to this caregiver who will also be responsible for any balances accrued. We are unable to become involved in the financial disputes between parents. Court orders are an agreement that outlines the financial matters for parents. Playful Journeys is not an involved party of that order.

Please sign below to signify that the caregivers involved have accepted these terms and conditions.

Parent/Legal Guardian: _____ Date: _____

Printed Name: _____

Parent/Legal Guardian: _____ Date: _____

Printed Name: _____

Parent/Legal Guardian: _____ Date: _____

Printed Name: _____

Parent/Legal Guardian: _____ Date: _____

Printed Name: _____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and Playful Journey staff) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between you and Playful Journeys.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, Playful Journeys may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if Playful Journeys believe it is necessary, Playful Journeys may determine that we return to telehealth services for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, Playful Journeys will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the COVID-19 (or other public health risk).

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep you and the staff at Playful Journeys safe from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- ____You will only keep your in-person appointment if you are symptoms free.
- ____You will take your temperature before coming to each appointment. If it is elevated (100.4 Fahrenheit or more), or if you have other symptoms of COVID-19, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, we won't charge you our normal cancellation fee.
- ____You will wait in your car or outside no earlier than 5 minutes before our appointment time.
- ____You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

- ____You will adhere to the safe distancing precautions we have set up in the waiting room or therapy room. For example, you will not move chairs or sit where we have signs asking you not to sit.
- ____You will wear a mask in all areas of the office as will the staff for Playful Journeys.
- ____You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with the Playful Journeys Staff.
- ____You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- ____If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- ____You will take steps between appointments to minimize your exposure to COVID-19. "including but not limited to practicing social distancing, proper hand washing/hand hygiene, wearing a mask, etc.
- ____If you have a job that exposes you to other people who are infected, you will immediately let the staff at Playful Journeys know.
- ____If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let the staff at Playful Journeys know.
- ____If a resident of your home tests positive for COVID-19, you will immediately let the staff at Playful Journeys know and we will then [begin] resume treatment via telehealth.

Playful Journeys may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
Playful Journeys has taken steps to reduce the risk of spreading COVID-19 within the office and we have posted our efforts on our website and in the office. Please let us know if you have questions about these efforts.

If You or I Are Sick
You understand that Playful Journeys is committed to keeping you and the staff at Playful Journeys safe from the spread of this virus. If you show up for an appointment and the staff at Playful Journeys believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If any of the staff at Playful Journeys test positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, Playful Journeys will be required to notify local health authorities that you have been in the office. If Playful Journeys reports this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____	_____
Patient/Client	Date
_____	_____
Clinician	Date

Office Safety Precautions in Effect During the Pandemic

Playful Journeys is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- Playful Journeys staff wear masks.
- Playful Journeys maintains safe distancing.
- Restroom soap dispensers are maintained, and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

Playful Journeys Counseling Center

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Electronic Correspondence

As therapy is involves sensitive information and is protected by HIPAA federal law, communication outside of session is of utmost concern. Therefore, it is very important that you take some time to consider how you wish to be contacted should your clinician need to communicate with you. The age of technology is both an improvement in communication as well as a challenge to therapists. Below is a description of how our clinic handles correspondence in each manner.

- ❑ **Email**

Our email server is Microsoft 365 and there is a signed HIPAA Business Agreement in place. It is a secure server and password protected, however, *please be aware that your personal email may not be secure*. Our clinicians follow confidentiality rules when dealing with your PHI in email. It will become part of your clinical record, should you choose to correspond in this manner with your clinician. You can also opt to have appointment reminders sent via email; however, you may not respond to the notification as it is from Valant, our practice management program. You may opt to have an email reminder sent to you about your appointments.

_____*Initial here if you would like appointment reminders via email.*

- ❑ **Texting**

You may also opt to have your appointment reminders come via text. The texts come directly from Valant, our practice management program.

_____*Initial here if you would like appointment reminders via text.*

- ❑ **Phone**

Our main number is 907-290-3603. Our receptionist, practice manager, or clinicians will answer it personally during regular business hours. If you leave a message, expect it to be returned within 24-48 hours. Phone conversation content, at the discretion of your clinician, will also be part of your clinical record. If a clinician returns your call via his or her own personal cell, please be respectful of their boundaries and only utilize the office phone to contact them during office hours.

_____*Initial here if you would like a reminder via home phone.*

I agree to have my clinician correspond with me according to the box(es) checked above.

_____ _____

Signature Date

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Notice of Conflict of Interest

Due to the nature of our business and the commitment that our clinicians have to their clients to provide the best possible care for our families, we are unable to provide services to children and their families who are represented by Kenneth J. Goldman, P.C. or Carmen Spiropalous, CSP.

Conflicts of interest, by nature, are considered to be confidential and our office is not privileged to discuss the details.

Please be advised that if this law office represents one or both parents that our office cannot provide services to your family.

If one or more parties in the family become clients of this law office in the future, then our office will be forced to terminate care immediately.

We apologize for the inconvenience and thank you for your understanding. We are happy to provide referrals upon request.

Parent Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

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Informed Consent to Treat

Welcome to our clinic! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), the federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice), which is attached to this agreement, explain HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. A copy of your HIPAA rights is available for review in our office. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement at any time. If there are still unpaid charges or any other financial obligation on the account at this time, then please be aware that Playful Journeys Counseling Center will still have a right to any and all charges that incurred prior to the agreement termination. Therapy is a relationship between two or more people, which works, in part because of clearly defined rights and responsibilities held by each person. This helps to create a safe environment to take risks and the support to become empowered to change.

Therapy Services

Therapy is a process of seeking resolution of distressing feelings or problems. This process is dependent on the type of problems you hope to address. It requires a very active effort on your part. In order to be the most successful, you will have to work on things we talk about both during our sessions and at home. Therapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, anger, guilt, and helplessness. Therapy often requires discussing unpleasant aspects of your life. Therapy has also been shown to have benefits for people who actively participate. It can lead to a significant reduction in distressing feelings, better relationships, and resolution of specific problems, but there are no guarantees that you will experience all of these benefits. If you do not notice improvement from therapy within a couple of months, please talk to your clinician right away.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will discuss any initial impressions of what our work may include and create an initial treatment plan. Please evaluate this information as well as your comfort level working with your clinician. Therapy involves a large commitment of time, money, and energy, so it is important to select your therapist carefully. We encourage and will need ongoing feedback from you as to your needs in order to establish the most successful treatment plan. Any questions you may have regarding any procedures can be addressed as they arise. The therapeutic relationship has been shown throughout the research to be the most important factor in benefitting from the process. It must be emotionally very safe to discuss and explore vulnerabilities.

Therapy Sessions

The initial evaluation period will last from two to four sessions. Once a treatment plan is agreed upon, we typically schedule one 45-minute session per week at a mutually agreed upon time, although, if necessary, sessions may be longer or more frequent. As therapy progresses, sessions will move to biweekly, and finally once per month as termination nears.

**** If your child is scheduled for individual therapy with a clinician and you have errands to run, please return at least 20 minutes prior to the session stop time so you will have a chance to talk with the clinician, reschedule etc. For safety and privacy reasons, leaving your child in the waiting room unsupervised is not permitted.*

****If your child is under 5 years of age, please remain in the waiting area in order to be available for toileting issues, tears, sickness, etc. We believe in utilizing primary attachment figures first.*

Psychiatric Evaluation and Medication Management

A psychiatric evaluation with and/or without medication management services is a comprehensive evaluation that includes, but is not limited to, the gathering of data from the patient, family members, community members (e.g., teachers), and other professional disciplines (e.g., therapists, primary care providers, social workers etc.). A psychiatric evaluation may include, but is not limited to, a team-based approach to work towards holistic goals and the least restrictive use of medications and interventions. The prescribing and/or recommendation of medications including but not limited to traditional western medicine and alternative options can and/or may be explored. This will be determined in a case-by-case basis and as desired by the patient and/or guardian.

Availability

Clinicians are not available 24 hours a day. Playful Journeys has standard office hours. You can reach your clinician by calling the direct line and leaving a brief message on our confidential voice mail. If you are difficult to reach, please leave times when you will be available. If you cannot reach our staff and feel you or your child are in crisis, you may call your family physician, the Crisis Line at 376-2411, or go to the emergency room at the nearest hospital and ask for the doctor on-call. If your clinician is unavailable for an extended period of time, you shall be provided with the name of a trusted colleague whom you can contact if necessary.

There may be times when emails and calls are returned outside office hours as the clinicians' personal time permits. Please do not expect that your email or messages will be read or heard outside of normal business hours. If your clinician does not return your call or email within 24 – 48 hours, please notify us by calling the main number.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information about you in your clinical record. If you provide our office with an appropriate written request, you are legally entitled to receive a copy of the records. Because these are professional records, they can be misinterpreted and/or may be upsetting to you. If you wish to review the records, it is recommended that you review them in your clinician's presence so that you can discuss the contents or have them forwarded to another mental health professional that can help you to understand them.

Privacy of Minor Clients

Natural parents who have not had their parental rights terminated are able, by law, to access the child's medical records unless it can be proven that this would not be in the child's best interest.
The treatment records of minors should not be accessed for any reason as it significantly impacts your child's trust in their clinician. Your clinician will be working from the perspective to improve the family relationships and will include parents as your child is ready and in ways that your child is willing. The therapeutic relationship with your clinician is vital and will be built upon trust. Therapy does not work if a client has to worry who is going to see or hear what they talk about. If you persist in requesting the records of your child, then Playful Journeys reserves the right to terminate treatment with your child. If this should occur, it is important that 1 – 2 closure sessions be conducted so that the child understands the process and does not leave therapy with a negative view. He or she may need to access it again in the future.

HIPAA standards state that minors have a right to privacy even though a parent can legally attain their records. Our office asks parents and legal guardians to respect their child's confidentiality and not access their treatment records. We thank you for putting your trust in us to help your child through the issues they are facing. Therapy with children and adolescents works best when they can have a place to sort out their thoughts and feelings without worrying if they are going to hurt someone's feelings or be in trouble. When treating a minor, it is our policy to provide parents with any information concerning your child's safety and well-being. We will work with your child to get to the place to be able to communicate information to you. This may take some time, which will be allowed within appropriate boundaries. If your child is a danger to his or herself or others, your clinician will discuss this with you immediately.

We will be talking to your child about "rules" we have in therapy that make counseling work for kids and would like for you to be informed of them in advance:

1) Confidentiality (see below)
2) They can never get in trouble for things they say in therapy.
3) Kids get to say if adults "get it right" or not; and,
4) They don't have to talk about anything that is too hard to talk about. This helps kids feel safe and supported.

These rules give children the positive, safe environment where they have appropriate control to build a relationship based on trust and be a part in creating a treatment plan with goals and objectives that go at a pace that they can emotionally handle.

Confidentiality

In general, the law protects the communication between clients and therapist, and our office can only release information about our work with others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. Information shared in individual sessions or circumstances by a minor client will be shared with the parents if the therapist finds it to be beneficial to the therapeutic process. High-risk behaviors may or may not be reported to parents – sexual activity and drug use disclosures are protected at a more stringent standard as stated in Alaska statutes.

2. We may occasionally find it helpful to consult with other mental health professionals about a case. We regularly staff clients in supervision. During a consultation, we make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you don't object, your clinician may not always tell you about these consultations unless it is important to your work together. Your clinician will note all consultations in your clinical record.

3. Disclosures required by health insurers in order to receive payment will be required.

Depending on your insurance provider this may include a clinical diagnosis, treatment plan, and other relevant information in order to extend benefits. Though all insurance companies claim to keep information about you confidential, it will become part of their files and your clinician has no control over what they do with it once it is in their hands.

4. There are some situations where we are permitted or required to disclose information without either your consent or authorization. If such a situation arises, your clinician will make every effort to discuss it with you before taking any action and your clinician will try to limit any disclosure to what is necessary. When reporting child abuse, it may be deemed that it is not in the child's best interest to discuss the situation with you.

5. The law requires the reporting of child physical and sexual abuse, both past, unreported events as well as current. This would include domestic violence witnessed by children, in addition to substance use that impacts parenting and child neglect.

6. An attorney may subpoena your clinician's records to court. It is office policy to protect client confidentiality to the best of our ability. Alternatives, such as treatment summaries, will be discussed should this arise. If ordered by the court, however, your clinician is obligated to disclose any information requested.

7. If your clinician believes that a client is threatening serious bodily harm to self or another, we are required to take protective actions, which may include notifying the potential victim, and/or notifying the police. In the case of suicidal preoccupation or intent, hospitalization for the client or contact with family members or others who can help provide protection may be sought.

8. If a government agency is requesting the information for health oversight activities, your clinician is required to provide it for them.

9. If a client files a complaint or lawsuit against our office or your clinician, we may disclose relevant information regarding that client in order to defend ourselves.

Additional concerns or questions can be addressed at our first meeting. The laws governing the issue of confidentiality are quite complex and we are not attorneys. Should you need specific advice, legal consultation might be helpful.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your clinician amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. We will be happy to discuss any of these rights with you.

You have the right to:

1. To be treated with respect and kindness.
2. To participate in ethical, professional treatment for their mental health.
3. To be a part of creating their own diagnoses, goals and objectives.
4. To present any grievances to their clinician or his or her supervisor.
5. To fully understand what the course of treatment looks like including assessment, treatment

planning, interventions, prognosis and treatment completion.
6. To be fully informed of interventions and have an active discussion as to if they are the best fit for them.
7. To have a regularly scheduled appointment that works for your family as best as Playful Journeys' schedule can accommodate.
8. To have your physical and emotional space be respected.
9. To be apprised of treatment progress and have access to your or your child's clinician to provide updates or concerns. It is important in session planning to let the clinician know this information prior to your child going back for their session.
10. To fully understand your bill and the charges that occur.

You have the responsibility to:

1. Treat others with kindness and respect in our clinic.
2. To make scheduled appointments. Therapy requires a rhythm and regular attendance is necessary.
3. To actively participate in the treatment process. This may include your child being able to be honest about not wanting to be here. It is important that a child is not forced to come to therapy and that it is never used as a reward, consequence or punishment.
4. To follow treatment recommendations and give your clinician feedback about the helpfulness of interventions. Therapy will not work if treatment recommendations are not followed, and a referral may be necessary.
5. To first discuss any problems that may arise with your clinician and then, if not resolved, contact Lori Houston for further assistance. Severe grievances may be filed with the appropriate licensing board if not resolved in house.
6. To be respectful of your clinician's time in session, understanding that the therapy hour is a 50-minute hour in order to accommodate note writing and necessary breaks. Please be as brief as possible during any between session contacts.
7. To provide accurate and timely updates and concerns to yours or your child's clinician.
8. To exercise patience and some flexibility in scheduling and treat our office manager respectfully. It is difficult to accommodate every client as well as clinician's schedules.
9. To make your payment at the time of your session. If you need assistance in this regard, it is your responsibility to let our office manager know. It may become necessary to make a referral in this circumstance.
10. To read and follow the guidelines set forth in this Informed Consent to Treat.

Social Networking

At Playful Journeys Counseling Center, our primary concern is our client's privacy. Our office does have a Facebook page so that any links, resources, events, etc. can be shared easily within our community. However, please be aware that if you follow or like our Facebook page then your privacy may be compromised. You are welcome to use your own discretion in choosing whether or not to participate on our Facebook page. The same information can be found on our website as well.

Our office requests that our clients do not use social media to contact their clinician or our office staff. Social media sites are not secure, and our office does not monitor the messaging portion of these sites regularly. This also includes posting on our Facebook wall as the information would then become public due to the nature of our Facebook page. Depending on what is posted, it may also become a part of your legal medical record.

Please do not engage with your clinician on their private social media pages as they are required by our policy to not respond. Regardless of whether or not you are a current or former client, this can and will still compromise your confidentiality. We appreciate your understanding.

The best form of communication to have with your clinician and/or our office staff is via phone or email. Please do not hesitate to call with any questions or concerns.

Playful Journeys Counseling Center

Print Name: _____

Informed Consent to Treat

_____I have been given a copy of and agree to abide by the cancellation policy.
_____I have read, understood, and agree with the privacy of minor client's portion.
_____I have been offered and understood the HIPPA Notice of Privacy Practices.
_____I acknowledge that any involvement to Playful Journeys Counseling Center's social media pages is at my own discretion.
_____I acknowledge that I have had an opportunity to read and review the HIPAA notice and privacy practices of this office and have been offered a copy for my personal files.
_____I authorize Playful Journeys Counseling Center to provide psychotherapy, psychiatric evaluation and/or medication management for myself or child within the aforementioned guidelines of professional practice.

By signing this document, it indicates that you have read the information in this consent to treat and agree to abide by its terms during our professional relationship. It also serves as an acknowledgement that you have received the HIPAA Notice form described above.

_____ _____
Client Signature (If 16 or older) Date

_____ _____
Legal Guardian Signature Date

_____

Print Name/Relationship to Patient

Playful Journeys Counseling Center

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FINANCIAL POLICY AND AGREEMENT

Clients with Insurance:

It is important to verify and understand your insurance policy requirements, limitations, and what your insurance offers for mental health benefits prior to your appointment. These benefits are a part of a contract that you hold with your insurance company. Our office cannot be held responsible for the terms of these benefits. Clients are ultimately responsible for any services that are not covered by the insurance. Co-payment amounts are due at the time of service. Additionally, the client is also responsible for the timely payment of the account balances accrued.

Our office is preferred with Premera Blue Cross Blue Shield, Tricare, Aetna, and Alaska Medicaid. Any services billed to these companies will be considered at the "in-network" rates. We also bill all other insurance carriers for our clinicians, except for Medicare. The self-pay discount is available if psychotherapy treatment is pursued by our Medicare population.

Please be advised that if our office does not receive payment or further processing from the insurance company within 120 days, then the balance may become the clients and/or legal guardians' responsibility.

It is also important for our clients and/or legal guardians to understand that Playful Journeys Counseling Center may send pertinent medical documentation to the insurance companies to ensure proper claims processing and payment.

Cancellations or Missed Appointments:

We appreciate your cooperation to help provide appointment availability for all of our clients. A cancellation or missed appointment less than 24 hours from the scheduled time will result in a $60.00 fee applied directly to the client's account.

Please be aware that insurance companies do not cover these charges and will not be billed. The fee will be due by the next scheduled visit.

Special consideration will be made at the discretion of your clinician.

Electronic Communication Fees:

Any contact via phone or email that incurs more than 15 minutes of time form our clinical staff will be charged for services at 30-minute increments. These charges are not billable to insurance.

Clinical Administrative Fees:

If additional documentation is needed from one of our clinicians to further assist the client, then our office may apply a charge for completion that is dependent upon the time involved and complexity of the documentation.

Statements:

Our office will send a monthly statement to the address provided by the client and/or legal guardian. The statements will have the processing from the insurance company included to ensure that the balance is accurate and final. Please be aware that payment is due no more than 30 days of the statement date unless prior payment arrangements have been made.

Payment:

Payments can be made payable to Playful Journeys Counseling Center and mailed to the address on your statement. Payers can also call our office at 907-290-3603 during our regular business hours to pay by phone. Our office accepts cash, check, and all major credit cards. Please note that a $35.00 fee will be added to your account for any checks that are returned from the bank due to insufficient funds.

Our office will require that a credit card be kept on file for all copays, co insurances, missed appointment fees and outstanding balances over 120 days. The credit card on file will be ran on the day services are rendered. Playful Journeys Counseling Center ensures the privacy of our cardholders with our federally compliant and encrypted electronic credit card processing system. It is the responsibility of the card holder to contact our office if other arrangements need to be discussed.

Late charges of 10.5% may be applied to any account that has had an outstanding balance of a year or more after the 90-day insurance billing grace period.

Refunds:

Any refunds to be processed may take up to four weeks for processing. Our office will mail the refund to the appropriate party, whether client or insurance, to the address that we currently have on file.

Self-Pay Clients:

All clients that do not have commercial insurance and will be paying for services in full at the time of service will receive a 22% discounted rate.

Payment Arrangements:

Arrangements can be made if the client and/or legal guardian is unable to meet the financial obligations as outlined in the Financial Policy and Agreement. Arrangements must be made prior to the due date of the statement received by calling our office directly at 907-376-9091. Our office has the ability to offer interest free monthly payment plans unless collection action has occurred on an outstanding balance.

Collections for Unpaid Balance:

If charges for services rendered have not been paid after the insurance has processed and a payment arrangement has not been made according to Playful Journeys Counseling Center's formal payment plan arrangement, then our office reserves the right to utilize Cornerstone Credit Services for our collection needs.

The client and/or legal guardian will be responsible for a $100.00 fee for collection processing. This fee will be added to the accounts outstanding balance.

In the event that the account is sent to Cornerstone Credit Services, Playful Journeys Counseling Center will no longer be providing monthly statements. Any further inquiry regarding the delinquent accounts, the initiation of legal action and credit reporting must be presented to Cornerstone Credit Services who can be reached by phone at 907-770-8100. Additionally, all future appointments will be cancelled, and appropriate referrals will be given.

Under certain circumstances and usually emergent care, our Clinical Director may approve our clinicians to render services not to exceed 30 days post collection activity.

Questions and concerns may be directed to the Administrative Coordinator

Print Name: _____

FINANCIAL POLICY AND AGREEMENT

If there is any clarification needed, please to not hesitate to ask our office staff questions that you may have prior to initialing the following terms for this agreement.

_____ I consent to treatment by the providers of Playful Journeys Counseling Center.
_____ I understand that I am responsible for knowing my insurance policy requirements, limitations, and mental health benefits and that I will be responsible for care not covered by my insurance.
_____ I authorize the release of pertinent medical information to insurance carriers.
_____ I authorize my insurance benefits be paid directly to Playful Journeys Counseling Center unless I have paid for the services rendered in full prior.
_____ I understand that I am responsible for keeping Playful Journeys Counseling Center informed of any changes in my insurance and that I will be financially responsible for any charge accrued if this information is not provided in a timely manner.
_____ I understand that I am obligated to pay co-payments, co-insurances, and deductibles as required by my health insurance.
____ I authorize Playful Journeys Counseling Center to charge my credit card that is on file for copays, co-insurance, missed appointment fee on the day services is rendered and balances that are over 120 days.
I accept responsibility for the payment of all non-covered services to include:
_____ Less than 24-hour notice for the cancellation of or a missed appointment ($60.00)
_____ Non-sufficient fund fee for returned checks ($35.00)
_____ I understand that any outstanding balance may be turned over to Cornerstone Credit Services if the balance of my account is not paid in the timely manner outlined in the policy. My signature below authorizes Playful Journeys Counseling Center to disclose my account information to Cornerstone Credit Services for the purpose of collection action.
_____ I understand that billing services will cease from Playful Journeys Counseling Center should the account become delinquent (a delinquent account is considered to be any account that has not be paid in full per the policy guidelines) and instead will be in direct contact with Cornerstone Credit Services for the duration of the debt.
_____ I understand that the collection agency will report all unpaid debt to the major credit reporting agencies and can initiate legal action to collect payment on a delinquent account if necessary.
_____ I understand that I will be charged a $100.00 fee for collection processing and that I will be responsible for these, and any court costs incurred.
_____ I understand that should my account become delinquent, all future appointments will be cancelled, and Playful Journeys Counseling Center will only render care for the next 30 days at the discretion of the Clinical Director and in emergent situations.

My Signature below indicates that I have carefully read the Financial Policy and Agreement, understand, and accept the terms of this agreement, and agree to my financial responsibility set forth in this agreement.

_____ _____
Signature Date

Credit Card Authorization Form

Please complete all fields below. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ❒ MasterCard ❒ VISA ❒ Discover ❒ AMEX ❒ Other
Cardholder Name (as shown on card):
Card Number:
CVV (the 3-digits on the back):
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I,_____, authorize Playful Journeys Inc to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____

Customer Signature Date

Playful Journeys Counseling Center

www.playfuljpurneys.com

634 S Bailey Street, Ste. 103
Palmer, AK 99645
Ph 907-290-3603
Fax 907-931-6379

Telehealth Informed Consent

What are Telehealth services and when are they used?

Telehealth services are used when mental health clinicians cannot be physically present with you or your child to evaluate and treat your mental health needs and, if appropriate, prescribe medications. HIPAA compliant video platforms are used to communicate via computer video cameras to send both voice and image between you and your clinician. You will be able to see and hear your clinician and share activities together if appropriate. The video communication software includes measures to safeguard data and protect against corruption.

What are the benefits and limitations of Telehealth services?

Telehealth allows services to continue uninterrupted if a client is sick or cannot otherwise attend in person sessions. It is facilitated in the privacy of your own home where clients often feel safe and are in familiar surroundings. Some clients, especially children and teens, are engaged with technology and will be excited to use this new format. It will allow them to show their clinician around their space at home if they wish. Video conferencing will also allow for interactive games. No recording of the session occurs during the time together and no information is stored digitally.

There may be some challenges that telehealth will require us to work through together. It will take some time to adjust and become comfortable with a new format. There may be some technology issues that arise that will have to be addressed to make sessions go smoothly. There will be an interruption in themes of play that your child was involved with in the playroom. New ideas and preplanning can help with this. In person connection will be another challenge as comfort and empathy are difficult emotions to convey over video chat. Privacy for you or child at home will have to be explored so that all feel comfortable that you/they can continue to share what you/they need to with their therapist. There are risks with the transmission of personal health information over technology that include but are not limited to: breaches of

confidentiality, theft of personal information, and disruption of services due to technical difficulties. Our staff are using a HIPAA compliant software and a stable internet connection to minimize these risks.

What will I need for Telehealth sessions?

You will need a device with a camera such as a computer, tablet, or phone with working audio. Headphones are nice as they decrease background noise or echo. It will be important to familiarize yourself as much as possible with the technology prior to the session. You will need a space that you feel is comfortable, free from distractions, and private. It is your responsibility to maintain a private space during our sessions to assure confidentiality. Your therapist will email you a list of ideas prior to the session so that you can gather any needed supplies from around your home.

What will sessions look like using Telehealth?

Sessions will generally be the same, just not in person. After you start Telehealth Services you will be asked to identify yourself and addressed that you are engaging in this service. You and your therapist will talk about how to use the new format and what options are available. As with in person therapy, this should be an open conversation about what is working and what is not working. Once therapist and clients are comfortable with the technology, ideas about activities can be explored that address the client's treatment goals, just as in person. It is important to remember that progress should continue to be monitored during this time as change in format can affect treatment progress. Results using telehealth cannot be guaranteed. Your sessions will be documented in the same way as in person sessions and for insurance purposes. It is the responsibility of the clinician to restart the call should service be disrupted for any reason. If your clinician is unable to reconnect, they will call telephonically. It will be your responsibility to be available to answer the call to follow up on any remaining issues that need to be addressed during the session. It is also important to have an adult authorized to speak to your clinician present and able to take a call should an emergent need arise during session if your child is receiving telehealth services.

What happens if I choose not to consent to Telehealth services?

You may not wish to consent for Telehealth services. You may also discontinue this service at any time. We may not be able to provide services and we will work with you to find other alternatives. These may include continuing counseling when you are able to return to the office, setting up a time to come for an in-person session when others are less likely to be present, a referral to another clinician, or other options that best meet the needs of your family. Your decision will be respected.

By signing below, I understand and agree that:

1. I have given authorization for my personal health information to be transmitted via images and audio data through an interactive video connection to and from your clinician at Playful Journeys Counseling Center. This includes transmission via computer and mobile apps.
2. I will provide my own equipment to communicate with and understand that entering my data on another person's (relative, employer, etc.) computer compromises my confidentiality and I do so at my own risk.
3. I will assure my own privacy within my home or chosen space. I am assured of my clinician maintaining my privacy by facilitating sessions within a confidential space.
4. Both clinician and client will inform each other of other parties present in the therapy space during telehealth sessions.
5. My clinician has explained limitations and benefits as well as how sessions will be conducted. This may include such issues as how emotional reactions, emergencies, and issues with technology will be handled. I understand that my therapist will not be physically present, and this may inhibit progress.
6. I agree to have open communication about how telehealth services are working and address any challenges with my clinician.
7. I will have a parent or other authorized adult present and available if my child is receiving telehealth services.
8. I understand that telehealth services are a new delivery method for professional services and has not yet been fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
9. It is my clinician's responsibility to restart the video call if disruption occurs.
10. Telehealth sessions are similar to in-person sessions in that your progress depends on what you share with your clinician.
11. In rare circumstances, security protocols could fail, causing a breach of privacy of personal health information.
12. Insurance will be billed as a telehealth service. It is your responsibility to preauthorize this service and any sessions not covered will be your responsibility.
13. I reserve the right to discontinue this consent for Telehealth services at any time. This agreement may also be terminated by your clinician if he or she feels it is not the appropriate venue for you or your child.
14. If a safety concern is disclosed during session, every effort will be made to arrive at a safety plan. If your clinician does not feel secure in yours or your child safety, he or she will ask you to go to the nearest ER or call the local law enforcement to do a welfare check

I consent to Telehealth services for myself or my child, in circumstances in which in person sessions are not available at Playful Journeys Counseling Center, or during times that I am unable to be present at the office. My clinician has discussed the information provided above with me.

_____ _____

Signature of client Age Date

_____ _____

Signature of parent or guardian Date

_____ _____

Signature of Guardian Ad Litem Date

This confidential information is provided to you in accordance with State and Federal laws from the Tele behavioral Health Institute.

634 S Bailey Street
Ste. 103
Palmer AK 99645
907.290-3603 ph.
907.931-6379 fax

AUTHORIZATION TO RELEASE INFORMATION

Client's Name: _____ DOB: _____

*I request and authorize **Playful Journeys Counseling Center** to receive and/ or release my personal health information listed below to the following individuals:*

1) _____ _____
Name of Agency/Individual Phone

_____ _____
Address Fax

2) _____ _____
Name of Agency/Individual Phone

_____ _____
Address Fax

The following information is to be released:

( ) Verbal Information related to (specify) _____
( ) Treatment Summary
( ) Clinical Notes and Treatment plan (specify dates) _____
( ) Other _____

This information is to be released for the following reasons:

( ) Coordination of care / Billing
( ) Referral
( ) Court testimony or preparation
( ) Evaluation purposes
( ) Supervision or consultation

I understand that the information disclosed will be used solely in the manner that I have granted my permission. This release is valid from this date _____ and will be valid only through _____.

Also, I understand that I can revoke this agreement with expressed intent either verbally or in writing. I have a right to specify the information that is released and understand that it will be used solely for the purposes I have requested above.

_____ _____
Signature of client Age Date

_____ _____
Signature of parent or guardian Date

_____ _____
Signature of guardian ad litem Date