All Ways Mental Health Care, LLC
d/b/a Deborah A. Martin Inc.

Confidential

CLIENT REGISTRATION

Date: _____

Last Name: _____ First Name: _____

Home Address: _____

Email Address: _____ Date of Birth: _____

Cell Phone: _____ Landline/Work Phone: _____

I will be using the following method for my sessions (circle one): Computer/Laptop Tablet Cell

I agree to receive appointment reminders via (circle one): Text Email Voicemail

Relationship Status (circle one): Single Married Widowed Divorced Never Married Domestic Partnership

Gender (circle one): Male Female Other: _____

Sexual Orientation (circle one): Heterosexual Lesbian/Gay Other:

Employment (circle one): Employed Disabled Student Unemployed Retired

If employed, where: _____

Children/Ages: _____

Who lives with you (name & relationship): _____

_____

Emergency Contact Information:
Name: _____
Relationship to you: _____
Phone Number: _____

Referred for Treatment by: _____ On: _____

Pint Client Name: _____

Client/Parent Signature: _____ Date: _____

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HIPAA COMPLIANCE - CLIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES ___ NO ___

May we leave a message on your answering machine at home or on your cell phone? YES ___ NO ___

May we discuss your medical condition with any member of your family? YES ___ NO ___

If YES, please name the members allowed (first and last name, relationship to you.)

_____

_____

Print Client Name: _____

Client/Parent Signature: _____ Date: _____

All Ways Mental Health Care, LLC
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Notice of Privacy Practices (3/03) HIPAA

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance use, and disclosure of your health records:
We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal of our legal duties and privacy practices with respect to that information.

We are required to abide by the terms of this notice currently in effect.
We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All/any changes will be provided to you.

There are several situations in which we may use or disclose to other people or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received a notice of privacy practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or healthcare operations requires you to sign an authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your acknowledgement or authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed acknowledgement that you received this notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

TREATMENT: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may be necessary to share your health information with another healthcare provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

PAYMENT: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health care plan pre-certification and pre-authorization of services, or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and healthcare data processing through our system.

There are certain circumstances under which we may use or disclose your health information without first obtaining your acknowledgement or authorization. Those circumstances involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety because of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object, we may disclose to a member of your family, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or disclose protected health information to notify or assist in notifying a family member, person representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

COMMUNICATION BARRIERS AND EMERGENCIES: We may use or disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as responsibly practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to contain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization which may be revoked at any time. Except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney because of injuries sustained in an automobile accident, or to educational authorities without your written permission.

You have certain rights regarding your health record information, as follows:

1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to your care. We are not required to agree to the restriction; however, if we agree, will comply with it, except regarding emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2) You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be managed.
3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for those in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a responsible fee for providing a copy of your health records, or a summary of your records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of information.
4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this notice, must be made in writing and addressed to the privacy officer at our address. We will respond to your request in a timely fashion.
5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a responsible fee for each subsequent request for an accounting within the same twelve-month period.
6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the privacy officer (in the case of complaints to us) your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's website, http://www.hhs.gov/ocr/hipaa.

Print Client Name: _____

Client/Parent Signature: _____ Date: _____

All Ways Mental Health Care, LLC
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MEDICAL AND MENTAL HEALTH INFORMATION

Date: _____
Client Last Name: _____ First Name: _____
Age: ____ Race: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Allergies to:
Medication: _____
Food: _____
Primary Care Physician (Name/Location/Number): _____
_____
Psychiatrist (Name/Location/Number): _____
_____
Date of last appointment: _____
Previous Therapist(S) (Name/Location/Number): _____
_____
Diagnosed Medical Conditions: _____
_____
Diagnosed Mental Health Conditions: _____

Prescribed Medications:
1) Name: _____ Dosage: _____
Reason: _____ How long: _____
2) Name: _____ Dosage: _____
Reason: _____ How long: _____
3) Name: _____ Dosage: _____
Reason: _____ How long: _____
4) Name: _____ Dosage: _____
Reason: _____ How long: _____
5) Name: _____ Dosage: _____
Reason: _____ How long: _____
6) Name: _____ Dosage: _____
Reason: _____ How long: _____

Over-The-Counter Mediation:
1) Name: _____ Dosage: _____
Reason: _____ How long: _____
2) Name: _____ Dosage: _____
Reason: _____ How long: _____
3) Name: _____ Dosage: _____
Reason: _____ How long: _____
4) Name: _____ Dosage: _____
Reason: _____ How long: _____

Client Last Name: _____ First Name: _____

History of Hospitalizations:

1) Reason: _____ Date: _____ Outcome: _____
2) Reason: _____ Date: _____ Outcome: _____
3) Reason: _____ Date: _____ Outcome: _____

History of Baker Acts or Residential/Inpatient Treatment:

1) Reason: _____ Date: _____ Outcome: _____
2) Reason: _____ Date: _____ Outcome: _____
3) Reason: _____ Date: _____ Outcome: _____

Substance Use:

1) Alcohol:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
2) Marijuana:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
3) Pain Relievers:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
4) Hallucinogens:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
5) Depressants:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
6) Cocaine:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
7) Stimulants:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
8) Inhalants:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
9) Meth:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___
10) Heroin:	Misuse ___	Rarely Use ___	Never Use ___	History of Using ___

What are your current mental health concerns: _____

_____

_____

Level of distress: _____

_____

What do you hope to gain or change from participating in therapy: _____

_____

_____

Print Client Name: _____

Signature of Client/Parent: _____ Date: _____

Print Therapist Name: _____

Signature of Therapist: _____ Date: _____

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SYMPTOM CHECKLIST

Last Name: _____ First Name: _____ Date: _____

Please check any symptoms you have experienced within the last 6 months. Which has caused you bothersome distress.

MOOD:

Sadness	Mood Swings	Worthless	Useless	Fatigue
No pleasure	Fatigue	Withdrawn	Hypersensitive	Irritable
Feel Alone	Lethargic	Less Active	Think about death	Hopeless
Talk of dying	Cry a Lot	Annoy Easily	No One Loves Me	Helpless
Negative attitude	Harming Self	Attempted Harm	Numb	Other:

FEARS

Being Alone	Nightmares	Crowded Places	Strangers	People
Medication	Germs	Darkness	Flashbacks	Ghosts
Thunder	Lightening	Changes	Animals	Fire
Being Hurt	Driving	Sleeping	Other:	

ANXIETY

Feel Foolish	Restless	Worse at Night	Always Worried	Avoid Triggers
Can't Relax	Trembling	Feel on Edge	Tired/Fatigue	Rapid Breaths
Nervous	Sweating	Can't do things	GI Problems	Can't Sleep
Worry for no reason	Can't Control It	Causes Irritability	Other:	

ANGER

Verbal Anger	Throw/Hit Things	Hit People	Easy to Anger
Quick Anger	Harms Self	Argumentative	Fights
Other:			

ATTENTION SPAN

Can't Focus	Interrupts Others	Careless	Unorganized	
Talk Fast	Easily Distracted	Can't be Still	Impulsive	
Can't Finish Things	Can't follow directions	Poor Listener	Hard to Concentrate	Other:

BEHAVIORAL ISSUES

Hoarding	Stealing	Poor Hygiene	Fire Setting	Rituals
Picks at Skin	Perfection	Promiscuous	Bites Fingernails	No brushing Teeth
Obsessed With:	Compulsive With:	Other:		

NUTRITIONAL HABITS

Binging	Purging	Never eats	Skips Meals	Chronic Constipation
Diarrhea	Over Eats	Junk Food	Weight Loss	Weight Gain

TRAUMAS:

Put a "**C**" for currently bothersome. Put an **X** if you've witnessed or experienced the event.

Natural Disaster	Loss of a Pet	Auto Accident	Medial Trauma	Divorce
Physical Abuse	Mental Abuse	Sexual Abuse	Emotional Abuse	Rape/Incest
Sexual Assault	Domestic Violence	Kidnapped	Murder	Custody Issues
Loss of Family Member	Other:			

ADDICTIONS

Please describe using your own words: _____

_____

_____

_____

OTHER ISSUES

Please include other issues which are of a concern to you but not on any list above or use this space to explain your concerns in more detail: _____

_____

_____

_____

Print Client Name: _____

Client/Parent Signature: _____ Date: _____

All Ways Mental Health Care, LLC
d/b/a Deborah Martin Inc.

TELEMENTAL HEALTH INFORMED CONSENT

I understand and agree to receive Telemental Health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and the Deborah A Martin, Inc. Therapy Agreement form.

I understand the potential risks of Telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session;2) (the video or audio transmission may not be clear; and 3)! may be asked to go to my therapist's office in person if it is determined that Telemental health is not an appropriate method of treatment for me.

I recognize the benefits of Telemental health, which may include the following: l) reduced cost and time commitment for treatment due to the elimination of travel: 2) ability to receive services near my home or from my home, and 3) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via video conferencing. understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores al! notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during video conferencing Is free of other people to ensure my confidentiality. Furthermore, I understand that recording my session is prohibited.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety

My Signature indicates that I agree to participate in telehealth under the conditions described in this document.

Client Name (please print): _____ Date: _____

Legal Guardian (If applicable): Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____

All Ways Mental Health Care, LLC
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CLIENTS RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- Be treated with courtesy, respect, and dignity. You have the right to privacy.
- Prompt and fair answers to questions.
- Know who is providing services and who oversees your care.
- Know what support services are available and if there are interpreters if you do not speak English.
- Know what rules and regulations apply to how you act.
- Refuse care, unless the law says care must be given.
- Tell us if you are not satisfied with anything we have done or said we will not do.
- Information and counseling on how to pay for your care, if asked.
- Know before any care is given if the provider or facility takes Medicaid.
- Get an estimate of how much it will cost before care is given, if asked.
- Get a clear and easy to understand bill and have the bill explained to you if you ask.
- Get help regardless of your race, ethnicity, religion, disability, or how you can pay.
- Help with any emergency problem that will get worse if help is not given.
- Be informed when treatment is for experimental research.
- Opt in or out of any proposed experimental research.
- Get easy-to-follow information on your care options and what other kinds of care are available to you.
- Be told what problem you may have, what care is planned, what other kind of care is available, risks and outcomes. Take part in decisions about your care. You have the right to decline care.

YOU ARE RESPONSIBLE FOR:

- Telling your therapist, to the best of your ability, everything you know about your problem to include what sicknesses you had in the past, if you have you been in the hospital before, what medication you have taken and/or are taking, and other things about your health.
- Telling your provider about any changes in how you feel.
- Letting your provider know you understand your treatment care plan and that you understand what you are supposed to do to help yourself.
- Making sure you follow your treatment care plan.
- Not missing appointments and calling 48 hours in advance if you need to reschedule the appointment because after one no show/no call, you will lose your standing appointment.
- Paying the therapist's regular rate for no show/no call appointments.
- Paying the therapist's regular rate for cancellations unless there is a legitimate emergency.
- What happens if you refuse help or do not follow the care plan.
- Following all rules on patient/client care and conduct.

By signing, I, the CLIENT, agree that I understand my rights and responsibilities.

Client Name: _____ Date: _____
Client/Parent Signature: _____

By signing, I, your THERAPIST, agree that I have explained your rights and responsibilities and provided you with a copy.

Therapist Signature: _____ Date: _____

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INFORMED CONSENT AGREEMENT

CONFIDENTIALITY: All records to include written information or any electronic data shall be marked "Confidential". I understand that discussions between my therapist and myself are confidential. No such information shall be released without my written consent EXCEPT in the specific circumstances mandated by the law including:

1) Disclosure that I have harmed myself or intend to harm myself.
2) Disclosure that I intend to harm another.
3) Disclosure that Isomeone else is harming me.
4) Specific Court Orders which mandate the release of specific records.

I also understand that I am releasing and holding my therapist harmless if one of the standards above requires my therapist to disclose confidential information as mandated by law or as required by my insurance company.

MY RIGHT: I have the right to:

1) Be treated with respect and dignity.
2) Have my privacy protected.
3) Receive services which are appropriate for my age and culture.
4) Understand treatment options and alternatives.
5) Get care that doesn't discriminate based on age, gender, race, or type of illness.

PERMISSION TO TREAT: I acknowledge that it is my choice to participate in mental health therapy with the therapist of my choice; that I may withdraw my consent for treatment at any time; that my therapist may use an assortment of evidence-based treatment to meet my needs; that therapy has risks and benefits and at times we may discuss difficult topics which can cause uncomfortable feelings like sadness, anger, guilt, etc., that I may call the Suicide Hotline at 988 which is available 24 hours a day, 7 days a week; that benefits of therapy may include better functioning with self and/or others, however, there are no guarantees regarding what I may experience. I understand that mental health therapy involves active participation from me. The first few sessions with my new therapist will include rapport building, identifying needed areas, and developing a treatment plan. I may ask questions about my treatment at any time.

Print Client Name: _____

Client/Parent Signature: _____ Date Signed: _____

Print Therapist Name: _____

Therapist Signature: _____ Date Signed: _____

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NO VIDEO OR AUDIO RECORDING OF SESSIONS PERMITTED

From a legal perspective, the law requires a "two-party consent for audio or video recording of a therapy session." This means that all parties to the potential recording must consent for the recording to take place. A therapist does not have a legal or ethical obligation to allow clients to record sessions.

Client Name: _____ Date: _____

Client/Parent Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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GENERAL AUTHORIZATION FOR TREATMENT

Date: _____

Client Name: _____

I understand that this practice only provides clinical services such as individual therapy, family therapy or bariatric evaluations and does not prescribe medication.

Client/Parent Signature: _____ Date Signed: _____

Therapist Signature: _____

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FINANCIAL / INSURANCE AGREEMENT

SELECT ONE:

( ) I, _____, plan to pay for my mental health treatment directly to therapist. My therapist's rate for a 53-minute session is $100.00. I understand that payment is due prior to each session. (If you chose this option, just sign and date below).

( ) I, _____, plan to use the following insurance for my mental health treatment:

POLICY HOLDER INFORMATION: A copy of your insurance card is required at the time of service.

First Name: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Social Security#: _____
Employer/School: _____
Cell Phone: _____ Work Phone: _____

AGENCY/INSURANCE INFORMATION

Primary Insurance Carrier Name: _____ Insured's Policy#: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
EAP Name: _____ Authorization#: _____ Number of visits: _____
Start Date: _____ Stop Date: _____
Secondary Insurance: Yes No
If Yes, Insurance Carrier Name: _____ Policy#: _____
Subscribers Name: _____ Subscribers Date of Birth: _____

Please read the following carefully and sign below.

Assignment of Benefits and Release of Information for Clients with Insurance

I give permission to All Ways Mental Health Care, LLC d/b/a Deborah A. Martin Inc. & Associates LLC billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles, and non-covered services.

ALL CLIENTS: I understand that if I am a no-show for my session, I agree to pay a $50.00 fee. I understand that if my insurance (not Medicaid) or EAP does not cover the cost of missed visits, I agree to pay the fee before scheduling my next session.

Print Name of Responsible Party: _____
Client/Parent Signature: _____ Date: _____