Client Information

ARROW
COUNSELING SERVICES

Today's Date: _____

Full Name _____

Preferred Name _____

Date of Birth _____ Age _____

Gender_____

Phone _____

Email _____

Address _____City/State/Zip _____

Occupation _____ Employer _____

Relationship Status (please circle) Single / Engaged / Married / Widowed / Separated / Divorced / Remarried / Cohabitating

Partner's Name _____

Partner's Occupation _____

List members of your family and/or all others living with you

Name	Gender (M/F)	Age	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When you are contacted, I want to ensure your confidentiality and privacy.
Please indicate whether or not a detailed message may be left.

Primary Phone _____
Detailed Voice Message Yes / No Text Message Yes / No

Secondary Phone _____
Detailed Voice Message Yes / No Text Message Yes / No

Person to notify in an emergency:
Name _____ Phone _____
Relationship to Client _____

If the client is under 18 years of age, complete this section:

Parents' Marital Status Single / Engaged / Married / Widowed / Separated / Divorced

Mother's Name _____
Primary Phone _____ Text Message Yes / No

Address_____ City, State, ZIP _____

Employment _____

Father's Name _____

Primary Phone _____ Text Message Yes / No

Address _____ City, State, ZIP _____

Employment _____

If divorced, have parents remarried? Father: Yes / No Mother: Yes / No

Name of custodial/ primary residential party _____

If there are step-parents, please provide their names:

Step-Mother _____ Step-Father _____

Counseling Information

Please describe your primary reason for seeking therapy services.

_____

_____

Are your concerns affecting your job or school? If so, how?

_____

_____

What are your goals for counseling?

_____

_____

In what ways do you expect counseling to help you?

_____

_____

What would be a sign that you are getting on track?

_____

_____

How did you hear about me?
____ Referral - If so, from who? _____
____ Psychology Today
____ Google
____ Social Media

Medical/Mental Health History:

Are you currently under a physician's care? Yes ____No ____

If yes, tell me more: _____

Are you currently taking any medication? Yes ____ No ____

If yes, please list below:

Medication	Reason	Dosage	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had previous therapy experiences? Yes ____ No ____

If so, when and where? _____

List any current medical or mental health diagnosis:

_____

Have you ever been hospitalized for medical concerns? Yes ____ No_____

Have you ever been hospitalized for mental health concerns? Yes ____ No ____

Have you ever been arrested or convicted of a crime? Yes ___ No ___
If yes, tell me more:

_____

How would you describe your spiritual life?

_____

Who do you currently use for social/emotional support?

_____

Have you experienced a traumatic experience/ event? Yes ___ No___
If yes, tell me more:

_____

Please check all that apply to you:

Present	Past		Present	Past	
☐	☐	Anxiety	☐	☐	Trauma
☐	☐	Panic Attacks	☐	☐	Problems at Work
☐	☐	Shyness/ Social Anxiety	☐	☐	Problems at School
☐	☐	Obsessive/ Compulsive Behaviors	☐	☐	Problems in Relationships
☐	☐	Paranoid Thoughts	☐	☐	Problems in Parenting
☐	☐	Hearing Voices	☐	☐	Financial Concerns
☐	☐	Depression	☐	☐	Family of Origin Issues
☐	☐	Irritability	☐	☐	Faith Concerns
☐	☐	Stress	☐	☐	Chronic Pain
☐	☐	Fatigue/ Low Energy	☐	☐	Chronic Illness
☐	☐	Difficulty Concentrating	☐	☐	Difficulty Sleeping
☐	☐	Isolation from Others	☐	☐	Poor Hygiene
☐	☐	Aggressive Behavior	☐	☐	Alcohol and/or Drug Use
☐	☐	Thoughts of Self-Harm	☐	☐	Pornography Use
☐	☐	Thoughts of Harming Others	☐	☐	Excessive Video/ Online Game Use
☐	☐	History of Self- Harm or Suicidal Thoughts	☐	☐	Unwanted Sexual Experience
			☐	☐	Patterns of Disordered Eating
☐	☐	History of Harming Others	☐	☐	Recent Death or Loss

FAMILY MENTAL HEALTH HISTORY: (Check any of the following that are/were present in your family and who)

_____ Depression _____

_____ Anxiety _____

_____ Substance Abuse _____

_____ Suicide Attempt _____

_____ Sexual Abuse _____

_____ Eating Disorder _____

_____ Other Psychiatric/ Emotional Disturbance (explain) _____

_____

INFORMED CONSENT AND HIPAA NOTIFICATION

The following information is provided to assist clients in understanding policies & procedures.

Appointments

Your first appointment will be the Intake Session where I get information about your story, your current concerns and goals for coming to therapy. After this initial assessment, we will schedule future sessions. I normally recommend new clients come weekly at the beginning if possible so that we can dive into the work more efficiently but ultimately it is up to each client on what they feel they need. When you arrive for your session, please have a seat in the waiting area and I will come meet you at the time of your session.

Cancellation Policy

Please give me at least 24 hours notice if you must cancel a session. Sometimes illnesses or other emergencies might prevent you from this, which is perfectly understandable and we can discuss that at the time. However, that time is reserved specifically for your session, so I must charge you **70% of the session fee if it is not canceled at least 24 hours in advance.** This helps to offset my lost hour of work but also keeps you from having to pay the full session fee. I will bill the late cancellation fee to the credit card on file, unless you request me to do otherwise.

Emergencies and Telephone Calls

While you will be seen at a reserved appointment time that fits your individual scheduling demands, there may arise situations when you feel as though you need to speak with me between appointments. If you feel such a need, you may call, message, or email me and I will get back with you as soon as I can. If the call will be longer than 5-10 minutes, I may suggest a 25 minute phone session at half the price of a regular session.
If you are experiencing an emergency, you need to go immediately to the emergency room at the nearest hospital or call the crisis hotline at 855-274-7471.

Benefits & Risks

Counseling can involve both benefits and a degree of risk. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and loneliness. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Therapy often leads to better relationships, solutions to specific problems, and regulation of distressful feelings. Through this process, we will target your specific treatment needs and identify the therapeutic modalities that work the best for you. The therapist-client relationship often involves self-disclosure and confrontation, as well as encouragement and support.

HIPAA Notification for Clients

Arrow Counseling Services is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by informing clients of how they use and disclose personal health information (PHI). PHI includes the following:

Name; Address; Telephone Number; E-mail Address; Social Security Number; Medical Information (including initial assessment, progress notes, discharge summaries, treatment plans, etc. Any documentation related to your care)

Client Records of Disclosure

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of at the individual's home.

Please make sure you have indicated on the second page ways you wish to be contacted or not contacted

Issues of Confidentiality and Privileged Communications

Privileged communication laws in the State of Tennessee means that no one is allowed to gain access to your personal information (PHI) without your expressed, written consent. All communications are kept private, confidential, and privileged. This is a key aspect of the counseling relationship and one that we work to protect in all situations.

Occasionally, however, for your safety and the safety of others, it becomes necessary for confidentiality to be broken.

The following is a list of serious events for which, by Tennessee State Law, your therapist is required to break confidentiality: (a) If there is imminent danger of serious harm to yourself and/or other people, a therapist may reveal such information to the intended victim and/ or agencies necessary to prevent such harm to yourself or another person; (b) If there is evidence revealed of physical and/or sexual abuse of children, the therapist must report this information to the appropriate authorities; (c) If a court of law issue a legitimate subpoena, ReEnvision Counseling is required by law to provide the information specifically described in the subpoena. (d) for therapists who are under a temporary license and receiving supervision from a licensed professional to collaborate and gain support. (e) for the purpose of pursuing professional excellence, we will occasionally collaborate with our team of professionals in staff meetings, but we always ask a client's permission before using any identifying information.

Telehealth Services

In the event that the client and therapist cannot meet in person for sessions, there is the option to participate in Telehealth Services.

"Telehealth" can include both video and audio forms of communication, via the internet or telephone. Telehealth services do not include texting or email. Advantages and disadvantages exist in using this method as it offers a way to assist people to meet their mental health needs digitally; however, it may not provide the same level of comfort or seem as complete when talking about personal or private matters. Ultimately, in-person sessions are recommended if possible but it is understandable that there will be limits at different times so telehealth is a great alternative.

Scheduling a telehealth appointment involves reserving time specifically for you. Just as with in-person appointments, you are responsible for keeping all telehealth appointments. Cancellations and unkept appointments are treated just like in-person cancellations and unkept appointments, which means the 70% of the fee will be charged. The therapist is not responsible for the client's ability to participate in the session, including technological limitations.

The link for the video session is:

Doxy.me/micahloyd

When the client logs in, they will be in the "waiting room" until the therapist begins the video call. The client is responsible for their own hardware and software, audio and video peripherals, and connectivity and bandwidth considerations.

At the time of the telehealth appointment, it is the client's responsibility to have their electronic device on, video conferencing software launched, and be ready to start the session at the time of the scheduled telehealth appointment.

Confidentiality

The laws that protect the confidentiality of your medical information in the office also apply to telehealth sessions, including mandatory and permissive exceptions to confidentiality.

The client and psychotherapist both agree to keep the same privacy safeguards as during an in-person session. The environment should be free from unexpected or unauthorized intrusions or disruptions to our communication. There is a risk of being overheard by a third party near you if you do not conduct the session in an enclosed private room, with reasonable sound barriers, and with no one else present or observing.

The client and therapist both agree to not record the telehealth sessions without prior written consent of both parties.

Security

No electronic transmission system is considered completely safe from intrusion. Interception of communication by third parties remains technically possible. Due to the complexities of electronic media and the internet, risks of telehealth include the potential for the release of private information, including audio and images. So, the therapist cannot fully guarantee the security of telehealth sessions. You are responsible for information security on your computer, laptop, tablet, or smartphone.

Payment

Just like in-person services, telehealth services are a professional service, and a fee is charged at the same rate as in-person services.

Statement of Client Rights & Responsibilities

Client Rights - Clients have a right to the following:

- To be treated with dignity and respect.
- To fair treatment in accordance with Title VI of the Civil Rights Acts of 1964 and to not be discriminated against. Services are offered to all eligible persons regardless of their race, religion, ethnicity, gender, sexual orientation, age, disability, income level, etc.
- For all their treatment and information to be kept private. Records may only be released by client's permission.
- To easily access timely care in a timely fashion.
- To know about their treatment choices, regardless of cost or coverage by a client's benefit plan.
- To share in developing their plan of care
- To information in a language they can understand.
- To a clear explanation of their condition and treatment options.
- To ask their provider about their work history and training.
- To know about advocacy and community groups and prevention services.
- To give input on this Statement of Rights and Responsibilities.
- To freely voice concerns or complaints and to have those acted upon.

- To know of their rights and responsibilities in the treatment process.

Client Responsibilities - Clients have a responsibility to do the following:

- To give providers honest information so that providers can deliver the best care possible.
- To ask questions about their care and/or treatment in order to better understand it.
- To follow the treatment plan.
- To tell their provider and primary care doctor about medication changes, including medications given to them by others.
- To keep their appointments. Clients should call their providers as soon as they know they need to cancel visits.
- To let their provider know when the treatment plan isn't working for them.
- To let their provider know about problems with payment.
- To report any abuse or fraud.
- To openly share any concerns they may have about the quality of care they receive.
- To treat those giving care to them with dignity and respect.

FEE PAYMENT POLICY AND AUTHORIZATION FORM

Payments are to be made at the time of the session unless other arrangements have been made. The fee is based on a clinical hour of 50 minutes. The payment can be made by way of cash, check or card. Checks can either be made to 'Micah Loyd' or 'Arrow Counseling.' If you choose to pay with a card, there will be an additional $5.00 fee added to your payment.

50 minute session - $125
80 minute session - $190

Subpoena to Court for Expert Testimony-	
Non-Refundable Up-Front Retainer fee:	$500/ one-time fee
Court Appearance and Preparation:	$250/ hour
Additional Expenses for Court/ Additional Practice Fees	TBD

Insurance/ Third Party Billing

I will gladly create a superbill with the information needed to file an insurance claim. Coverage for therapy varies according to a client's plan and the insurance company. Full payment for the session is due at the time of service. I do not file insurance claims, and I am not on insurance panels. The superbill will be sent to you so that you can submit it to your insurance company for possible reimbursement.

GOOD FAITH ESTIMATE

What is it?
Beginning January 1, 2022, federal laws regulating client care have been updated to include the "No Surprises" Act. Under the law, healthcare providers need to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services called a "Good Faith Estimate" (GFE) explaining how much your medical care will cost.

The act is described as "new federal protections against surprise medical bills. Surprise medical bills arise when insured consumers inadvertently receive care from out-of-network hospitals, doctors, or other providers they *did not choose*." This new regulation is designed to provide transparency to patients regarding their expected medical expenses and to protect them from surprises when they receive their medical bills. It allows patients to understand how much their health care will cost before they receive services.

How does this affect me in therapy here?
It is highly unlikely this would affect our work together. There will be no situation in which you would "inadvertently" receive care from me or with no choice. Also, the final rules about how to implement this in a practice such as mine have not been written yet by the federal government. I am "out of network" for all insurance companies. My practice is private pay only; I do not charge, bill or engage with insurance companies. I avoid diagnoses when possible. I only accept cash, check or credit card payments at the time of service. My fee is stated up front and is predictable. I do not carry balances. The fee for one session must be paid before the next session starts.

There are a number of factors that make It challenging to provide an estimate on how long it will take for a client to complete therapeutic treatment, and much depends on the individual client and their goals in seeking therapy. Some clients are satisfied with a reduction in symptoms while others continue longer because it feels beneficial to do so. Others begin to schedule less frequently, and may continue to come in for "tune ups" or when issues arise. Ultimately, as the client, it is your decision when to stop therapy.

How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and I will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge or less frequent visits.

According to the American Psychological Association, "on average 15 to 20 sessions are required for 50 percent of patients to recover as indicated by self-reported symptom measures". Additionally, they state

that through the working relationship between the client and counselor sometimes the preference is for "longer periods (e.g., 20 to 30 sessions over six months), to achieve more complete symptom remission and to feel confident in the skills needed to maintain treatment gains". (https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment)

The counselor is the expert in the field, and the client is the expert in their own life. The counseling journey is a shared process between therapist and client at every turn of therapy, and it is neither practical nor possible for organic, healthy growth to occur if the therapist and client are continually tasked with re-writing an expense projection every step of the way.

Clients are always encouraged to voice their thoughts and preferences, including choice of therapist, session length, types of interventions used, and focus of each session. Therapists are tasked with providing clinical and financial feedback to clients about various ways to reach these goals and reasonable expectations concerning the parameters clients desire.

For a good faith estimate: the amount you would owe if you were to attend therapy for 52 sessions in a year (weekly, without skipping any weeks for holidays, break, vacation, unplanned events/sickness, etc.).

A GFE for my services is simple = Fee per session X Number of Sessions.

Example: $125 x 52 (50 min, sessions in a year) = $6,500
$190 x 52 (80 min, sessions in a year) = $9,880

The above examples are provided to give an idea of the financial expectations for a calendar year. The frequency and duration is dependent on your individual needs, goals, and desires. The number of sessions is determined collaboratively and cannot ethically or realistically be estimated, and certainly not before we've gotten to know each other.

Disclaimer:

- This Good Faith Estimate shows the cost of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment

We prefer an overly cautious and conservative approach when asked to project a client's potential expense. Rest assured that I will be as transparent with you about the costs of the services we agree on together. You will have no surprises here. In the meantime, you may certainly ask me about any costs about which you may be unsure, and I will provide you with clear information.

Information required for the GFE

Services Offered: Psychotherapy Sessions (Individual, Couple, Family)

Common Diagnostic Codes Used at Arrow Counseling Services: (*however, the list is not exhaustive. With that said, diagnosis codes can change based on many factors. Please speak to your therapist with any questions or concerns.)*

- Adjustment Disorder (F43.23)
- Mental Disorder, Not Otherwise Specified (F99)
- Depression (F32.9)
- Anxiety (F41.1)
- Bipolar (F31.9)
- PTSD/Post Traumatic Stress Disorder (F43.10)

Service Codes for Services Provided:

- 90834: 45-50 minute psychotherapy session ($125)
- 90847/46: Family/Couples psychotherapy session ($125)
- 90837: 53+ minute extended psychotherapy session ($190)

Provider Information:

Name: Micah Loyd, LPC/MHSP
NPI: 1619435799
Tax ID: L0596763520
Location Where Services Provided: Services are provided in the office (575 S Royal St. Jackson, TN) or via telehealth.

WALK AND TALK THERAPY SESSIONS

I do give the option at times for a walk and talk therapy session. This is not something that can be offered every time we meet due to several factors. Please ask me about this further if this is something you are interested in. There is a separate informed consent for this type of therapy.

Arrow Counseling Services requires a credit card on file to be used only for missed appointments and late cancellation fees. In addition, you can *choose* to authorize your therapist to charge you card automatically for sessions that you attend.

Credit/ Debit Card Information

Name on Card _____ Card Number _____

Expiration Date _____ CVV Number _____

Billing ZIP Code _____ Email Address _____

Recurring Charge Authorization

The undersigned card member consents and permits Arrow Counseling Services to automatically charge the standard rate for counseling sessions that I attend. I understand there will be an additional $5.00 fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service.

_____ _____

Signature of Client or Parent/ Guardian *Date*

Authorization

By signing below, I acknowledge that I have read, agreed to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties, including organizations or individuals who are being invoiced for the client's services, for billing purposes and payment of medical benefits to the therapist.

_____ _____

Signature of Client or Parent/ Guardian *Date*

AGREEMENT TO POLICIES

By initialing and signing below, I acknowledge that I have read, understood, and agree to the following procedures and policies (please initial by each one):

_____ Client Notification of Privacy Rights (HIPPA)

_____ Good Faith Estimate

_____ Client Policies & Informed Consent

_____ Client's Rights & Responsibilities

_____ Fee Payment Policy & Authorization Form

Printed Name of Client _____

Signature of Client (or Parent/Guardian) _____

Date _____

Provider's Signature _____

Date _____

**I reserve the right to update the policies and procedures as needed but will inform the client of any changes made to what they have signed*

Therapist Contact information:

Physical Address: 575 South Royal Street - Jackson, TN 38301

Mailing address: 200 Dr. Martin Luther King Dr. #7163 - Jackson, TN 38302

Phone: 731.298.0313

Email: micahloyd@acsjackson.com

Website: acsjackson.com