Aspirations Behavioral Health, Inc.

FOUNDER: KRISTIAN WILSON, LMHC

ADDRESS: BIGHORN TRAIL JACKSONVILLE, FLORIDA 32222

TEL: 904-597-6304

FAX: 904-404-8351

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POLICIES, PROCEDURE AND INFORMED CONSENT FOR COUNSELING

INTRODUCTION

This agreement is intended to provide you with important information regarding the policies and procedures of ASPIRATIONS BEHAVIORAL HEALTH, INC. and to clarify the terms of the professional mental health counselor relationship between your therapist, Kristian Wilson,and you/your family. Any questions or concerns regarding the consent to treatment should be discussed prior to signing it. Please read the entire document carefully and ask any questions before signing the document. Please initial each section to indicate that you have read and understood that particular section.

_____ Initial

THERAPIST BACKGROUND AND QUALIFICATIONS

Upon request, ASPIRATIONS BEHAVIORAL HEALTH, INC. will discuss its Therapist professional background information with you and provide you information regarding his/her experience, training, special interests, and professional orientation. You are free to ask questions at any time about the background, experience and professional orientation of the Therapist.

_____ Initial

PROFESSIONAL SERVICES RENDERED

ASPIRATIONS BEHAVIORAL HEALTH, INC. offers several services including Conducting mental health assessments and counselling, Online mental health counselling services, Developing individualized treatment plans, Running preventative mental wellness classes or workshops, Making treatment referrals, Leading individual or group therapy sessions and behavioral services.

_____ Initial

APPOINTMENTS AND CANCELLATIONS

Appointments are made by calling 904-606-1182, Monday through Friday between the hours of 8:00 am and 5:00 pm. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. Clients who repeatedly miss appointments may be discharged from services (see the No Show & Cancellation Policy form). Your therapist reserves the right to cancel your appointment if you show up sick or with minor children that might interfere with the counseling session.

_____ Initial

RISK AND BENEFITS OF THERAPY

Therapy is the Greek word for change. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, increased ability to relate to others, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in school, social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the client(s), including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc.

_____ Initial

FEES AND PAYMENTS

Payment for individual sessions is due at the beginning of each session. Payment for group sessions is due according to the procedures determined for each particular group. Sessions longer than your scheduled appointment are charged for the additional time pro rata. We reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payers. From time-to-time, we may engage in telephone contact with you for purposes other than scheduling sessions. You will be responsible for payment of the agreed upon fee on a pro rata basis. In addition, from time-to-time, we may engage in telephone contact with third parties at client's request and with client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis). Payment can be made in the following ways:

i. Cash
ii. Credit or Debit card

The fees are as follows:

CREDIT CARD AUTHOR1ZAT1ON

Being the cardholder, by signing below, I understand and I agree to the terms set forth in this agreement, agree to pay, and specifically authorize ASPIRATIONS BEHAVIORAL HEALTH, INC to charge my credit card for clinical services provided, for services not cancelled within 24

hours. no show fees, and any additional charges associated with my account as stated in the Payment Agreement/Fee Schedule.

ASPIRATIONS BEHAVIORAL HEALTH, INC will provide me with a weekly or monthly invoice detailing dates of services and applicable fees and will include receipts for those fees.

I further agree that in the event my cred it card becomes in valid, I will provide ASPIRATIONS BEHAVIORAL HEALTH, INC with a new valid credit card upon request to be charged for the payment of any outstanding balance.

I understand that if I fail to maintain a valid credit card, on file, for charges to my account, that I will be responsible for any legal fees associated with collection and an additional $30 collection fee on balances over 30 days past due.
_____ Initial

Please Complete the Following:

Client's Name: _____

Signature of Client and/or Guardian: _____

Name of Cardholder _____

Card Number _____ Expiring Date: _____

Security Code (3-4 digit code on the back of the card): _____

Billing Zip Code: _____

RETURN CHECK POLICY
You will be responsible for the amount of any returned checks plus a $35 returned check fee which includes bank fees and administrative costs.
_____ Initial

RECORDS AND RECORDS KEEPING
ASPIRATIONS BEHAVIORAL HEALTH, INC. will keep records in accordance with the ethical and legal standards of my profession. Records may be re-quested at any time in writing. Records will be stored in a locked file cabinet or by a secured on-line practice management software system. Records will be kept for 7 years after you've terminated therapy.
_____ Initial

RECORDING SESSION

To ensure the confidentiality of your sessions, no recording of sessions on any electronic devices will be permitted by the client or any ASPIRATIONS BEHAVIORAL HEALTH, INC. counseling staff. If it is ascertained that there would be a benefit to recording sessions or a part of sessions (for example, recording of relaxation exercises or for educational or therapeutic purposes), a written consent form must be signed by the client and ASPIRATIONS BEHAVIORAL HEALTH, INC. Counseling staff.

_____ Initial

CONFIDENTIALITY

A therapist's office needs to be a safe place where you can feel comfortable sharing personal information. Therefore, ASPIRATIONS BEHAVIORAL HEALTH, INC. Counseling adheres to a strict confidentiality policy. We will not reveal any of your personal information to anyone without your written permission. This includes all of your personal information, including your name and any other identifying information. The only exception to this rule is in cases of safety. According to the law, we are required to ensure your safety and the safety of others and will contact hospitals, police or child or adult protective services if it is suspected that you are going to attempt suicide, attempt to kill another person, if it is suspected that a child or elderly person is being abused or neglected or if you require emergency medical treatment while in our care.

If you would like us to have contact with anyone, please let us know and we will complete a Records Release Authorization form. This includes family, friends, doctors, and employers.

_____ Initial

EXEMPTION TO CONFIDENTIALITY

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

_____ Initial

MINORS AND CONFIDENTIALITY

Communications between therapists and patients who are minors (under the age of 18) are confidential. How-ever, parents and other guardians who consented for their child's treatment are often involved in their treatment. Within my professional judgment, I will discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

_____ Initial

CANCELLATION/NO SHOW POLICY

ASPIRATIONS BEHAVIORAL HEALTH, INC. requires 24hours notice if you are unable to keep an appointment. If you cancel less than 24 hours in advance, or if you do not show up for your appointment, you will be charged $120 for the missed session.

If you cancel your appointment with less than 24 hours notice, there will be a $45 charge for the missed session. However, emergencies do occur, and the fee will be reduced to a $35 charge if the appointment is cancelled for one of the following reasons:

i. You cancel because of work or school obligations.
ii. You cancel because of personal illness or illness with a family member.
iii. You cancel because of unexpected transportation problems.

There is a limit of 2 exceptions for emergencies (as listed in above) per calendar year. After 2 exceptions to the cancellation policy for late cancellations, you will be charged the full late cancellation fee of $45.

Your insurance will not pay for no shows or late cancellations. This fee is your personal responsibility. If you find yourself running late for your session, please call as soon as you are aware of the delay. Without notification that you will be late, your appointment will no longer be available after 15 minutes and you will be billed for a missed session (no show fee).

_____ Initial

DUTY TO WARN

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another

person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.
_____ Initial

THERAPIST'S INCAPACITY OR DEATH
In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent and Privacy Practices Receipt, you give your consent to another licensed mental health professional at ASPIRATIONS BEHAVIORAL HEALTH, INC. to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.
_____ Initial

TERMINATION OF THERAPHY
You may terminate therapy at any time. ASPIRATIONS BEHAVIORAL HEALTH, INC. also, reserves the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside of my scope of competence or practice, or client is not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, we will generally recommend that client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. ASPIRATIONS BEHAVIORAL HEALTH, INC. will also attempt to ensure a smooth transition to another therapist by offering referrals to client, if requested.
_____ Initial

MENTAL HEALTH EMERGENCIES
ASPIRATIONS BEHAVIORAL HEALTH, INC. does not provide 24-hour crisis intervention services for mental health emergencies (when you are in danger of hurting yourself or someone else). In the case of a mental health emergency, you can contact the following:

i. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
ii. Emergency: 911

Or

Relative or Friend (Emergency contact)

Address:	
Phone:	Email:

_____ Initial

QUESTIONS AND COMPALINTS

If you have any questions about this no-tice or any complaints about my privacy practices, or would like to know how to file a complaint with the Board of Behavioral Sciences or the Secretary of the Department of Health and Human Services, please contact me at:

ASPIRATIONS BEHAVIORAL HEALTH, INC.
ADDRESS: BIGHORN TRAIL JACKSONVILLE, FLORIDA 32222
TEL: 904-597-6304
FAX: 904-404-8351
E-MAIL: info@aspirationshealth.com
_____ Initial

ACKNOWLEDGEMENT

By signing below, client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with their therapist and has had any questions with regard to its terms and conditions answered. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in behavioral or other services with Therapist. Moreover, client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ Initial

I, _____, have read this Informed Consent document, I understand it and agree to comply.

_____ _____

Client signature Date

INTAKE FORM

Client Name: _____ Age: ___ Gender: ___ Date: _____

Date of Birth: _____ Social Security Number: _____

Home Phone number: _____ Cell Phone: _____

Employer: _____ Email:_____

Address of Residence: _____

Country of Residence: _____

Is Client the responsible party? (Circle) Yes No

Name of Responsible Party (If different from client): _____

Relationship to Client: _____

Client/Responsible Party Billing Address:

_____

Marital Status: (circle) Single Married Widow(er) Cohabitating Remarried Other

Name of Spouse or Partner: _____

Spouse or Partner Address: _____

Phone: _____ Email: _____ DOB: _____

Employer: _____ SSN: _____

Emergency Contact: _____ Phone No: _____

Address: _____

Relationship to Patient: _____

Preferred Method of Contact for Appointment Reminder or Therapist Contact

_____ Phone _____ Text _____ Email

PLEASE COMPLETE THIS PAGE IF CLIENT IS UNDER 18

Father's Name: _____ DOB: _____ SSN#: _____

Father's Address (11 different than client): _____

Mother's Name: _____ DOB: _____ SSN#: _____

Mother's Address (If different than client): _____

Parents Relationship: (circle) Married Divorced Separated Widow(er) Never Married

Client's Legal Guardian(s): _____

Provide contact information here if not listed elsewhere on form:

Address: _____

SSN#:_____ DOB: _____ Phone: _____

If parents are not together or child is currently in foster care or adopted, who has the right to make medical decisions? _____

Please provide therapist with custody and other legal paperwork needed to ensure therapist has

permission by guardians to see client. Without necessary paperwork therapist may be unable to see the client.

Aspirations
Behavioral Health
Because Everyone Needs Someone
Kristian Wilson, LMHC

PAYMENT AGREEMENT/FEE SCHEDULE

(Initial each line item and sign below)

_____ Payment is due at the time of your appointment. Cash, check, and credit card are acceptable forms of payment

_____ The standard fee for services is $120 per 50–60-minute individual, couples, or family counseling or coaching session (on the phone, in the office, virtual)

_____Co-payments are determined by your insurance carrier. Co-payments are due in full at the time of session.

_____A fee of $35 will be assessed for a returned check and future payments must be made in cash.

_____Cancellations require 24 hours notice prior to the time of the appointment. You will be charged the full agreed upon See, contained in the Cancellation Policy, for cancelling appointments with less than 24 hours notice or for missing appointments without prior notice.

_____I understand that it is my responsibility to keep a valid credit card on file for co-payments, no-show fees, and cancellation fees. I acknowledge, that should I fail to keep a valid credit card on file for these costs, which I will be responsible for all legal fees associated with collection on my account and an additional $30 collection fee.

_____Phone calls in excess of 15 minutes will be billed to the client's account in accordance with the standard session fee.

_____Treatment may be interrupted or terminated; after 2 unpaid no shows, due to 2

consecutive cancellations, or after unresolved debt of 2 or more sessions.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above Payment Agreement and enter into the agreement willingly and voluntarily.

Signature of Client or Legal Guardian: _____ Date: _____

FACILITY POLICIES

Initial on the line provided for each statement. (If client is a minor both Client and Guardian initial and sign).

_____ I understand that l am responsible for my children's behavior (If client is a minor). I agree not to leave children unattended at this facility for any reason. I understand that supervision for children is not provided before, after, or during my therapy or coaching session. I agree to pick up my children immediately alter their session.

_____ I understand while in therapy or coaching sessions, I will not be allowed to harm myself, others, or any property. 1f I become a threat of harm to any of these, the authorities wit be notified immediately arid I will be held responsible for any damages incurred.

_____ I am aware that ASPIRATIONS BEHAVIORAL HEALTH, INC. is not responsible for any items left In the therapy/coaching room during or a tier sessions.

_____ I understand that my therapist or coach is being supervised by a licensed professional and that session material may be discussed in the context of supervision, training, and consultation.

_____ I agree to give ASPIRATIONS BEHAVIORAL HEALTH, INC. permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.

_____ I understand that recommendations for nutrition, supplements, exercise and other healthcare suggestions are not intended to replace medical advice and treatment from your primary care physician.

_____ I understand that occasionally ASPIRATIONS BEHAVIORAL HEALTH, INC. sends newsletters and other information to clients and other interested parties unless otherwise personally directed/requested in writing.

_____ I/We have willingly placed my/ourselves in the program of ASPIRATIONS BEHAVIORAL HEALTH, INC. and do authorize to act in my best interests and to perform any treatment and/or coaching that is deemed proper and fit.

_____ By means of my/our signature, I/we hereby release ASPIRATIONS BEHAVIORAL HEALTH, INC., its staff and directors from all suit, libel, damages or legal litigation or any kind that could be brought against them for any reason by us on our behalf.

_____ I understand that ASPIRATIONS BEHAVIORAL HEALTH, INC. will not get involved in any regal proceedings of any kind including but not limited to custody disputes and divorce proceedings.

_____ I/We do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

I attest that I have reviewed, reviewed, understood and agreed to abide by all of the above-initialed policies, disclosures, and acknowledgements:

Client Name: _____ Signature: _____ Date: ____

Guardian Name: _____ Signature: _____ Date: _____

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Because Everyone Needs Someone
Kristian Wilson, LMHC

Please check all that apply to you and may be a focus of treatment:

Anxiety	Depression
Relationships and Boundary Issues	Parenting Concerns
Lying/Manipulation	Academic Problems (Children and Adolescents)
Behavioral Problems (Children and Adolescents)	Marital Concerns
Dealing with Divorce Parenting Concerns	Risk of harming yourself or others
Anger Issues	Developmental Problems
Sleep Problems	Confidence/Self-Esteem Issues
Feeling Isolated from Others	Afraid or Suspicious
Losing Track of Time	Nightmares
Intrusive Memories	Sexual Issues
Stress Management	Traumatic Experiences
Sexual Abuse	Physical Abuse (Including Domestic Violence)
Emotional/Mental Abuse	Loss of Control
Destructive Life Patterns	Substance Abuse (Past and/or Present)
Family of Origin Issues	Career Changes

Financial Problems

Specific Fears or Panic

Memory Problems

Other:

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about ASPIRATIONS BEHAVIORAL HEALTH INC.?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?