James O. Hale MS, Behavioral Health Services, Inc.
Licensed Professional Counselor
Licensed Alcohol and Drug Counselor
– Mental Health

"A Place of New Beginnings"

WELCOME!

The goal is to help you identify and cope more effectively with problems of daily living and inner conflicts that may disrupt your ability to function effectively. This may be accomplished by:

- Increasing personal awareness.
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
- Identifying personal treatment goals.
- Identifying and making use of new and more effective coping strategies.

You are responsible for providing necessary information to facilitate effective assessment, treatment, and/or referral. You are expected to play an active role in your treatment, including the identification of treatment goals and accessing your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in counseling often depends much more on what you do between sessions than on what happens in the session.

Thank you for giving me this opportunity to walk with you during this difficult time in our life

Sincerely,

J- Hale

Jim Hale, MS, LPC, LADC-MH

James O. Hale MS, Behavioral Health Services, Inc.
Licensed Professional Counselor Licensed Alcohol
and Drug Counselor – Mental Health

ADULT CHECKLIST OF CONCERNS

Name:_____Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

___I have no problem or concern bringing me here
___Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
___Aggression, violence
___Alcohol use
___Anger, hostility, arguing, irritability
___Anxiety, nervousness
___Attention, concentration, distractibility
___Career concerns, goals, and choices
___Childhood issues (your own childhood)
___Children, child management, child care, parenting
___Codependence
___Confusion
___Compulsions
___Custody of children
___Decision making, indecision, mixed feelings, putting off decisions
___Delusions (false ideas)
___Dependence
___Depression, low mood, sadness, crying
___Divorce, separation
___Drug use—prescription medications, over-the-counter medications, street drugs
___Eating problems—overeating, undereating, appetite, vomiting (see "Weight and diet issues")
___Emptiness
___Failure
___Fatigue, tiredness, low energy
___Fears, phobias
___Financial or money troubles, debt, impulsive spending, low income
___Friendships
___Gambling
___Grieving, mourning, deaths, losses, divorce
___Guilt
___Headaches, other kinds of pains

(cont.)

___ Health, illness, medical concerns, physical problems
___ Inferiority feelings
___ Interpersonal conflicts
___ Impulsiveness, loss of control, outbursts
___ Irresponsibility
___ Judgment problems, risk taking
___ Legal matters, charges, suits
___ Loneliness
___ Marital conflict, distance/coldness, infidelity/affairs, remarriage
___ Memory problems
___ Menstrual problems, PMS, menopause
___ Mood swings
___ Motivation, laziness
___ Nervousness, tension
___ Obsessions, compulsions (thoughts or actions that repeat themselves)
___ Oversensitivity to rejection
___ Panic or anxiety attacks
___ Perfectionism
___ Pessimism
___ Procrastination, work inhibitions, laziness
___ Relationship problems
___ School problems (see also "Career concerns . . .")
___ Self-centeredness
___ Self-esteem
___ Self-neglect, poor self-care
___ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
___ Shyness, oversensitivity to criticism
___ Sleep problems—too much, too little, insomnia, nightmares
___ Smoking and tobacco use
___ Spiritual or religious concerns
___ Stress, relaxation, stress management, stress disorders, tension
___ Suspiciousness
___ Suicidal thoughts
___ Temper problems, self-control, low frustration tolerance
___ Thought disorganization and confusion
___ Threats, violence
___ Weight and diet issues
___ Withdrawal, isolating
___ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

___ _____
___ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

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Patient Information

Today's Date:_____

Patient's Full Legal Name: _____

Patient's Preferred Name:_____ Age: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Please circle best contact number: Home: _____ Cell: _____ Work: _____

Email: _____

How did you hear about me? Internet: *YES/NO* if so, which site: _____

Did someone give you my name to call? If so, Name: _____ Phone: _____

May I have permission to thank this person? *YES/NO*

Social Security Number:_____ Employer:_____

Occupation:_____

Marital Status: _____ Name of Spouse: _____ Spouse Birthday: _____

Primary Care Physician:_____ Phone: _____

May we contact you PCP to update them on your care? *YES/NO*

Nearest Relative (not living at same address): _____Relationship: _____Phone: _____

Persons with whom we may discuss your medical care (please list with contact number):

_____ _____

Person financially responsible: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

HISTORY OF PRESENT PROBLEM

Purpose of this appointment: _____

_____

Have you ever had the same or a similar condition? *YES/NO*

If yes, when and describe: _____

_____

PAST HISTORY

Do you ever have (Place a check by conditions that apply to you):

_____ Anxiety _____ Anger _____ Alcoholism _____ Adoption Issues _____ Abandonment

_____ Depression _____ Drug Addiction ____ PTSD _____ Other _____

Have you been treated for any health condition by a physician in the last year? *YES/NO*

If yes, please describe: _____

What medications are you taking? (List name and dosage) _____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? ____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise?_____ If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? _____ If not, why do you think? _____

What are your hobbies? _____

_____

What percentage of time during the day (at home or at your job away from home) do you spend?

Under normal stress: ____ % Under considerable stress: _____ % Resting or relaxed: _____%

FAMILY HISTORY:

Parents:

Father: living _____ deceased _____ (check one) Current age if still living: _____

Cause of death and age at death if deceased: _____

Mother: living _____ deceased _____ (check one) Current age if still living: _____

Cause of death and age at death if deceased: _____

Check if applicable to you:

_____ I am adopted. As an adopted child, little is known of my birth parents or family?_____

Do you have family members who suffer from the same condition you do? _____ If so, please list:

_____

Family Diseases:
(if applicable, indicate whether family member is Father, Mother, Sibling(s))

_____ Anxiety _____ Anger _____ Alcoholism _____ Adoption Issues _____ Abandonment

_____ Depression _____ Drug Addiction ____ PTSD _____ Eating Disorder ____

Bipolar _____ Schizophrenia ____ Other _____ Other _____

Where did you grow up? _____

Did your family move around a lot? ___ If yes, please describe: _____

How many siblings do you have? _____

Which family members are you close to? _____

Describe your childhood: _____

_____

Were you ever abuse (physically, sexually, emotionally)? _____

Who did you rely on for emotional support? _____

Do you have any type of belief system (moral, spiritual, cultural, religious) that influences your life? _____

If yes, please describe: _____

RELATIONSHIP HISTORY:

What is your sexual orientation? _____

What is your marital status? ____ Single _____ Married ____ Divorced ___ Widowed ___ Separated

_____ Partnered _____ Other

Describe your current relationship, including any stressors: _____

Describe any prior relationship or marriage and the reason for the divorce/breakup: _____

_____

List any children you have including their first name and age: _____

_____

Any problems with your children? _____

List all the people who reside in your home: _____

_____

RISK ASSESSMENT:

Have you ever had thoughts of hurting yourself?	_____ Past	_____ Now
Have you ever had thoughts of committing suicide?	_____ Past	_____ Now
Have you ever had a plan to commit suicide?	_____ Past	_____ Now
Have you ever made threats to kill yourself?	_____ Past	_____ Now
Have you ever made a suicide attempt?	_____ Past	_____ Now
Have you ever mutilated yourself?	_____ Past	_____ Now
Have you ever had thoughts of harming someone?	_____ Past	_____ Now
Have you ever had plans to harm someone?	_____ Past	_____ Now
Have you ever attempted to harm someone?	_____ Past	_____ Now
Have you ever made threats to harm someone?	_____ Past	_____ Now

Is there any other information that would be helpful for your counselor to know? _____

_____

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

"A Place of New Beginnings"

James O. Hale MS, Behavioral Health Services, Inc.
Licensed Professional Counselor
Licensed Alcohol and Drug Counselor
– Mental Health

Client Information and Office Policy Statement

New Client: Welcome!

Thank you for choosing James Hale Behavioral Health for your counseling needs. We would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. Your therapist will answer any questions you have regarding any of these policies.

Getting to Know You

In the first session you complete introductory paperwork and meet with your clinician. You will talk about your reasons for coming and your current situation. You will be asked questions about the history of your family as well as your own history. You and your clinician will make a treatment plan focusing on your behavioral health needs within your first two sessions. The frequency of your sessions will be based on your individual assessment.

Treatment Process

You and your therapist will work together to identify treatment goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problem you are experiencing so that your clinician can better assist you in treatment planning.

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

- Increasing personal awareness
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals
- Identify personal treatment goals
- Promoting wholeness through psychological and spiritual healing and growth

You are expected to play an active role in your treatment including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. ***Your progress in therapy depends much more on what <u>you do</u> between sessions than on what happens in the session.***

Your Clinician

Jim Hale has a Master's degree in Counseling Psychology. Upon completing the educational, supervision, and passing his state licensing board exams, the Oklahoma Department of Health has licensed Jim Hale as a Licensed Professional Counselor (LPC) and the Oklahoma Board of Licensed Alcohol/Drug Counselors has licensed him as a Licensed Alcohol and Drug Counselor (LADC). He has over a decade of experience working with families, marriages, adults, children, and addictions.

Clinician Responsibilities

Your clinician is responsible for providing you with quality professional service. This includes treating you with respect, maintaining your confidentiality (see below) and informing you about your condition/diagnosis and treatment options. Information about treatment options will include potential benefits and risks associated with those options. In order to meet these responsibilities, your clinician may consult with other clinicians as necessary. This would be discussed with you.

Confidentiality

Written permission is required to release any information to another agency or to receive any information from another agency. The only exceptions to this policy occur when the clinician has concerns about possible elder or child abuse/neglect or when the clinician believes there is serious threat of self-harm or harm to others. Clinicians are required by law to notify appropriate persons/agencies under these circumstances.

Client Responsibilities

Office hours are Monday through Friday and flexible depending on the amount of clients at any given time. It is important that you are on time for your appointments and that you call 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or failure to cancel with at least a prior 24 hour notice will result in a charge to you of the full usual and customary fee or, if you covered under a managed care policy, the full contracted fee with your managed care company for the scheduled service that was missed. There are no exceptions to this policy.

After Hours

This office is not designed to be an emergency facility. In the event of an emergency call 911 or go to your local emergency room for assistance. For urgent needs contact your primary care physician or leave a message with your therapist. He will usually return your call within 36 hours, except on weekends and/or holidays.

Fee Policy

As a courtesy, we will verify, pre-certify and submit your insurance claim. Your benefits, costs, and copayments as they pertain to your treatment will be discussed with you. Any amount that your insurance company will not be paying is due from you at the time services are rendered. If there are problems with meeting financial obligations, please inform your counselor. You are responsible for providing this office with copies of your insurance card(s) or any changes with your insurance or coverage. Failure to do so may result in a denial of your claim.

Paperwork

There are times when you may need paperwork completed by the clinician. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to sixty minutes or more to be completed. Be sure to drop paperwork off to this office as early as possible.

Your Satisfaction is Important to Us

Please feel free to raise any concerns with your clinician at any time. If you are dissatisfied with this office we ask that you speak with your clinician.

Refusal to Pay Bill and Behavioral and Compliance Policies

Payment Policies: All payments are due in full *at the time of service(s)* and are to be paid by cash, check, or credit card at the beginning of sessions before counseling is to begin. It is the therapist's right and at his discretion to utilize his option of writing off any charges for services rendered and/or to do any portion of counseling paperwork, etc. pro bono. **However any dispute over a bill, *renders all previously written off charges void,* and *all fees will be reinstated.***

If the client or other responsible party fails to pay his/her bill within ten (10) days of services rendered, then any and all charges for counseling, paperwork, and any other service rendered by the therapist/James Hale Behavioral Health *will be charged* to the client or other responsible party *even if the charges were previously written off.* If the client or other responsible party fails to pay his/her bill within thirty (30) days of services rendered, the client *will be required to pay* all attorney fees, filing charges, lost wages from work, and compensation for any time required of the therapist to reclaim the debt owed by said client or responsible party.

Behavioral and Compliant Policies: If the client/responsible party or any other person related to the client by blood or association threatens the therapist or any other individual associated with James Hale Behavioral Health in any way whatsoever, *the following guidelines will apply and be strictly enforced:* The aforementioned person(s) *will not* be allowed on the premises of James Hale Behavioral Health; *may not* contact in person, by phone, mail, email, or text the therapist or any other individual associated with James Hale Behavioral Health; *will not* go to the homes of the therapist, other employees of or any other individual(s) associated with James Hale Behavioral Health and furthermore *will not* speak to, threaten, harass, stalk said person(s) in any way, shape, or form thereof. *If any of these guidelines are violated, charges will be pressed with local authorities and a Victim Protective Order (VPO) will be filed.*

Furthermore, if the client/responsible party or anyone on behalf of the client makes a complaint against the therapist, *the client/responsible party will pay* New Vision Professional Counseling's/the therapist's *attorney and legal fees in full* for said entity/person(s) to dispute the claim. If the therapist is found not guilty and said claim against the therapist was decided upon to be unfounded, *the client/responsible party will pay* for the therapist's *lost wages* from work during the hours of 8 am to *5* pm and *any other time required* of the therapist to settle the matter *at the rate of $150.00per hour* as well as provide compensation for any other expenses that may occur during or as a result of the claim.

If any harassment, threat(s)/threatening behavior, damaging remarks or slander has occurred against the therapist or James Hale Behavioral Health, *a minimum of $1,000.00 in damages will be awarded* for forcing said therapist to endure this hardship. Also, the therapist *will prosecute* any individual(s) or party that libels the name and/or reputation of the therapist and/or the entity of New Vision Professional Counseling and will additionally *seek compensation for all damages* up to the full extent allowable by law.

It is the goal of your therapist at James Hale Behavioral Health to help you and your family. This document, explanation of policies, and the language used herein is *required* to be signed by all clients and individuals associated with or receiving services through James Hale Behavioral Health to ensure the safety and well-being of all clients and individuals as well as diminish any misunderstanding that may occur by providing information, explaining procedures, and allowing for an opportunity to ask questions. Thank you for your understanding and cooperation in this matter. By signing below you are stating that you have read, understand, and agree to all the terms and conditions stated above as well as assume complete and total responsibility to satisfy them in full.

Client Signature_____Date_____

Therapist Signature_____Date_____

"A Place of New Beginnings"

James O. Hale MS, Behavioral Health Services, Inc.
Licensed Professional Counselor
Licensed Alcohol and Drug Counselor
– Mental Health

General Consent for Treatment for Adults

Jim Hale, MS, LPC, LADC-MH

Client's Name _____ Therapist's Name _____

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any other persons outside James Hale Behavioral Health (JHBH) except in the following circumstances: (a) court orders and subpoenas, (b) to defend legal action against the JHBH, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If I request that JHBH submit reimbursement forms for your insurance, complete confidentiality cannot be agreed. If I file a lawsuit related to mental health issues, JHBH records may also be accessed by the court.

2. While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions.

3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my assessment or treatment. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations purposes, but the therapist is not bound to agree with my request.

4. I understand that it is impossible to assure privacy of any communication by electronic means (email, texts, faxes). Email should never be used to communicate any urgent matter to the JHBH.

5. Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction. My name or any identifying information will not be used in such research.

6. JHBH is open at varying times Monday through Thursday, and it does not offer after-hours services. My therapist and I will set appointments. For after-hours emergencies, I should call 911.

7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations. I understand that I am responsible for working with my therapist to help ensure better treatment outcomes.

8. JHBH therapists are not medical doctors therefore they do not prescribe medications and are not authorized to practice medicine. If my therapist thinks that I should consider medication as a part of treatment, and I want to try this, my therapist will refer me to a physician with whom they would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and I should have regular physical exams and speak with the doctor about all my symptoms.

9. I consent to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.

10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination of any further services to me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours beforemy session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency.

24 Hour Appointment Cancellation Policy

Effective January 1, 2015: If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged for the cost of the session.

Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. By signing below, you acknowledge that you have read and understand the Cancellation Policy for Jim Hale, LPC, LADC as described above.

11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce and court-mandated services.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree and commit to play an active role in my treatment process.

I understand there is a "Zero Tolerance" policy for any violent/aggressive actions, words (threats), gestures, and the like. At the discretion of the attending therapist these actions will result in immediate termination. We will not compromise safety and will maintain this boundary for the benefit of all.

I understand I will be charged the full hourly fee if I "no-show" for an appointment or do not provide at least a twenty-four (24) hour notice of cancellation.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If here is anyone you do not want to receive your medical records, please inform our office.

Signature of Patient or Parent/Guardian	Date
Printed Name (Relationship if not Client)	Date
Witness Signature	Date

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Communication Release Form

TECHNOLOGY

Many clients choose to use cell phones, cordless phones, faxes, email, and texts during the counseling process. It is important for you to know that these methods come with additional risks. These risks include, but are not limited to the following:

- Both email and text messaging used by Jim Hale, LPC, LADC-MH *is not encrypted.*
- The possibility of technology failure, resulting in messages/information not being received.
- The possibility of misunderstandings is increased with text-based modalities, such as email, due to the absence of nonverbal/visual cues.
- Use of email may result in various servers creating permanent records of these transactions.
- Many employers and government agencies review email archives on a routine basis, record letters typed on a keyboard, and/or engage in data mining programs to identify transmissions containing specified content.
- My email is checked daily BUT may result in a possible lag in tum around/response.
- Confidentiality may be breached at many points when using electronic communication, including unauthorized monitoring/interception of transmissions from your computer and my own; it may also be breached as the information passes through the servers along the route to each other. This means that it is possible that third parties may access your records/communication.
- What is said online might be viewed by others.
- Assessment/diagnosis often becomes more difficult without the benefit of face to face contact.
- I do not provide technology-assisted distance counseling
- Your insurance company may also consider our electronic communication in all forms to be part of the medical record and request them.

I cannot guarantee confidentiality when you and I are communicating via cell phone, cordless phone, fax, email, or computer. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you may make an informed choice about when/where/how to use these tools. **If you use any of these methods to contact me, you are giving me permission to do the same.**

Phone # you authorize Jim Hale, LPC, LADC-MH to use:_____

Voice mail message authorized at number above? **Yes** **No**

Text *(no encryption.)* authorized at number above? **Yes** **No**

Email *(no encryption)* auth? **Yes** **No**

The email address you authorize is:_____

_____

USPS using home address authorized? If no, address to use: **Yes** **No**

Home/Other Address: _____

_____

Signature of Patient or Parent/Guardian	Date
Printed Name (Relationship if not Client)	Date
Witness Signature	Date

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STATEMENT OF PROFESSIONAL DISCLOSURE

Welcome to my practice. I am required by Oklahoma law to inform you about my professional training, orientation /techniques, experience, fees, credentials and policies. Please read below.

Training: M. S. Counseling Psychology, Southern Nazarene University
Over 300 hours of continuing education in various areas of the counseling profession.

Orientation: Cognitive Behavioral, Behavioral, Eclectic, and Reality therapies. I also provide book recommendations, handouts, readings and 'homework' based on clients' needs and treatment goals.

Experience: Therapist since 2000 (inpatient, outpatient, corrections, day treatment, nonprofit drug & alcohol agency and private practice) working with adults, children and adolescents in individual, couples and family therapy.

Fees: Fee for a 50 minute intake and assessment session is $130, thereafter, fees for a 50 minute session is $90.Extended session and packages are also available. Clients using insurance are responsible for deductibles and co-pays as dictated by their provider.

Policies regarding late cancellations and communicating with therapist:

1. Cancellations less than 24 hours prior to appointment time will result in a charge of $25 for first occurrence. All subsequent late cancellations will result in a charge of $90.
2. Clients can leave a message on the confidential voicemail at any time and calls will be returned no later than next business day under normal circumstances. After business hours (Monday-Friday 9 a.m. to 4:30 p.m.), calls requiring an immediate response will be returned as soon as possible. If you do not hear from me or I am unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. If you feel unable to keep yourself safe, call 911 or go to your nearest emergency room.
3. Text messages and emails are not guaranteed private or secure methods of communication. Therefore, they should be minimal and for scheduling purposes only. Electronic communications that are therapeutic in nature will be conducted by phone only.

Credentials: Licensed Professional Counselor (Number 2262)
State Board of Behavioral Health Licensure
(BBHL) 3815 N. Santa Fe, Suite IIO; Oklahoma
City, OK 73118. Telephone: (405) 522-3697

Licensed Alcohol and Drug Counselor (Number 56)
Oklahoma State Board of Licensed Alcohol and Drug Counselors
101 NE 51st Street; Post Office Box 54388; Oklahoma City, OK 73154-1388
Telephone: (405) 521-0779

I have reviewed and understand the above information and policies. I understand that I can access the laws and regulations which govern the above licenses, including requirements for licensure of each license. Furthermore, I understand that I can contact (without giving my name), the licensing entities listed above.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed Name (Relationship if not Client) Date

_____ _____
Witness Signature Date

You will receive a copy of this and all other forms you have signed.

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Patient/Client Rights & Responsibilities, HIPPA, & Privacy Practices

Patient Rights & Responsibilities

In the course of care a patient/client has both rights and responsibilities. I understand that I have the right to:

- Be treated with respect and recognition of my dignity and right to privacy
- Receive care that is considerate and respects my personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about my managed care company's services, practitioners, clinical guidelines, quality improvement program and patient rights and responsibilities
- Reasonable access to care regardless of my race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding my treatment planning
- Discuss with my treating professionals appropriate or medically necessary treatment options for my condition regardless of cost or benefit coverage
- Have family members participate in treatment planning and if I am over the age of 12 to participate in such planning
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support
    - Provision of services within the least restrictive environment possible
    - An individualized treatment or program plan
    - Periodic review of the treatment or program plan
    - An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that arise in the provision of care and services, including:
    - Resolving conflict
    - Withholding resuscitative services
    - Forgoing or withdrawing life-sustaining treatment
    - Participating in investigational studies or clinical trials
- Designate a surrogate decision maker if I am incapable of understanding a proposed treatment or procedure or am unable to communicate my wishes regarding care
- Be informed, along with my family, of my rights in a language I/we understand
- Voice complaints or appeals about my managed care company, provider of care or privacy practices
- Make recommendations regarding my managed care company's rights and responsibilities policies
- Be informed of rules and regulations concerning my own conduct
- Be informed of the reason for any utilization management adverse determination

including the
specific utilization review criteria or benefits provision used in determination

- Have utilization management decisions based on appropriateness of care
- Request access to my Protected Health Information (PHI) or other records that are in the possession of my managed care company
- Request to inspect and obtain a copy of my PHI, to amend my PHI or to restrict the use of my PHI, and to receive an accounting of disclosures of PHI

I understand that I am responsible for:

Providing (to the extent possible) my treating clinician and managed care company with information needed in order to receive appropriate care:

Following plans and instructions for care that I have agreed on with my treating clinician

- Understanding my health problems and participating, to the degree possible, in developing, with my treating clinician, mutually agreed upon treatment goals

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Printed Name (Relationship if not Client) Date

_____ _____

Witness Signature Date

You will receive a copy of this and all other forms you have signed.

Patient Health Information Consent Form HIPPA

We want you to know how your Patient Health Information (PHI) is going to be used in this

office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested Pm to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable
work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been train.ed in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS
about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.

10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient or Parent/Guardian _____ Date _____

Printed Name (Relationship if not Client) Date

Witness Signature Date

You will receive a copy of this and all other forms you have signed.

Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed by Jim Hale, LPC,LADC-MH and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit, a record is made of your symptoms, assessments, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of Jim Hale, LPC, LADC-MH, the information within which belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health insurance Portability and Accountability Act (HIPAA) and requirements of Virginia law.

Your mental health and/or medical record serve as the following:

- A basis for planning your care and treatment
- A means of communication among the health professionals who may contribute to your care
- A legal document describing the care you received
- A means by which you or a third-party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Jim Hale, LPC, LADC-MH

I am required to

- Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you.
- Abide by the terms of this notice currently In effect I have the right to change the notice of privacy practices and to make the new provisions effective for all protected health information that is maintained, including that obtained prior to the change. Should my information practices change, I will post new changes in the reception room and provide you with a copy, upon request.
- Notify you if I am unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate with you about protected health information by alternative means or at alternative locations, e.g. you may not want a family member to know that you are being seen by Jim Hale, LPC, LADC-MH. At your request, I will communicate with you, if needed at a different location.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of privacy practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of, therapynotes and a few other exceptions may apply. Copy charges may apply.
- Request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes therapy notes and any audio/video tapes that may have been made with your permission by your mental health clinician.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- request a restriction on certain uses and disclosures of protected health information, but I am not required to agree to the restriction request. You should address your restriction request in writing to Diane Hofstadter, LPC, and I will notify you within 10days if I cannot agree to the restriction.

- Request that I amend your health information by submitting a written request with the reasons supporting the request to Diane Hofstadter, LPC. I am not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment and Health Operations Jim Hale, LPC, LADC-MH, *will use your PHI, with your consent, in the following circumstances:*

- *Treatment* information obtained by your therapist or from a nurse, physician, dentist or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.
- *For payment, if applicable.* I may send a bill. The information on or accompanying the bill may include information that identifies you as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.
- *For health care operations.* Members Jim Hale, LPC, LADC-MH, administration may use information in your health record to assess the performance and operations of services. This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services provided.
- *Disclosure to others outside of* Jim Hale, LPC, LADC-MH,: if you give a written authorization, you may revoke it in writing at any time, but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. I will not use or disclose your health information without your authorization, except as described below to report serious threat to health or safety or child and adult abuse or neglect.
-

Jim Hale, LPC, LADC-MH, *will use your PHI, without your consent or authorization, in the following circumstances:*

- *Child Abuse.* f there is reasonable cause to suspect that a child I know in the course of professional duties has been abused or neglected or have reason to believe that a child we known in the course of the professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- *Adult and Domestic Abuse.* If I believe that a vulnerable adult (ex. incapacitated or facility resident) is the victim of abuse, neglect or domestic violence or the possible victim of other crimes, I may report such information to the relevant county department or state official.
- *Serious Threat to Health or Safety.* If I have reason to believe, exercising best judgment and professional care and skill, that you may cause serious harm to yourself or another person, we may take steps, without your consent, to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in order to protect you or another person from harm. This may include instituting

commitment proceedings.

- *Judicial or administrative proceedings.* If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when a third party is evaluating you or where the evaluation is court ordered.
- *As required by law for national security and law enforcement.* I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.
- *law/Health Oversight.* As required by law I may disclose your health information. For example, if the State of Oklahoma requests that I release records to them in order to investigate a complaint against a provider; I must comply with such a request.
- *Research:* At this time, Jim Hale, LPC, LADC-MH, is not conducting research of any kind.
- *Worker's Compensation:* I may disclose health information to the extent authorized by you and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law; I may be required to testify.
- *As required by law for purposes of public health:* e.g. as required by law, i may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Business Associates:* There are some services provided to Diane Hofstadter, LPC, through contracts with business associates. Examples include computer support for the scheduling system. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. Business associates are required to safeguard your information.

For More information or to report a problem

If you have questions and would like additional information, please ask your therapist. Diane Hofstadter, LPC, who will provide you with additional information. If you are concerned that your privacy rights have been violated or if you disagree with a decision made about access to your health information, or if you would like to make a request to amend or restrict the use or disclosure of your health information, you may contact me in writing at:

Jim Hale, LPC,
LADC-MH
3035 NW 63rd Street,
Suite 200
Oklahoma City, OK
73116

If you believe that your privacy rights have been violated, you can also file a complaint with the Secretary of the U.S. Department of Health and Human Services:

U.S. Department of Health & Human Services
200 Independence Avenue, S. W.
Washington, D.C.
1-877-600-7431 Toll Free

You may also visit this web site for additional information and help: HHS.gov

Jim Hale, LPC, LADC-MH, respects your right to the privacy of your health information. There will be no retaliation in any way for filing a complaint with me or the U.S. Department of Health and Human Services.

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Diane Hofstadter's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jim Hale, LPC, LADC-MH at 405-816-7735.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative · Date

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

"A Place of New Beginnings"

James O. Hale MS, Behavioral Health Services, Inc.
Licensed Professional Counselor
Licensed Alcohol and Drug Counselor
– Mental Health

Emergency Contact Numbers to Call After Hours

New Vision Professional Counseling is not a counseling practice that provides 24 hour emergency service for those in crisis. However, we understand there are times when you may require immediate assistance. Therefore we provide you with the following list of agencies that are advertised as being available either "after hours" or 24 hours. We assume no association with or responsibility for any of the agencies listed below. We do not advocate one over another. We are completely independent of all the agencies listed below and are not liable for any information or treatment they provide for you. Once again, we assume zero responsibility for their actions. This list is not meant to be exhaustive or all-inclusive. The numbers below are simply provided as a service to help you in the event you are not able to make contact with your therapist in a crisis situation.

By signing below, you are stating that you have been given a copy of this emergency contact sheet. You are also stating that you have been provided with an opportunity to ask any questions regarding how and when to use these numbers.

911	All Emergencies
211	24 Hour Crisis Line
1-800-273-8255	24 Hour Lifeline/Suicide Hotline
405-235-9812	Lend a Hand Parent Child Center
405-951-2273	Integris Mental Health
405-272-6216 405-272-4900	St. Anthony's Behavioral Health
405-949-1866	Women's Crisis Services
405-232-2709	City Rescue Mission
405-848-2273	Family Telephone Helpline

By signing below, you are stating that you have been given a copy of this emergency contact sheet. You are also stating that you have been provided with an opportunity to ask any questions regarding how and when to use these numbers.

Signature of Patient or Parent/Guardian	Date
Printed Name (Relationship if not Client)	Date
Witness Signature	Date

You will receive a copy of this and all other forms you have signed.

James Hale MS Behavioral Health Services Inc.

Authorization to Release Confidential Information

I, _____ _____ _____
(Name of Client) (Date of Birth) (Social Security Number)

HEREBY AUTHORIZE:

James Hale Behavioral Health
3035 NW 63rd St, Suite 200
Oklahoma City, OK 73116

TO COMMUNICATE AND EXCHANGE INFORMATION WITH:

_____
_____
_____
_____

The information indicated below for the following purposes: (please initial or check)

☐ Treatment Planning ☐ Submission of Court/Progress Reports ☐ Insurance Eligibility/Health Benefits
☐ Follow Up ☐ Family Involvement/Responsible Party ☐ Other _____

Method of Release:

☐ Fax ☐ Written ☐ Verbal ☐ Video ☐ Audio ☐ Other _____

Reports to Be Furnished:

☐ Psychosocial Assessment ☐ Referral Form ☐ Progress Report/Court report
☐ Treatment Plan ☐ Discharge Summary ☐ Other _____

Note to recipients of alcohol and drug abuse records:
This information has been disclosed from your records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient/client.

The information you authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also known as the Acquired Immune Deficiency Syndrome (AIDS).

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. Federal regulations prohibit James Hale Behavioral Health from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I (or my legally authorized representative) may revoke this consent (in writing) at any time by contacting as James Hale Behavioral Health staff member unless action has already been taken. I may present this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be one (1) year from the date of signature or upon occurrence of the following event: _____ _____. A photocopy of this authorization shall be considered as valid as the original. This consent will expire on termination of services and when all third party payer claims are satisfied or not to be exceeded one year from signing. (For patients/clients referred by the Criminal Justice System, this consent expires no later than the date of final disposition of any criminal proceedings).

I further understand that my treatment services are not contingent upon, or influenced by, my decision to permit the information release, and by signing below, I indicate that my consent to the release of information is given freely and voluntarily.

_____
Patient/Client Signature Date

_____
Parent/Legal Guardian Signature Date

_____
Staff Member/Witness Signature Date