AI Initial Consent for Treatment
General Consent for Evaluation and Treatment

TO THE CLIENT: Welcome! At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluations necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary evaluations and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your counselor about the purpose, potential risks and benefits of any procedure recommended for you. If you have any concerns regarding any assessment tool or treatment recommended, we encourage you to ask questions.

I voluntarily request a counselor/therapist, or the designees as deemed necessary, to perform reasonable and necessary evaluations, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, treatments, or interventions are recommended, I will be asked to read and sign additional consent forms prior to the treatments(s) or procedure(s).

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

I acknowledge that not all services provided by **Alternative Interventions, Inc** are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the Health Center as an out-of-network provider, and/or my failure to provide my insurance card.

Authorization (PLEASE COMPLETE):

I authorize payment directly to **Alternative Interventions, Inc** for services for which the Center accepts payment. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ __________________________

Signature of Client or Representative Date

____ __________________________

Printed Name of Client or Representative Date

ALTERNATIVE INTERVENTIONS, Inc

TeleMental Health Informed Consent

I, (**Client Name**),_____________________________________ hereby consent to participate in TeleMental Health with, **Anthony Bass** of **ALTERNATIVE INTERVENTIONS, Inc.**, as part of my psychotherapy in the state of Missouri only. I understand that TeleMental Health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to TeleMental Health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with TeleMental Health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to TeleMental Health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that TeleMental Health services are not appropriate and a higher level of care is required.

6) I understand that during a TeleMental Health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at **(314) 910.0078** to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

ALTERNATIVE INTERVENTIONS, Inc

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is **(Address and Phone Number):**

____

____

and my emergency contact person's **(name, address, phone, and relationship)**:

____

____

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_________________________________ _____________

Signature of client/parent/legal guardian Date

_________________ _____________

Signature of therapist Date

Alternative Interventions INITIAL TREATMENT PLAN

<table>
<tr><th colspan="2">CLIENT</th></tr>
<tr><td colspan="2">NAME:</td></tr>
<tr><td>DOB:</td><td>AGE:</td></tr>
<tr><td colspan="2">SSN #:</td></tr>
<tr><th colspan="2">BRIEFLY DESCRIBE REASON FOR REFERRAL or VISIT</th></tr>
<tr><td colspan="2">(e.g. infidelity, Frequent arguments, difficulty resolving problems, frequent misunderstandings, poor communication, or boundary violations)</td></tr>
<tr><th colspan="2">BRIEFLY DESCRIBE PROBLEM/SYMPTONS</th></tr>
<tr><td colspan="2">(e.g. not speaking, sleeplessness, yelling, slapping, or hitting, increased depression, anxiety, stress, or sadness)</td></tr>
<tr><th colspan="2">BRIEFLY DESCRIBE YOUR DESIRED GOALS</th></tr>
<tr><td colspan="2">(e.g. Enhance trust, develop a loving marriage or partnership, develop positive communication style)</td></tr>
<tr><td>CLIENT(s) /GUARDIAN SIGNATURES:</td><td>DATE:</td></tr>
<tr><td>CLINICIAN SIGNATURE:</td><td>DATE:</td></tr>
</table>

By signing this document you agree to allow this initial treatment plan agreement to serve as authorization for your initial treatment plan and verbal permission for the development of a modified master treatment plan based on assessment outcomes and ongoing issues presented during the course of your treatment while utilizing a telehealth platform.

Alternative Interventions, Ins

NO SHOW & CANCELLATION POLICY

When you schedule an appointment with at **Alternative Intervention, Inc. (AI)** office that time is reserved just for you. That is why we require **24-hour advance notification of cancellations**. You may leave a message on our voicemail any day of the week. The time you called will be posted with the message. Should you fail to show for your scheduled appointment or cancel less than the required 24 hours in advance, you will be charged a fee of **$25** for missed sessions. If you are being seen at a reduced fee and pay less than $25 per session, the fee will be your usual session charge. We appreciate the courtesy you extend to us by honoring this agreement. Please note that we **cannot** bill your insurance company for missed sessions or for late cancellations. You will not be scheduled for additional sessions by your therapist until the fee is paid.

If we are billing Medicaid, an Employee Assistance Program, or certain third parties, the $25 fee may not be applicable. In this case, after **two no shows** or cancellations within 24 hours of your appointment time, you will not be allowed to reschedule an appointment. You may be placed on a call- back list to be seen later or on a different date.

If you have **three no shows** or late cancellations within a calendar month, you may be discharged from services.

By signing this agreement, you are acknowledging that you understand the policies listed above and that you will abide by this agreement.

I, the undersigned, accept and agree to all the above terms during my treatment at **Alternative Interventions, Inc**.

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Printed Name of Client

____ ____________________

Signature of Client Date

____ ____________________

Signature of (MSS) Staff Date

Notice of Alternative Interventions, Inc. Privacy Practices

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is especially important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the state of Missouri to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice took effect on April 14, 2007 and will be in effect until we replace it. We have the right to change any of these privacy practices if those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at **Alternative Interventions, Inc.** These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy at no charge to you. If you request a copy of this notice at any time in the future, we will provide you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information…

1. To your physician or other healthcare provider who are also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third-party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization, it will only impact your health information from that point on.

7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that is necessary to respond to the emergency.

8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a client is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our organization's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

____ ____________________

Client Signature Date

____ ____________________

Staff Signature Date