INTAKE PAPERWORK

This is a multi-page PDF document that includes all of my intake paperwork - in the order listed below. Most if it is "read only". *There is **NO** need to print out this entire document! Everything can be completed at the office.*

#1 and #2 are the two main documents. These can be scanned/filled out/signed and emailed to me ahead of time - or you can just do them at the office.

1) Intake Questionnaire
2) Authorization for Treatment

#3 and #4 are "read only". Sign at the office. Don't get bogged down by their length and complexity. I'll hit the high points with you.

3) No Surprises Billing Act and Good Faith Estimate
4) HIPAA Statement

#5 and #6 are optional, based on what you need. We can complete these if applicable to you.

5) Telehealth Addendum (*only if you are doing tele-health*)
6) Release of Information (*only if you need me to release your records or information about you to a third party*)

#1 and #2 can be scanned/ filled out/ signed and emailed to me ahead of time - *or* - you can just do them at the office.

Documents #1 and #2 below

ELBOW TREE
christian counseling | neurofeedback

Clinical Intake and Personal Data

Name(s):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Other:_____

Email:_____Website:_____

(**Please circle any addresses, phone numbers or e-mails that you DO NOT want me using to reach you OR leaving a message. I do not want to compromise your confidentiality or create an uncomfortable situation.)**

Are you Married? _____ For How Long?_____

Previous Marriages? (Him)_____ How Many?_____ (Her)_____ How Many?_____

Are your parents divorced? (Him):_____ How old were you?_____ (Her):_____ How old were you_____

Please give the following info for each person that currently lives in your home, ***including yourself***:

Name	Age	Relationship to Self

Are you currently taking any prescription psychiatric medications? _____

Dr./Drug	Reason	How Long

Do you have any current or expected legal involvement?_____ If yes, please explain:_____

_____

Are you currently under an order of protection?_____ If yes, please explain:_____

Who may we contact in the event of an emergency? Please mark your initials to give us permission to do this._____

Name:_____ Relationship:_____

Address:_____ Phone:_____

Do you currently attend a church? Which one?_____

What is your occupation? (Him):_____ (Her):_____

Have you ever been to see a counselor before? _____

Was it helpful? _____

How did you hear about Elbow Tree?_____

May we thank them for referring you?_____

What brings you to counseling today?_____

_____

_____

Do you have any other special circumstances or information that would be helpful for me to know?

_____

_____

***Are you allergic to dogs or do you have an aversion to them?_____

Our office is located in a dog friendly building and from time to time, we - or other tenants - may have one of our family dogs with us.

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Authorization, Information, & Consent for Treatment

Caleb McNaughton, M.A. - Candidate for Licensure in Tennessee

The following information is provided to our clients to assist them in understanding the policies and procedures at our office. We strive to provide care which is both affordable and of the highest quality. Please do not hesitate to ask questions at any time.

Scheduling Appointments:

To contact a therapist and make an appointment, call 423.517.7070. You may call at any time. Leave your name, a brief message and a contact number and your call will be returned as promptly as possible. Please make sure your voice-mailbox is set up, that it clearly identifies that it is yours by name, and that there is adequate space available to lodge a message in it. Unless your mailbox is clearly identified as yours, we cannot leave you a message upon our return call.

Appointments are on Eastern Time. As a courtesy, we will usually text before an appointment as a reminder. You are responsible for your scheduled time whether we are able to remind you or not. A twenty-four (24) hour notice is required if you must cancel your reserved time. Otherwise, late cancellations or no-shows will be charged the rate of your full **Session Fee**. Clients arriving late to appointments are responsible for the full **Session Fee** even though the full session will not be available. In case of inclement weather (e.g., snow and ice) please call the office to determine if we will be open.

Fees and Payment:

The fee for a 50-minute session is $110.00. Cash, personal checks, debit cards, credit cards, and health savings account cards are all accepted. All card charges will include a $3.00 service fee. It is the policy of *Elbow Tree Christian. Counseling, LLC* that the **Session Fee** is to be paid at the beginning of each session. There will be a $25.00 processing fee for all returned checks. An invoice or receipt will be available if you request one. If you have an upcoming session, but do not have the ability to pay, then you will need to cancel your appointment in advance and reschedule for a more suitable time.

Other contingent fees associated with your work may be: One (1) email counseling exchange, including one follow-up exchange - $60.00; other counseling related services (phone counseling, letters, preparing and sending records, etc.) - $2.00/minute. Also, counselors with the Co-op are not able to participate with insurance or as an out-of-network provider. No Co-op counselor is qualified to be a part of any court-ordered or legal process.

Fee Payment Agreement

I understand and agree that I will be charged for and required to pay for missed appointments, at the full **Session Fee**, if not cancelled at least 24 hours in advance.

50-minute Session Fee **$** _____

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

Communication Security:

Your confidentiality is of the utmost important to us. Outside of the counseling room, our communications can include telephone, video chatting, texting, email, snail mail, and online scheduling. When communications are "secure", it indicates that there are means in place, such as encryption, to keep things private. Front to back end encryption means that the sender and receiver are both operating on a secure & private channel. Ask your particular counselor about opportunities we have for you to participate in secure video chatting, email and texting. Telephone conversations and online scheduling are not able to be secured at this time, so keep this in mind when choosing to utilize these means of communication. It is our practice policy, in compliance with HIPAA, to not send a client's PHI (protected health information) over unsecured channels. PHI would include any "personally identifiable" health data. If you, as a client, send your PHI to us, it will be unsecured unless we have pre-established a secure channel together.

I accept and affirm *Elbow Tree Christian. Counseling*'s policies regarding secured communications pertaining to my PHI. My initials indicate that I accept, understand, and assume the risk of telephone calls, video chatting, texting, emailing and online scheduling that is not sender-receiver-sender encrypted. _____ (initials)

Emergencies and After-Hours Communication:

After office hours, if your situation is a medical emergency, please call 911 immediately or your local emergency services for assistance. Should you call or email me between appointments, please provide a clear message and include your return contact information. Your call or email will be responded to as promptly as possible, generally between 24-48 hours. Any in-between session communication will be subject to a reasonable fee, as stated above. In order for me to return your call and, if necessary, to leave you a voice-mail, please be sure your mailbox is set up, that it clearly identifies that it is yours by name, and that there is adequate space available to lodge a message in it. Unless your mailbox is identified as yours, I cannot leave you a message.

Supervision:

I, *Caleb McNaughton*, hold a master's degree in Clinical Mental Health Counseling and am actively seeing clients as a Candidate for Licensure in the State of Tennessee. I contract with Elbow Tree Christian Counseling, which provides me with an appropriate clinical setting, further professional development and weekly supervision as I accumulate direct client hours and supervision required for me to eventually be licensed in Tennessee. Once licensed, I will be able to practice on my own as an independent practitioner. My supervisor is Eryn Wilkinson, LPC-MHSP, Approved Supervisor in TN. Eryn has 8 years of clinical experience and has been supervising recent graduates from their master's programs, like myself, for 1 year. Her contact number is: 423.255.2310.

Privileged Communications:

Mental Health Providers, like myself, have a strong privileged communication law in Tennessee, which carries virtually the same legal status as that of attorney-client. As the client, your disclosures and communications are considered privileged and confidential, and your records are protected under federal and state regulations governing confidentiality and cannot be disclosed or released without your written consent unless the following circumstances are believed to or do exist; *(1) where the abuse or endangering neglect of children, the elderly, or the disabled or of incompetent individuals is known or reasonably suspected; (2) where the validity of a will of a former client is contested; (3) where such information is necessary for the counselor to defend him or herself against a malpractice action brought by a client; (4) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor; (5) in the context of civil commitment proceedings, (6) where an immediate lethal threat of self-inflicted harm is disclosed to the counselor; (7) where the client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue and the clinical record is required by the court, (8) where the client is examined pursuant to a court order, and (9) within the process of supervision and/or peer consultation, where I will need to review "non-identifying details" of your case with other counseling professionals.* With the foregoing exceptions in mind, all aspects of your record are kept private, confidential, and privileged unless you specifically sign and authorize a release of information divulging information from your clinical record.

Your Informed Consent to Receive Care:

INTAKE INTERVIEW: The intake interview is an opportunity for you and I to begin the work of identifying and evaluating the situation you are presenting. A main goal of this initial interview is to match your identified needs with the most helpful resources available. Occasionally, this will mean a referral to another therapist at Elbow Tree, the Cooperative, or an outside professional or agency. If an outside referral is deemed appropriate, the Cooperative will make every effort to connect you with the therapeutic resources best suited to meet the needs with which you initially present.

LIMITATIONS OF SERVICES: I understand that *Elbow Tree Christian. Counseling* services are limited to psychological and spiritual evaluation, assessment, consultation, and intervention. I understand that interventions may include consultation, counseling, and psychotherapy oriented toward helping you face life's challenges from a Biblical perspective. I understand that *Elbow Tree Christian. Counseling* is not promising a cure or offering any guarantee of results or improvement of any condition or situation. I understand that while Tennessee law may permit minors sixteen years and older to consent to mental health care without parental consent, Elbow Tree does not treat minors without parental permission or authorization.

ASSUMPTION OF RISKS: I understand that the potential risks of undergoing psychological and/or counseling services may include limited precision of psychological assessment procedures, possible disagreement with the opinions offered to me, and possible increased emotional distress concerning my situation. I also understand that any court order requiring me to obtain psychological services is an obligation solely between myself and the courts and NOT the provider. I accept full responsibility for payment of all charges rendered under such obligations.

COMPLAINT PROCEDURES: If you are dissatisfied with any aspect of our work, please inform Greg Seymour, owner of Elbow Tree Christian Counseling, immediately. This will make our work together more efficient and effective. If a problem arises requiring a legal remedy to solve, the client agrees to solve all problems through the means above or independent mediation and not in the pursuit of formal litigation.

Complaints should also be registered with the Tennessee Department of Health, Attn: Office of Investigations, 665 Mainstream Drive, 2nd Floor, Suite 201, Nashville, TN 37243, (1.800.852.2187).

Patient Authorization & Consent for Treatment

You have been provided with the preceding information fully informing you about the policies of our office and some of the parameters of the care you will receive. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered to a client. Since such limitations are always a function of the particular situation in question, an individualized treatment plan will be constructed and discussed with you. Please discuss any questions you have regarding these policies and/or procedures with me.

By signing below, you are acknowledging that you have read, understood, and are fully consenting to the policies and procedures of *Elbow Tree Christian. Counseling*, LLC. Your signature acknowledges your complete authorization for treatment and informed consent for care.

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

_____ _____

Witness Date

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. The Patient Notification of Privacy Rights document, provided to you, is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please ask for your therapist to provide you with further clarification.

By law, *Elbow Tree Christian. Counsel*, LLC is required to secure your signature indicating you have reviewed this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Greg Seymour, M.A., LPC-MHSP
HIPAA Compliance Officer

I, _____, have personally reviewed and, as needed, achieved a satisfactory understanding with my counselor of the Patient Notification of Privacy Rights document which provided me with a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I am satisfied with my understanding of this document and am signing this "acknowledgment form" as evidence of my satisfaction.

_____ _____
Signature of adult client or parent/legal guardian of client less than 18 years of age Date

_____ _____
Witness Date

☐ Copy of *Patient Notification of Privacy Rights* made available to client/parent/guardian

☐ Copy of *Patient Notification of Privacy Rights* declined by patient/parent/guardian

#3 and #4 are "read only". Sign at the office. Don't get bogged down by their length and complexity. I'll hit the high points with you.

Documents #3 and #4 below

ELBOWTREE GROUP

3069 S. Broad St. #7d - Chattanooga, TN 37408 - or - 1307 Hixson Pk. Chattanooga, TN 37405 - 423.517.7070

Dear Client,

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment. Please sign and date before your next appointment and return the signed document before your next appointment. If you have any questions, please don't hesitate to ask.

Thank you very much,

Elbow Tree Group

ELBOWTREE GROUP

3069 S. Broad St. #7d - Chattanooga, TN 37408 - or - 1307 Hixson Pk. Chattanooga, TN 37405 - 423.517.7070

THE NO SURPRISES ACT - STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider isn't in your health plan's network. This means the provider doesn't have an agreement with your plan. **Getting care from this provider could cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills, for example,

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You will owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider.

Patient name: _____

Date of Birth: _____ **Diagnosis:** _____

Out-of-network provider: _____

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you

are pursuing mandatory treatment. Please see the breakdown below of possible fees.

► **Review your detailed estimate.** See our good faith estimate below for a cost estimate for each item or service.

► **Call your health plan.** Your plan may have information about how much of these services are reimbursable.

► **Questions about this notice and estimate?** Call Greg Seymour, Elbow Tree Group Director, at. 423.517.7070

► **Questions about your rights?** Contact: Tennessee Board of Health, Call: 615.741.5735 or email: Unit1HRB.Health@tn.gov

Prior authorization or other care management limitations for In-Network provider services

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

By signing, I freely give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from the following provider:

□ _____

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under Federal law.
- I will get a bill for the full charges for these items and services.
- I was given a written notice on ___/___/___ explaining that my provider isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider in writing before getting services.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

The amounts below are only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed, subject to change and notification. It doesn't include any information about what your health plan may cover. **Contact your health plan to find out how much, if any, your plan will pay.**

It is Elbow Tree's published policy that we are "Out-of-Network" with all insurance companies and you simply pay the full session fee when you come. If you wish, licensed counselors can provide you with an itemized receipt for services you can use in filing for a possible reimbursement of a portion of your paid fee for service.

ELBOWTREE GROUP

3069 S. Broad St. #7d - Chattanooga, TN 37408 - or - 1307 Hixson Pk. Chattanooga, TN 37405 - 423.517.7070

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you isyour plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill

you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

(1) Greg Seymour, owner of the Elbow Tree Group by calling (423) 517-7070 or emailing greg@elbowtree.com

(2) The Tennessee Board of Health: The Health Care Complaint Portal allows consumers to file a complaint with the appropriate state agency. You will be asked a series of questions to help identify the nature of your complaint. After you have answered all of the questions, you will see a summary page with instructions on how to file your complaint.

Visit https://www.tn.gov/health/health-program-areas/health-professional-boards/report-a-concern.html

(valid from 7.1.23 until further notice)

CLIENT NAME: _____

Date of Service (If Known)	Service Code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evlauation, 50 minutes	$110.00
	90834	Psychotherapy, 38-52 minutes	$110.00
	90837	Psychotherapy, > 52 minutes (This fee is my hourly rate & is used for all prorated calculations as indicated.)	$2.20 / minute
	90846	Family Psychotherapy without Patient Present, 50 mintues	$110.00
	90847	Family Psychotherapy with Patient Present, 50 mintues	$110.00
	98966-98968	Telephone Assessment & Mgnt.	$2.20 / minute
	98970-98972	Online Digital Evaluation & Mgnt. (Responding to Email & Text Messages)	One (1) email counseling exchange, including one (1) follow-up exchange - $55
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Notice	You are Responsible for the Full Fee of the Missed Appointment - $110
	Production of Records	Copying, Collating, Notarizing, Mailing	$2.20 / minute
	Legal Engagement Fees	Phone Consults, Letters, Travel Time, Attendance at Court, etc. A minimum prepaid fee of eight (8) hours will be required per day to appear at court.	Prepaid $250.00 / Hour
	Returned Checks		$25.00 / Check
	All card charges	Debit cards, Credit cards, HSA cards used as payment for fees	$3.00 / Transaction / Hour

	Total Estimate:	This **Good Faith Estimate** explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and /or services you may need to receive the greatest benefit

ELBOWTREE GROUP

PATIENT NOTIFICATION OF PRIVACY RIGHTS

HIPAA

(THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

Updated January 1, 2022

Please do not remove from the office.

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, The Elbow Tree Group (ETG) [Elbow Tree Christian Counseling LLC, Christian Counselor Cooperative LLC (DBA - Elbow Tree Associates), Elbow Tree Counseling and Neurofeedback LLC, Watershed Counseling and Consulting, LLC and Foxhole Strategic Life Coaching LLC] is required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. You will have an opportunity to sign on the Professional Disclosure and Counseling Agreement. Thank you for your thoughtful consideration of these matters.

Greg Seymour, M.A. LPC-MHSP
Licensed Professional Counselor
Mental Health Service Provider
HIPAA Compliance Officer

I. Preamble

The Psychology Licensing Law provides extremely strong privileged communication protections for conversations between your Counselor and you in the context of your established professional relationship with your Counselor. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes and Raw Test Data and Protocols" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient himself/herself.

HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three (3) components: *Treatment, Payment, and health care Operations (*TPO*).*

Treatment refers to activities in which the Counselor provides, to coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when ETG obtains reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations (O) are activities related to the performance of ETG clinicians such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary".

The *use* of your protected health information refers to activities our office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* our office related to your care. *Disclosures* refers to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

Tennessee requires authorization and consent for treatment, payment and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. HMS may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing ETG to provide treatment and to conduct the administrative steps

associated with your care (i.e., file insurance for you).

Additionally, if you ever want ETG to send any of your protected health information of any sort to anyone outside the ETG office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of you signing an additional authorization form is an added protection to help insure that your protected health information is kept strictly confidential. An example of this type of release of information might be your request that a ETG clinician talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before a ETG clinician talks to that teacher, you will have first signed the proper authorization for the ETG clinician to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: the clinician's psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychologist-patient in treatment settings, HIPA permits keeping separate "psychotherapy notes." Psychotherapy notes are kept separate from the overall "designated medical record." "Psychotherapy notes and test forms and raw data-working notes" cannot be secured by insurance companies, nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are the clinician's notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that separated from the rest of the individual's medical record". "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes," which provide the following information about your care each time you have an appointment at ETG offices: medication prescriptions and monitoring, assessment/ treatment length of service, the modalities of care, frequency of treatment furnished, *results* of clinical tests (not raw data and test protocols-copyrighted test materials), and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing the release the clinician's psychotherapy notes. Most of the time release of the information in your record will be limited to only your "designated record set" which includes the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing (not raw data or protocols), and any authorization letters or summarizes of care you have authorized to be released on your behalf. Please note that the actual test questions or raw data of psychological tests which are protected by copyright laws and the need to protect patients from unintended, potentially harmful use are not part of your "designated mental health record".

You may, in writing, revoke all authorizations to disclosure protected health information at any

time. You cannot revoke an authorization for an activity already done through your previously signed authorization or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that ETG train and monitor the conduct of those performing ancillary administrative services for the practice and refers to these people as "Business Associates". In ETG, "business associates" includes our secretaries who provide services such as typing, making phone calls, and filing insurance claims – all activities which bring them into some measure of contact with your protected health information. Transcriptionist services are also contracted as well as telephone answering service. Bookkeeping services are also provided. Only the treating clinician and medical records staff have access to your designated medical record. Cleaning staff also have a signed agreement and do not have access to medical records, which are kept locked in filing cabinets in a locked room in a locked building. In compliance with HIPAA, regulations HMS has signed a formal contract with these business associates, which very clearly spells out to them the importance of protecting your mental health information as an absolute condition for employment. Greg Seymour, M.A., LPC-MHSP, HIPAA Compliance Officer, trains them in privacy practices, monitors their compliance, and corrects any errors, if they should occur.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information *may* be released without your consent or authorization for:

. Child abuse
. Suspected sexual abuse of a child
. Health Oversight Activities (i.e., licensing board for Professional counselors in Tennessee)
. Judicial or administrative proceedings (i.e., if you or I are ordered by the court)
. Serious Threat to Health or Safety (i.e., our "Duty to Warn" Law, national security threats)
. Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

ETG never releases any information of any sort for marketing purposes.

V. Patient's Rights and Clinician Duties

You have a right to the following:

. *The right to request restrictions* on certain uses and disclosures of your protected health information which the clinician may or may not agree to, but if the clinician does, such restrictions shall apply unless our agreement is changed in writing;

. *The right to receive confidential communications by alternative means and at*

alternative locations. For example, you may not want your bills sent to your home address so ETG will send them to another location of your choosing;

. *The right to inspect and copy* of your protected health information in the clinician's designated mental health record set and any billing records for as long as protected health information is maintained in the record;

. *The right to amend* material in your protected health information, although the clinician may deny an improper request and/or respond to any amendment(s) you make to your record of care.

. *The right to an accounting of non-authorized disclosures* of your protected health information;

. *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and

. *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask the clinician for further assistance on these matters. The clinician is required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and the clinician's duties regarding your PHI. The clinician reserves the right to change privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of ETG policies when you come for your future appointment(s). The clinician's duties as a Counseling Professional on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and the clinician's privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. These rules constitute the internal policies for executing privacy practices at ETG.

VI. Complaints

Greg Seymour, M.A., LPC-MHSP, is the appointed "Privacy Officer" for ETG regarding HIPAA regulations. If you have any concerns of any sort concerning how ETG might have somehow compromised your privacy rights, please do not hesitate to speak to Greg Seymour immediately about this matter. You will always find him willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written compliant to the Secretary of the U.S. Department of Health and Human Services.

VII. This notice shall go into effect April 1, 2003 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

#5 and #6 are optional, based on what you need. We can complete these if applicable to you.

Documents #5 and #6 below

ELBOW TREE
christian counseling | neurofeedback

3069 S. Broad St. #7d - Chattanooga, TN 37408 - 423.517.7070 - www.elbowtree.com

Authorization for Release of Information

I, _____, authorize Caleb McNaughton, M.A., to:
(patient or guardian)

_____ provide information as indicated: _____

_____ exchange information as indicated: _____

_____ receive information as indicated: _____

regarding _____ treatment and status to/with/from:
(patient's name) (circle)

Name:_____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that I may revoke this consent at any time by written request to the authorized person. The revocation is effective on the date the request is received and placed in the medical record.

Patient's DOB___/___/___ and SS#:_____

_____ _____

Signature Date Witness Date
(Patient or Guardian)

Information, Authorization & Informed Consent Addendum for Tele-Health

This is to be used in conjunction with, but does not replace, the Information, Authorization & Informed Consent for Treatment document that is required of all clients prior to starting psychotherapy/coaching services. You may find a current version of the initial Authorization document on your therapist's web page.

TELEHEALTH

If telehealth services are necessary or requested, I hereby consent to engaging in telehealth as a part of the Elbow Tree Group (Elbow Tree Christian Counseling, LLC; Elbow Tree Counseling and Neurofeedback, LLC; Foxhole Strategic Life Coaching, LLC; Watershed Counseling & Consulting) as part of my psychotherapy/coaching. I understand that "telehealth" includes the practice of diagnosis, treatment, goal setting, referral to resources, skills training, and psychoeducation through the use of internet-based video-conferencing. Telehealth psychotherapy/coaching may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy/coaching will occur primarily through interactive audio, video, email, texting and telephone communications.

Confidentiality: I understand that the current laws that protect privacy and confidentiality also apply to telehealth. Any exceptions to confidentiality are described in the Authorization document. I understand that no permanent video or voice recordings will be made or kept from telehealth sessions. I agree not to record or store video conference sessions.

Technology: I understand that I may need to download an application and/or software to use this platform if my therapist requires it. I also need to have a broadband Internet connection or a smartphone device with a good cellular connection.

Risks: I understand telehealth carries risks, including but not limited to: a) technological failures such as unclear video, loss of sound, poor connection or loss of connection; b) nonverbal cues are less readily perceivable to both therapist and client; c) limits to confidentiality. The Elbow Tree Group uses HIPAA compliant and encrypted technology for a) sending and receiving email; b) performing audio and video sessions and c) creating and storing client records. Under certain circumstances, we may use unsecured technology for a) scheduling communications; b) to navigate emergent or crisis situations or c) when Federal Emergency Protocols are in place and services need to be delivered when HIPAA compliant systems are overwhelmed or unavailable.

Financial Obligations: Fees associated with telehealth appointments are payable by credit or debit card only and reflect my current regular session fee. If a superbill is desired to file for out-of-network benefits with my insurance company, I am responsible for contacting my insurance company to determine my coverage for telehealth services.

By initialing, I am indicating that I have reviewed the "Telehealth" policy and agree to its terms. _____
By signing below, I acknowledge that my clinician reviewed all aspects of this authorization for treatment and informed consent. I understand that I may ask questions at any time regarding any aspect of this Authorization and agree to abide by its terms during our professional relationship. I acknowledge a hard copy of this Authorization has been made available to me.

_____ _____

Signature of Client (or Parent or Legal Guardian of Minor) Date