PERSONAL INFORMATION

Client's Name: _____

DOB: _____ Social Security No: _____ Sex: _____

Home #:_____ Cell #:_____ Work#:_____
(accept calls at work? ____Yes / ____ No)

Email address:_____

Home Address **(# & Street, City, State, Zip**): _____

_____

Contact preference: Cell # _____ Email _____

Marital Status: Single _____ Married _____ Widowed _____ Separated/Divorced _____

Family (Others living in the home):_____

Occupation:_____ Employer:_____ How Long:_____

In case of emergency contact: _____ Phone #:_____

Type of counseling sought: Individual _____ Family _____ Marital/Couples _____

Your reason for seeking counseling:_____

_____

_____

Have you previously seen a Therapist? If so - Therapist Name: _____

On a scale of 1-5 (i.e. 1-does not apply, 3-some concern, 5-significant problem) rank the response that best fits each area:

Marriage/Partner_____ Family_____ Child Rearing_____ Relationships_____ Job/School_____

Anxiety/Nerves_____ Mood/Depressed_____ General Health_____ Eating Habits_____ Finances_____

Sleeping_____ Concentration_____ Control Temper_____ Legal Situation_____ Alcohol Use_____

Drug Use _____ Spirituality _____ Other _____

Health summary – current medical problems _____

_____

Current Medication & Dosage _____

Primary Care Physician: _____

INSURANCE INFORMATION

If you plan to use Insurance to pay for services, TMg will, to the best of their ability, help you receive maximum benefits. However, you not your insurance company, are responsible for full payment of services. We will bill your insurance at our "Standard Fee" leaving you responsible for your copayment, deductible and charges not covered by the Insurance. In some cases pre-certification with your insurance company is necessary prior to sessions. If you have further questions please do not hesitate to ask.

Insured's Name:_____ Insured's DOB:_____

Insured's Employer:_____

ID Number:_____Group Number:_____

Insurance Company Name:_____/ Phone No:_____

Is there other insurance? Yes _____ No _____ If Yes list secondary Insurance information below

Insured's Name:_____ Insured's DOB:_____

Insured's Employer:_____

ID Number:_____Group Number:_____

Insurance Company Name:_____/ Phone No:_____

ASSIGNMENT OF INSURANCE BENEFITS

By signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Trinity Ministries Group Inc. to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I, _____, hereby authorize _____to pay and hereby assign directly to Trinity Ministries Group Inc., all benefits, if any, otherwise payable to me for services as described on this form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Trinity Ministries Group Inc., will be credited to my account in accordance with the above said assignments.

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I can request an Appeal directly through my Health Plan and that I risk nothing in exercising this right. I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint on my behalf directly to my Health Plan. I further understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California DOC has a toll-free number (1-800-400-0815) to receive complaints regarding health care plans. If I have a grievance I can contact my insurer and use the appeal and grievance process. If I need the DOS's help with a complaint involving an emergency appeal or with an appeal that has not been satisfactorily resolved by the plan, I can call the DOC's toll free number.

Client's Signature:_____ Date: _____

Or Signed by Personal Representative: _____

On Behalf of: _____ Date: _____

STANDARD FEE FOR SERVICES

Procedure Code	Description	LMFT Fee	Intern Fee	Trainee Fee
90791	History & Evaluation	$170.00 Initial _____	$65.00 Initial ____	$35.00 Initial ____
90832	Psychotherapy (16-37 min)	$ 60.00 Initial _____	$65.00 Initial ____	$35.00 Initial ____
90834	Psychotherapy (38-52 min)	$110.00 Initial _____	$65.00 Initial ____	$35.00 Initial ____
90837	Psychotherapy (53-89 min)	$130.00 Initial _____	$65.00 Initial ____	$35.00 Initial ____
90847	Family Psychotherapy w/Client	$125.00 Initial _____	$65.00 Initial ____	na
90846	Family Psychotherapy wo/Client	$125.00 Initial _____	$65.00 Initial ____	na
99404	EAP Psychotherapy (53-89 min)	Insurance Contract Fee	na	na
90853	Group Psychotherapy	$ 45.00 Initial _____	$45.00 Initial ____	na
90785	Add-on (ea. add'l 30 min in session)	$ 50.00 Initial _____	$45.00 Initial ____	na
90839	Psychotherapy for Crisis (60 min)	$120.00 Initial _____	$65.00 Initial ____	na
90889	Report Preparation	TBD by Therapist	TBD by Therapist	na
99056	Hourly Other explain:	TBD by Therapist	TBD by Therapist	na
LX-NS	> 24 hr. Cancel/Failed appointment	Standard Fee	Standard Fee	

NEGOTIATED FEE FOR SERVICES

A negotiated fee of: _____ per session has been agreed upon by the Therapist and the Client.

Therapist Initials: _____ Client Signature: _____

PAYMENT FOR SERVICES

TMg will accept cash, check, credit card and money orders. Your session time is very important to TMg. Streamlining payment conditions frees our counseling staff to concentrate on you and your issues when you arrive for your sessions. Therefore, TMg asks that you take the time to have your payment ready prior to your session. If you are paying by credit card you may present your card to your therapist or one of the office staff.

Returned Items (NSF), if a payment is returned by the bank there will be a $25.00 service fee in addition to the original amount of the check presented for payment.

Cancellation/No Show Policy, if I need to cancel or reschedule my appointment I must do so at least 24 hours or more in advance, otherwise I will be responsible to pay the full fee. If I do not show for a scheduled appointment I will be billed the full amount as well. Cancellation and no show charges are **NOT** covered by Insurance or VOC Compensation Program.

Client's Signature:_____ Date: _____

Or Signed by Personal Representative: _____

On Behalf of: _____ Date: _____

INFORMED CONSENT I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request. I also understand that while the course of this treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and myself.

Confidentiality, all communications made by you in the context of a therapeutic session are held in the strictest of confidence. Members of group therapy will be informed that they must be in agreement to participate. In order for information to be released to outside parties, you must sign a release of information. However, there are exceptions to confidentiality.

Exceptions: California law mandates that action must be taken in the following situations.

Danger to self or others – when information is communicated to a therapist that an individual intends to harm him/herself, or intends to harm others.

Child Abuse/Elder Abuse/Abuse of Handicapped – when a therapist (or other mandated reporter) receives information which creates a reasonable suspicion of child abuse/neglect; elder abuse; abuse of physically or mentally handicapped individuals. Information about the suspected abuse must be turned over to the appropriate governmental agency.

Escaping Prosecution – when a client attempts to use therapy as a means of escaping prosecution of a crime.

Insanity Plea – when a client makes an "insanity plea" as a defense in criminal proceedings.

Court order – when a court orders a psychological evaluation as part of legal proceedings, or your medical record is subpoenaed by the court, all information provided is accessible to the court.

Minors – when it is useful for minors to have confidentiality during therapy, except in cases specified by law, the parents have a right to information provided by the minor in the course of therapy.

Other circumstances when confidentiality may be broken.

Client's choice – if client chooses to have information released to another individual(s)

Insurance – confidentiality may be broken in order to provide the necessary information for processing insurance claims.

Client's Signature:_____ Date: _____

Or Signed by Personal Representative: _____

On Behalf of: _____ Date: _____

NOTCE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ('HIPAA") is a federal program that requires that all health records and other individually identifiable mental health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your mental health information is used.

AUTHORIZATION for RELEASE OF PROTECTED MENTAL HEALTH INFORMATION (HIPAA)

I, _____ hereby authorize
(Name of client)
_____.to release the following information
(Name of person or facility which has information)

To: _____
(Name and title or facility name to receive health information)
_____
(street address, city, state, Zip code) (Telephone number) (Fax number)

For the following purposes: _____

_____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization, I acknowledge receipt of the Notice of Privacy Practices that was given to me and I further understand that:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Client's Signature:_____ Date: _____

Or Signed by Personal Representative: _____

On Behalf of: _____ Date: _____

COMMUNICATION by EMAIL, TEXT / OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message or other electronic methods. Be informed that these methods, in their typical form, are not a confidential means of communication. If you use these methods to communicate, there is a reasonable chance that a third party may be able to intercept and eavesdrop on the messages. If there are people in your life you don't want accessing these communications, please talk with your Therapist about ways to keep your communication safe and confidential.

I _____ DO / _____ I DO NOT give permission for technology information to be utilized while I am in therapy.

_____ Text at the following number: _____ / Carrier of service: _____

_____ Email at the following email address _____

I have been informed of the risks of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive treatment. I also understand that I may terminate this consent at any time.

Client's Signature:_____Date: _____

EMERGENCY ACCESS

If you have an emergency, after regular office hours, you should contact your therapist at the number they have provided you or you may call the main office number 559-738-0700 to access your therapist personal voice mail. If this is an extreme emergency and you are unable to contact your therapist or wait for a call back please call 911 or proceed to the nearest Emergency room. You may also contact Tulare County Mental Health at 1-800-320-1616.

I have read and understand the above statement.

Client's Signature:_____ Date: _____

Or Signed by Personal Representative: _____

On Behalf of: _____ Date: _____

CREDIT CARD AUTHORIZATION

Contact/Billing Information: (as shown on credit card)

Client name if different from cardholder: _____

Cardholder Name (as shown on card): _____

_____

(street address, city, state, Zip code) (Telephone number)

Phone: _____

Credit Card Type: _____ Visa _____ MasterCard _____ American Express

Credit Card # _____ Exp. Date _____

Credit Card Security code: _____

Amount authorized: $_____

Please check the appropriate paragraph:

_____ One Time Use: I hereby authorize Trinity Ministries to charge the indicated credit the amount indicated above. This is a one-time charge authorization. I am not authorizing Trinity Ministries to setup my account within a recurring billing system; rather, I prefer to pay by check or cash on all future billings. I understand that if I want Trinity Ministries to charge any balances to my credit card in the future, I will need to submit another authorization form at that time, or choose the selection below.

_____ Recurring Billing: I hereby authorize Trinity Ministries to charge the indicated credit card on a periodic basis for the amount due on this client account. This Recurring Payment Authorization / Periodic Charge shall remain in force until cancelled by me in writing.

Authorization:

I hereby authorize Trinity Ministries to charge the indicated credit card. **I am aware that there is a policy of requiring 24 hours' notice to cancel an appointment, else the full fee is charged to the client account, and that my medical insurance, if any, cannot be charged for missed sessions**. I agree that this is either a one-time or periodic charge that will be made as indicated above, and will not dispute it in the future. In addition, I agree to reimburse Trinity Ministries for any cost involved with any dispute attempt regardless of outcome. To terminate the recurring billing process, if selected, I must cancel in writing. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this one time or recurring billing agreement with Trinity Ministries.

Signature of Card Holder (required) _____

Date: _____

CONSENT FOR TELEHEALTH SERVICES

1. PURPOSE. The purpose of this form is to obtain your consent for telehealth services with Trinity Ministries Group Inc...

2. NATURE OF TELEHEALTH. Telehealth involves the use of audio, video or other electronic communications to interact with you for appointment, treatment, care management, and self-management of your care. By consenting to telehealth services, personal health information may be discussed through the use of interactive video, audio and telecommunications technology (e.g., internet, email, or telephone).

3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telehealth include having access to your team and additional information without having to travel. A potential risk of telehealth is that because of your specific needs, or due to technical problems, a face-to-face appointment still may be necessary after the telehealth appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of your privacy. The alternative to telehealth appointment is a face-to-face visit.

4. MEDICAL INFORMATION AND RECORDS. All laws concerning access to your medical records and copies of medical records apply to telehealth. Dissemination of any information from the telehealth appointment to other entities shall not occur without your consent.

5. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telehealth appointment. During telehealth services, the Therapist will ensure he/she is in a confidential location where no one can see or hear the session. It is up to you as the consumer to protect your own confidentiality by receiving telehealth services in a private location. No one is permitted to record the session without permission from the other person(s).

6. RIGHTS. You may withhold or withdraw your consent to a telehealth appointment at any time before and/or during the appointment without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7. PHONE NUMBER: The Therapist will call you within 5 minutes if telehealth service is disrupted. What is the best phone number that we can call in the case of technical difficulties?

   (_____) _____ - _____

   Name: _____ Relationship to Client: _____

   Do you consent to treatment-related and appointment reminder text messages on the number(s) listed above? YES _____ NO _____

8. EMAIL ADDRESS: What is a current personal email address that you can receive email correspondence on?

   Email Address: _____

   Name: _____ Relationship to Client: _____

   Do you consent to treatment-related information and appointment reminder emails on the email listed above?

   YES _____ NO _____

CONSENT FOR TELEHEALTH SERVICES – CONT'D.

9. SAFETY PLAN: We need a safety plan that includes at least one emergency contact and the closest emergency room to your location in the event of a crisis situation.

   (required) Emergency Contact 1: (_____) _____ - _____

   Name: _____ Relationship to Client: _____

   (optional) Emergency Contact 2: (_____) _____ - _____

   Name: _____ Relationship to Client: _____ Nearest Emergency Room: _____

Additional Phone Numbers or Email Addresses to be used & for what purpose (if necessary):

_____

_____

The Therapist has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. Due to current COVID-19 restrictions, I am providing my verbal consent to receive telehealth services by Trinity Ministries Group Inc.

_____ **YES, I consent to receive telehealth services by Trinity Ministries Group Inc.**

_____ **NO, I do not consent to receive telehealth services by Trinity Ministries Group Inc.**

Would you like to be emailed this completed Telehealth Consent via email? **Yes** _____ **No** _____

_____ _____

Name of Client, 12 and older – Verbal Consent Received *Date*

_____ _____

Parent/Guardian Name – Verbal Consent Received *Date*

_____

Relationship to Identified Individual

_____ _____

Name of Client (please print) *Client ID*