HOPE
MENTAL HEALTH, LLC

Client Registration

Name: _____ Date: _____

Address (Street, City, State, Zip): _____

Home Phone: _____ Cell Phone: _____

D.O.B.: _____ Social Security #: _____ *HMH uses SSN for insurance purposes only

Race/Ethnicity: _____ Primary Language: ☐English ☐Spanish ☐Other _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

If Child:

Mother's Name: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____

Employer: _____ Work Phone: _____

DCBS/DJJ Worker: _____ Phone: _____

Responsible Party:

Name: _____ Phone: _____

Address (Street, City, State, Zip): _____

☐ Private Insurance Company Name _____ ID: _____

☐ Medicaid ID: _____ Provider: _____ ID: _____

☐ Medicare ID: _____ ☐Self-Pay

Family Physician: _____ Psychiatrist: _____

Physical Health Diagnosis: _____

REQUEST FOR ALTERNATE COMMUNICATION:

Please contact me at the number(s) listed above. ☐ Yes ☐ No

Please contact me ONLY at this number: _____

May we leave a message on Voice Mail and/or with another person? ☐ Yes ☐ No

If yes, please list any special instructions: _____

"Helping Other People Excel"

NOTICE OF PRIVACY PRACTICES RECEIPT

I understand that provision of services is not contingent upon my decision to authorize the release of my Protected Health Information (PHI) and I may revoke my authorization at any time. This authorization will expire one (1) year from today or sooner at my request.

The personnel of Hope Mental Health, LLC respects the privacy of every individual and family it serves. I also understand that Hope Mental Health, LLC will only release information regarding my diagnosis, treatment, etc. through my written consent.

I acknowledge that I have received the Notice of Privacy Practices from Hope Mental Health, LLC.

_____
Client Signature Date

_____
Legal Guardian Signature Date

_____
Witness Date

"Helping Other People Excel"

HOPE
MENTAL HEALTH, LLC

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a client and/or guardian of a client of Hope Mental Health, LLC, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks and/or months.

I understand that all information shared with the clinicians at Hope Mental Health is confidential and no information will be released without my consent, consent to release information is given through written circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being neglected and/or sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, all professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings and/or may lead to the recall of troubling memories.

If I have any questions regarding this consent form or about the services offered at Hope Mental Health, I may discuss them with my therapist. I have readd and understand the above. I consent to participate in the evaluation and treatment offered to me by Hope Mental Health. I understand that I may stop treatment at any time.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Date

_____ _____

Witness Date

"Helping Other People Excel"

MENTAL HEALTH, LLC

GUARANTOR AND INSURANCE INFORMATION

GUARANTOR

Person Responsible for Bill: _____ Phone: _____

Billing Address: _____

City/State/Zip: _____

INSURANCE

☐ Private Insurance ☐ Medicaid

Insurance Company Name: _____

Claims Address: _____

City/State/Zip: _____

Policy Holder: _____

Relationship to Client: _____

Identification Number: _____

Group Number & Group Employer: _____

I AGREE TO THE FOLLOWING POLICIES:

1. I authorize and instruct my insurance carrier to make direct payment to Hope Mental Health, LLC.
2. I authorize the release of any medical information to process insurance claims.
3. I accept full responsibility for all charges not paid by my insurance company, including but not limited to copays and deductibles.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Date

_____ _____

Witness Date

"Helping Other People Excel"

HOPE
MENTAL HEALTH, LLC

CLIENT PARTICIPATION POLICY

First, thank you for allowing HOPE Mental Health, LLC to be a part of your journey towards improving your mental and emotional health. HOPE stands for Helping Other People Excel, and we certainly hope to assist you with excelling in your life.

Your regular and active participation in the therapeutic process is essential. One of the most important ways for you to participate, is to be consistent with your scheduled appointments. Often, you are asked to complete homework assignments in between sessions, but even if you don't get homework from your therapist, it's a good idea to consider what was discovered in-session: jotting down questions or insights, journaling about your feelings, etc. We cannot force you to show up or do your homework. This is your therapy, and your progress is ultimately up to you.

However, we do ask you call at least 24-48 hours in advance if you know you will not be available for your appointment so we can fill your spot with another client. We also realize that emergencies come up and it may not always be possible to give this much notice. It is the policy of HOPE Mental Health, to automatically discharge after three appointment no-shows, no-calls, and/or habitual cancellations.

Our providers are well-educated and strive to stay abreast of the latest research-based methods. Our services are in high demand, and we often find it difficult to get everyone scheduled in a timely manner.

Again, thank you for allowing HOPE Mental Health, LLC to be an important part of your care.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Date

_____ _____

Witness Date

"Helping Other People Excel"

HOPE
MENTAL HEALTH, LLC

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

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

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, I 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 I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to telehealth services, I 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 if 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 Coronavirus (or other public health risk). This may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) 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 symptom free. _____
- You will take your temperature before coming to your appointment. If it is elevated (100 degrees Fahrenheit or more), or if you have other symptoms of the Coronavirus, you agree to cancel the appointment or proceed using telehealth. _____
- Upon arriving to your appointment, you agree to have your temperature taken. If your temperature is elevated to (100 degrees Fahrenheit or more), you will be asked to leave the office immediately. _____
- You will wait inside your car (not unless dropped off by public transportation) until no earlier than 5 minutes before your 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 and therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. _____
- You will wear a mask in all areas of the office (I [and my staff] will too). If you do not have one, you will have one available upon entering the building. _____
- You will keep a distance of 6 feet and there will be no physical contact (e.g., no shaking hands, hugs, etc.) with me [or staff]). _____
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash to sanitize your hands. _____
- If you are bringing your child, you will be 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. _____

- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. _____
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. _____
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know. _____

I 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
My practice has taken steps to reduce the risk of spreading the Coronavirus within the office and we have posted our efforts on our bulletin in the office. Please let me know if you have any questions about these efforts.

If You or I are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the Coronavirus, I 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, I may be required to notify local health authorities that you have been in the office. If I have to report this, I 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 I may do so without an additional 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.

_____ _____
Client/Guardian/Parent Signature Date

_____ _____
Witness Date

HOPE
MENTAL HEALTH, LLC

Consent for Telehealth Services

Client Name: _____ DOB: _____

Medicaid #: _____ MCO: _____ MCO #: _____

Insurance Co.: _____ Insurance #: _____

Telehealth involves the use of electronic communications to enable providers to deliver services to clients via live two-way audio and video.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient information and will include measures to safeguard this data and ensure its integrity against intentional or unintentional access.

Expected Benefits:

Improved access to care by enabling a client to access his/her clinician from a remote site.

Possible Risks:

Information transmitted may not be sufficient and an in-office appointment may be required.

Delays in treatment could occur due to failures of equipment.

In rare instances, security protocols could fail, resulting in a breach of protected health information.

By signing, I acknowledge that I understand telehealth is only one option for my treatment, I may also access in office treatment at any time during the treatment process providing it is safe to do. Furthermore, I understand the laws that protect my confidentiality also apply to telehealth, and that I can withdraw my consent to use Telehealth at any time.

I have read and understand the information provided above regarding telehealth services, have discussed this information with my clinician, and my questions have been answered to my satisfaction. I give my informed consent for the use of Telehealth as part of my treatment.

_____ _____
Parent/Guardian/Client Signature Date

_____ _____
Witness Date

"Helping Other People Excel"

V2.11-2022

HOPE
MENTAL HEALTH, LLC

FREEDOM OF CHOICE FORM

I, the undersigned, understand that the choice of providers is my responsibility and right as the client/parent/guardian. I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Treatment team has determined that the following service is needed for the client:

- ☐ Collateral Therapy
- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Case Management
- ☐ Family Therapy
- ☐ Other: _____

I have reviewed the list of providers for the services(s) and choose Hope Mental Health as my provider(s).

_____ _____
Client Signature Date

_____ _____
Legal Guardian Date

_____ _____
Witness Date

"Helping Other People Excel"

HOPE
MENTAL HEALTH, LLC

FEES FOR COURT APPEARANCES:

Record Review: $105.00 per hour

Travel: $105.00 per hour

Court time: $105.00 per hour

Client must pay 3 hours; at $105.00 per hour, prepayment before the therapist or other employee leaves the office.

Client will be billed for any extra (over the 3 hours) preparation time, plus travel and court time.

This amount is per therapist.

Client Signature	Date
Legal Guardian	Date
Witness	Date

****For Depositions please speak with the Business Manager**

"Helping Other People Excel"

V2.11-2022

HOPE MENTAL HEALTH

Authorization for the Release or Exchange of Information

Client Name: _____

DOB: _____ Social Security #: _____

Reason for Release: _____

Information To Be Released By Or Exchanged With:

Name: _____

Address: _____

Information To Be Released By Or Exchanged With:

Name: _____

Address: _____

Information To Be Released Or Exchanged (Please check or initial):

___ History & Physical Exam	___ Court/Agency Documents	___ Family Systems Evaluation
___ Discharge Summary	___ Mental Status	___ Consultation Reports
___ Psychiatric Evaluation	___ Treatment Plans	___ Educational Reports
___ Psychological Test Results	___ Progress Notes	___ Educational Tests & Reports
___ Chemical Recovery History	___ Therapist Orders	___ Attendance Record
___ Dates of Hospitalization	___ Diagnosis	___ Psychosocial Report
___ Medical Records	___ Crisis Intervention Reports	___ Lab Results

Other (specify): _____

_____ _____

Client Signature Date

_____ _____

Legal Guardian Date

_____ _____

Witness Date

I understand that once my Protected Health Information is disclosed pursuant to this authorization, it could be re-disclosed by a recipient that is not a health plan or healthcare provider, and the released information may no longer be protected by HIPAA federal privacy regulations. Hope Mental Health will request any recipient of your PHI not to re-disclose it without written consent.

It is understood that this authorization for release is subject to revocation at any time, and that unless another date is specified, this release will expire sixty (60) days after it is signed. Time Limitation of

Release: _____ Reason for Extension: _____

Approved: ____ Yes____ No Approved By: _____

HOPE
MENTAL HEALTH, LLC

SUPERVISION OF CLIENTS

Children under the age of 14 years are not to be left unattended at any time.

It is the policy of Hope Mental Health, LLC that the parents, guardians, or transporters must be present in the office until the therapist speaks with them and takes the client into therapy. Caregivers must return to the office 15 minutes prior to the end of the therapy session.

It is the policy of Hope Mental Health, LLC that any client in a high risk or crisis situation, be supervised by a parent, guardian, or transporter at all times. These situations include suicidal, homicidal, run away, and evaluation for residential or hospitalization services.

If a client under the age of 16 years chooses to leave the property of Hope Mental Health without their caretaker, guardian, or transporter, said child will be considered AWOL/Runaway risk and be reported to the Police immediately.

Client Signature	Date
Legal Guardian	Date
Witness	Date

"Helping Other People Excel"