PART 1: CLIENT INFORMATION

Name: _____ Date of Birth: ___/_____/_____ Age: _____

Address: _____ Zip: _____

Primary Phone: _____ Home / Cell / Work Ok to Leave a Message? Y / N

Secondary Phone: _____ Home / Cell / Work Ok to Leave a Message? Y / N

Email: _____

Emergency Contact: _____ Relation: _____ Phone: _____

_____ By initialing here, I give my provider permission to contact my emergency contact person if provider's calls are not returned within an adequate timeframe and she believes I am a threat to myself or others.

Education Completed: High School Some College College Degree Graduate Degree Post Graduate

I am working as a: Full/PT Employed Self-Employed Stay-At-Home Parent Student Unemployed Other

Employer: _____ Since: _____

How did you hear about us? Online Search Good Therapy Word of Mouth Other _____

Have you ever been in therapy before? Yes No Was therapy a positive experience? Yes No

If yes, briefly describe the reason and length of treatment:

_____

_____

Members of your family unit/ household: (Please list names, ages & relation to you)

_____

_____

_____

Faith Tradition or Religious Affiliation you were raised with: _____

Current Faith Tradition or Religious Affiliation: _____

PART 2: RELATIONSHIP STATUS

Please circle the choice(s) that best describe your current relationship:

Single	Never Married	Divorced	It's Complicated
Cohabitating	1st Marriage	Remarried	
Committed Partner	Separated	Widowed	

How long have you been in your current relationship? _____

Do you ever wish you had not gotten into a relationship with your current mate?

Frequently Occasionally Rarely Never

How often do you confide in your current partner? Almost Never Rarely In most things In everything

Have you and your partner ever separated? Yes No

If yes, indicate circumstances and dates of separation: _____

Have you consulted a lawyer regarding separation or divorce? Yes No If so, when _____

Is there a history of divorce/remarriage/affairs in your family of origin? Yes No

If so, please explain _____

_____

PART 3: HEALTH & MENTAL STATUS

Primary Care Physician Contact

Name: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Date of Last physical: _____ How often do you see this clinician? _____

Does this health care provider prescribe medications for any (circle) psychological/pain/sleep/addiction recovery/stress complaints or issues? Yes No

Other Physician, Psychiatrist, ARNP, Physician Assistant or Prescribing Practitioner you see with regularity:

Name of Provider: _____

Practice/Clinic: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

How often do you see this clinician? _____

Does this health care provider prescribe medications for any (circle) psychological/pain/sleep/addiction recovery/stress complaints or issues? Yes No

If you work with any other health care or holistic care providers, please indicate their names and what they treat:

_____

_____

If you have any chronic illness, medical conditions or injuries, please list them: _____

_____

Please list all prescription, contraception, herbal supplements and non-prescription medication you are presently taking, with dosage in milligrams:

_____

If you have recently stopped or changed medication, please list those, along with dates of change:

_____

Is there a history of substance abuse or alcoholism in your family of origin? Yes No

If so, what substance and by whom? Use back of page if needed.

_____

_____

Circle any of the following substances you use, indicating frequency for each:

Tobacco _____x day/week Marijuana _____x day/week

Alcohol _____x day/week Amphetamines _____x day/week

Caffeine _____x day/week Hallucinogens _____x day/week

Sedatives _____x day/week Diet or Pain Pills _____x day/week

Other (list):

_____

Have you experienced 10 or more pounds of weight gain or loss in the last 30 days? Yes No

Has your appetite changed? Yes, increased. Yes, decreased. No change

How many hours do you sleep, per night, in general? _____ Is your sleep interrupted? Yes No

If yes, please explain: _____

_____

Have you ever attempted suicide? Yes No Have you ever been hospitalized for suicidal thoughts? Yes No

If yes, please describe circumstances and include dates: _____

_____

Are you currently having suicidal thoughts? Yes No Do you have access to a gun or deadly weapon? Yes No

Do you currently have a Suicide plan? Yes No Has a member of your family attempted suicide? Yes No

If yes, please explain including who and when: _____

_____

List any other significant behavior changes in the last month: _____

_____

PART 4: SERVICES

Briefly describe your reason for seeking services at this time:

Circle *any that apply* to your reasons for seeking services today:

Major Life Transition	Infidelity	Physical Abuse	Suicidal Issues
Roles & Responsibilities	Jealousy	Sexual Abuse	Temper
Occupational Problems	Lack of Sexual Desire	Stress	Sleep Issues
Loss of Loved One	Family-Of-Origin Issues	Depression/Sadness	Anxiety/Fear
Mindfulness and Meditation	Health problems	Mood swings	Finances
Life/Job Coaching	Loneliness	Lack of closeness	Arguments
Domineering Partner	Legal Matters	Lack of Social Support	Parenting
Unmet Emotional Needs	Divorce/Separation	Spiritual/Religious Matters	

What do you wish to accomplish through our meetings (your goal)?

How will you know this problem has been resolved/when we don't need to meet anymore (what will have changed)?

PART 5: FEE POLICY

Unless other arrangements are made, payment is expected at the time of service. Cash, Charge, Health Savings Account Card, or Flexible Spending Account Card are acceptable forms of payment.

There is a $30 charge for each fifteen (15) minutes of a telephone consultation lasting longer that 5 minutes. Matters requiring lengthy email responses are billed at the same rate. For issues or questions requiring more than a brief phone conversation or email exchange you are encouraged to schedule an in-office visit to avoid this fee.

A minimum of 24-hour notice is required for rescheduling or canceling an appointment.

A $75 fee will be charged to your credit card **for the first session missed or cancelled without 24-hours notice**.

You will be charged the **full session fee for subsequent appointments rescheduled, cancelled, or missed with less than 24-hours notice**.

Repeated cancellations (more than two) without sufficient notice may result in the termination of services. The full fee is always charged for sessions missed completely. Multiple sessions missed result in the termination of services.

Credit Card #: _____ Valid Thru: _____ CVV/3-Digit Code: _____

Name on card: _____ Billing Zip Code: _____

By signing below, I attest that I understand and agree to the fee policy. I authorize my provider to charge my credit card for missed appointments, appointments not cancelled or rescheduled 24 hours before scheduled appointment time, missed appointments, co-payments, and any fees uncollected after 30 days.

Signature: _____ Date: _____

PART 6: INFORMED CONSENT AND CONFIDENTIALITY

I consent to participate in services offered by Louisville Mindfulness Center, PLLC (LMC, PLLC) and its providers. I understand my provider provides services within the scope of her/his license and training. I understand all communication between me and the providers within LMC, PLLC is held in strictest confidence. I consent to the consultation between providers at LMC, PLLC with the intention for them to offer me the best quality care whether I'm working individually, as a couple, or as a family. I understand that my case is kept confidential within LMC, PLLC unless I authorize the release of information outside of LMC, PLLC with a signature, or the provider is ordered by a court to release the information; threats to harm self/others are made by me, the client; abuse or neglect of a child or elderly person is suspected; and/or sexual exploitation by a provider. In the latter two cases, the provider is required by law to inform legal authorities and/or potential victims.

When couples and families are seen jointly and individually, Louisville Mindfulness Center, PLLC and my provider(s) cannot guarantee confidentiality between provider(s) and each client separately within the relationship.

I understand my provider may participate in consultation with other colleagues and supervisors outside of LMC, PLLC in which my appointments are discussed to offer me the best quality care. I understand my identity is kept confidential in these cases and only the content of the case is discussed. I understand my provider may bring another therapist into session or ask me to sign a waiver to be videotaped for supervision or teaching purposes.

Signature: _____ Date: _____

PART 7: TECHNOLOGY-ASSISTED SERVICES INFORMED CONSENT AND POLICIES

Technology-Assisted Mental Health Services, hereafter referred to as TAMHS, involved the use of electronic communications to enable therapists to provide services to individuals who choose access to care via technology assisted services. TAMHS may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting. TAMHS has over 60 years of development and continues to grow as a mode of delivering care and there may be some barriers compared to sitting with a provider in the same room. Limitations can be addressed and are minor depending on how well the sound and video are working during the TAMHS and depending on the level of care needed by the patient.

EXPECTED BENEFITS:

- Improved access to care by enabling individuals to access treatment from their home or office.
- Expanded access to providers with expertise that may not be available in your local community

POSSIBLE RISKS:

- Risks mostly included delays in treatment due to deficiencies or failures of equipment.
- Possible poor quality of resolution of images.
- In very rare instances, security protocols could fail, causing breach of privacy or personal information. Security measures are being taken to prevent a breach in privacy.
- Another risk is when the clients might not choose a private, secure location in which to participate in the TAMHS session.

ADDITIONAL POINTS FOR CLIENT UNDERSTANDING:

1. I understand that TAMHS are completely voluntary and that I can choose not to do or not to answer questions at any time.
2. I understand that none of the TAMHS sessions will be recorded or photographed by the therapist or client at any time.
3. I understand that the laws that protect privacy and confidentiality of client information also apply to TAMHS and that no information obtained in the use of TAMHS which identifies me will be disclosed to other entities without my consent.
4. I understand that because this is a TAMHS, there may be occasion that it will be necessary for technicians to assist with equipment. Such technicians will keep any information confidential.
5. I understand the TAMHS is done over a secure communication system that meets or surpasses HIPAA encryption standards. With this said, there is no absolute guarantee that a security breach is not possible, and I freely accept the very rare risk that this could affect confidentiality.
6. My provider explained to me how the TAMHS will be used and I know I can ask questions at any time. I understand the TAMHS sessions will not be exactly as in-person sessions, as I will not be in the same room as my therapist.
7. I understand there are potential risks of technology, including interruptions, unauthorized access, and technical difficulties. I understand my therapist or myself can discontinue the TAMHS sessions if it is felt that use of technology-assisted services is no longer effective or appropriate.
8. I understand that I may experience benefits from the use of TAMHS, but that no results can be guaranteed or assured.
9. I understand that if there's an emergency during a TAMHS session, my therapist will call emergency services and my emergency contacts.
10. I understand that if the TAMHS connection drops while I am in session, I will have a phone line available and will contact my therapist.
11. I understand that I will be asked to create a safety plan with my therapist in case of an emergency as needed.
12. I acknowledge that my therapist can only meet with me using TAMHS when I am located in the state in which he/she is licensed.

I understand the information provided above regarding TAMHS. I can, will, and/or have discuss(ed) the consent with my provider at any time. I hereby give my informed consent for the use of TAMHS in the delivery of care.

Signature: _____ Date: _____

Electronic Communication Consent

Email and digital communication offers an efficient way to communicate with providers at Louisville Mindfulness Center, PLLC (LMC, PLLC). From appointment reminders to providing updates and information, email allows us to avoid some of the frustrations of "phone tag," finding appropriate times to make phone calls and voice mail communication that may not convey all the necessary data. However, this medium is not without its risks.

RISKS OF USING EMAIL AND DIGITAL COMMUNICATION

Transmitting client information by email has a number of risks that clients should consider before using email. These include, but are not limited to, the following risks:

- Emails, texts, and voicemails can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Backup copies may exist even after they are sent or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails transmitted through their systems.
- Email can be used to introduce viruses into computer systems.
- Emails may not be secure, and therefore it is possible that the confidentiality of such communications may be breeched by a third party. Email can be intercepted, altered, forwarded, or used without authorization or detection.

GUIDELINES FOR USE OF EMAIL AND DIGITAL COMMUNICATION

LMC, PLLC cannot guarantee, but will use reasonable means, to maintain security and confidentiality of email information sent and received. We will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct. Clients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent matters or emergency situation. In an emergency, call 9-1-1, National Crisis Hotline at **1-800-273-TALK,** the local crisis line **502-589-4313**, or go to your nearest emergency room. My provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
- Please make emails, texts, and voicemails concise. Please schedule an appointment if the issue is too complex or sensitive to discuss via email.
- Your provider will check email on a regular basis, however, there may be exceptions to this. In addition, there can be server problems or line/connection problems. Your provider will not check email when out of the office or on vacation.
- Most email messages will be filed electronically in the client record.
- Client identifiable emails will not be forwarded to others outside the practice without the client's prior written consent, except as authorized or required by law.
- My provider does not distribute a client's email address to a third party.
- My provider is not liable for breach of confidentiality caused by the client or any third party.
- **Use caution when using your employer's computer.**
- Inform your provider of changes in your email address or mailing address.
- Ordinarily there will be no charge for use of periodic, brief emails. Should a message require a lengthy response a regular correspondence rate will apply. The client can then choose to discuss the matter during the scheduled session rather than paying a correspondence fee.
- I understand the risks associated with the use of email communication with Your provider and consent to the conditions and instructions outline.

I acknowledge that I have read and understand this consent form. I willingly consent to treatment with LMC, PLLC,

Signature: _____ Date: _____

Email Address to be Used: _____

NOTICE OF PRIVACY PRACTICES

Client Confidentiality is respected, and information is only released about you in accordance with state and federal laws.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes policies related to the use of the records of your care at this private practice facility. I am required to give you this Notice about (1) the use and disclosure of your health information, (2) my legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of this Notice at any time by emailing to LouisvilleMindfulnessCenter@gmail.com and requesting the Notice of Privacy Practices. For more information about privacy practices please contact the above email address or make your request in writing at the address below.

1. Use and disclosure of health information: The minimum necessary health information is disclosed about you for your treatment, for payment of your services and for health care operations.

a. For Treatment: Health information for the purposes of referral to another health care professional for concurrent or transfer of treatment will be provided only when the client has completed a signed authorization for release of information.

b. For Payment: Information may need to be disclosed to obtain payment of services. For example, insurance companies or other agencies may be provided with the minimum necessary information in order for them to pay for your treatment. Should your insurance company require information other than identifying information, dates of service, diagnosis, CPT Codes and provider information, you will be asked to sign an authorization for release of information. Identifying information and balance due may also be disclosed to collection agencies in accordance with fair practices laws for small businesses.

2. Information disclosed without your consent: Under Kentucky and Federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. Your personal health information may be disclosed in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for worker's compensation.

c. Public Health Activities. If it was concluded that you were an immediate danger to yourself or others, health information may be disclosed about you to authorities, as well as to alert any other person who may be in danger.

d. Child/Elder Abuse. Information may be disclosed about you in relation to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. Information may be disclosed about you if a crime is committed on the premises or against staff or clinicians, or if it is believed someone else is in danger.

f. National Security, Intelligence Activities, and Protective Services to the President or others. Health information may be released about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.

g. Health Oversight Activities. Information may be disclosed about you to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting agencies may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. Business Associates. The minimum necessary health information may be provided to our business associates that perform functions on my behalf or that provide this office with services if the information is necessary to perform such functions. All of my business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any of the information other than specified for the purposes of their contracted activity, such as financial auditing.

i. Marketing. No information will be disclosed to a third party for the purposes of telemarketing, direct mail marketing or marketing through electronic mail.

j. Scheduling appointments. Your phone number and email may be used to call you or to leave messages to schedule or remind you of appointments. Your address may be used to mail monthly statements or other billing information.

3. Your Rights Regarding Your Health Insurance

a. Right to Inspect and Copy. You have the right to look at or get a copy of your record with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. Right to Amend. You have the right to request that your record be amended. Your request must be in writing and it must explain why the information should be amended. Your request may be denied under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive an accounting of the disclosures made of your health information after April 14, 2003, for most purposes other than treatment, payment or health care operations. To request an accounting of disclosures, you must submit your request in writing.

d. Right to Request Restrictions. You have the right to request a restriction or a limitation on health information disclosed about you. For example, you could ask that no information shared with an insurance company in which you would be responsible to pay in full for services provided. While you are in treatment or after treatment has terminated, a written request should be mailed to 8009 New La Grange Rd, Suite 1, Louisville, KY 40222. Your request may be denied under certain circumstances and after serious consideration or unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communication. You have the right to request that communications with you about health information be disclosed in a certain way or sent to a specified address. You must make this request in writing, and it must specify the alternate means through which you may be reached. Every attempt to accommodate reasonable requests will be made.

f. Right to Obtain a Paper Copy of this Notice. You have the right to obtain a copy of this notice and can make such requests through email for an electronic copy or by sending your request in writing with a SASE to 8009 New La Grange Rd, Suite 1, Louisville, KY 40222.

Any other uses or disclosures not set out in this Notice will be made only with your written authorization. You may revoke authorization for release of information at any time by sending your revocation in writing. Revocations will become effective only after they have been received and filed and will only be for disclosures not already completed.

The right to change the Privacy Practices is reserved provided applicable law permits such changes. Before the effective date of a material change, changes to this Notice will be made and dispersed. The practice is required to abide by the terms of this Notice beginning April 2003.

Questions and Complaints: If you believe your privacy rights have been violated, you may file a complaint with the US Department of Health and Human Services. This notice is effective April 14, 2003.

Signature: _____ Date: _____