Another Road Counseling
Registration for Minor

CLIENT INFORMATION				
Client First Name:	Last Name:	Middle:	Today's Date:	
Address:		City:	Zip:	
Date of Birth:	Identified Gender:	Sex Insurance has on file:	Pronouns:	Marital Status: S M D W Other:
Primary Phone:	Other Phone: (specify)	Social Security Number:		
If Student, School Attending & Grade:	If Working, Employer:	Nickname/what you want me to call you:		
Parent/guardian's name and phone number:	Other parent/guardian's name and phone number:			
Emergency Contact Name & relationship to you:	Emergency Contact's Phone number:			

Initial: _______ I give permission for Another Road Counseling LLC to contact the Emergency Contact(s) listed above in case of crisis or emergency.

INSURANCE INFORMATION (Include copy of insurance card)			
Primary Insurance:	Policy # or Enrollee ID:	Group#:	
Subscriber Name:	Subscriber DOB:	Subscriber SSN:	Relationship to Subscriber:
Address (if different):		City:	Zip:
Secondary Insurance:	Policy # or Enrollee ID:	Group#:	
Subscriber Name:	Subscriber DOB:	Subscriber SSN:	Relationship to Subscriber:
Address (if different):		City:	Zip:
How did you find Another Road / who referred you?			

I understand that payment is due at the time of service unless other arrangements have been made. I authorize Another Road Counseling LLC, the billing office hired by the provider, or the insurance company to release of any medical information required to secure the processing and payment of benefits. I agree to have the benefits from my insurance assigned to the provider. I agree that I am responsible for full payment of this account and all fees and costs for the collection of this account. I also understand that I will be charged $60 for a "No Show" or "Late Cancel" fee of less than 24 hours unless otherwise approved.

PARENT/GUARDIAN SIGNATURE　　PRINTED NAME　　DATE

CLINICIAN SIGNATURE　　Abigail DuPree LMSW
PRINTED NAME　　DATE

Another Road Counseling
Consent to Treatment

I understand that:

I am requesting services from Another Road Counseling LLC and authorize the therapist to provide treatment, recommendations and/or referrals considered necessary, helpful and appropriate.

Treatment is voluntarily and my consent to treatment may be withdrawn at any time. If I do not attend a therapy appointment for 2 months, my case will be automatically closed. I may reopen my case by contacting Another Road Counseling LLC to request an appointment.

I will participate in developing my treatment plan which will define a vision for my future and my goals, roles, and responsibilities as well as my wants and desires.

I may feel better from treatment, however Another Road Counseling LLC does not promise that this will happen or how long it will last. Following my treatment plan will help to give me the best chance to feel better.

Through implementation of the treatment plan, the therapist will assist me in understanding procedures used, the purpose of treatment, and the reasonable expected benefits of treatment. There are possible risks and/or discomforts associated with treatment. Alternatives to treatment which may be helpful are available on the open marketplace. There are other options for treatment available with other therapists or local clinics. At any time, I may choose to leave Another Road Counseling LLC to seek alternative treatment.

Therapy can lead to an increase in distress and symptoms and if this occurs it is my responsibility to notify my therapist of changes to ensure that services are meeting my needs and expectations.

I may be taken to an emergency room if the therapist thinks I need treatment right away that cannot be given to me at this clinic.

I have received and reviewed the Notice of Privacy Practices.

My treatment information is protected, confidential, and my therapist will respect my right to privacy.

My records and other personal data are only given out with my prior, written permission. This is done after the reason for giving out the information has been told to me unless it is for accrediting, licensing, payment, financial, therapist supervision, quality care review, insurance audit, and/or if it is an emergency.

My treatment information may also be released, by law, to the proper authority / person if it is needed to keep others or myself from being harmed.

If I am a parent of a minor, I am expected to participate in my child's treatment.

It is important that I express satisfaction and dissatisfaction with services and discuss my needs and preferences throughout my treatment to ensure that my services are meeting my needs and goals.

CLIENT SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE
CLINICIAN SIGNATURE	Abigail DuPree LMSW PRINTED NAME	DATE

Another Road Counseling
Financial Agreement

I understand that:
At the beginning of the session, I will pay for any costs not covered by my insurance company including co-pays, deductibles and uncovered services by cash or check (payable to Another Road Counseling LLC).

Some insurance require pre-authorization and some do not. If my insurance requires pre-authorization, Another Road Counseling LLC may have to obtain an authorization number. If it is my responsibility to obtain authorization, I will do so.

Every effort will be made to use my insurance. I am responsible for knowing my benefits including what is covered with my insurance policy. Depending on my insurance provider, I may be responsible for an annual deductible or copayment. It is my responsibility to keep financial accounts current including copays, deductibles, and service fees.

Another Road Counseling LLC has the right to charge me $60 for missed appointments and cancellations with less than 24 hours notification. Missed appointments or cancellations fees *cannot* be billed to my insurance company. The first late cancellation fee will be waived as a curtesy. Exceptions may be made with the consent of the therapist.

If for any reason a check is returned on my account I will be responsible for a $30 returned check fee in addition to original fee(s) for service(s).

I will inform Another Road Counseling LLC of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

If my balance remains unpaid for more than 90 calendar days and/or exceeds $200, Another Road Counseling LLC may refer my account to a collection agency and future services may be withheld.

My costs can change if my insurance benefits change. I agree to pay the fee established by my insurance company or agreed upon at the beginning of therapy. A sliding scale may be discussed if insurance is not involved depending upon my personal financial situation, and exceptions can be made with consent of therapist.

I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility.

If there are legal issues related to your case that require my communication with lawyers or attendance at court, you will be responsible to pay Another Road Counseling LLC $200 per hour for services including time spent on the phone, in person, and travel time.

I have read the above information and have had the chance to get my questions answered. I agree to the conditions and terms of this agreement.

CLIENT SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE
CLINICIAN SIGNATURE	Abigail DuPree LMSW PRINTED NAME	DATE

Another Road Counseling
Confidentiality Statement

All information shared in this office is confidential unless a specific release of information is signed by you with the following exceptions:

- You express your planned intention of harming yourself or your emotional/mental state is observed by the therapist to put you at risk.
- You express that you intend to do bodily harm to another person. (In that event, I am obligated by law to take reasonable precautions to ensure others' safety.)
- You share that you have in the past and / or present emotionally, physically or sexually abused a minor.
- You are a minor and you share that you are currently or have been physically or sexually abused, or your therapist determines that you are at significant risk.
- Your insurance company or their contracted affiliate requests information relative to payment of your claim or to audit services or another process is required to collect unpaid fees, or any legal defense is required by your therapist.
- Your therapist receives a signed court order by a judge to testify in court, or to provide records.
- You complain of physical symptoms, or you develop any physical symptoms while receiving counseling / therapy. You will be requested to obtain a physical examination to rule out medical basis for symptoms, and allow your therapist to speak with your physician.
- You are currently taking medication for a mental health condition, or if you need psychiatric care while receiving therapy, or if you have had previous Mental Health services. You will be requested to permit your therapist to speak with your prescribing physician, psychiatrist, or clinic.

In the above instances, your therapist will take appropriate action to ensure your safety. Otherwise, information cannot be revealed without your written permission. Another Road Counseling LLC has no control over the confidentiality of any information once it is disclosed outside of this office. If you have any questions about who has access to your information, please contact others to whom you have authorized information to be released.

CLIENT SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE
CLINICIAN SIGNATURE	Abigail DuPree LMSW PRINTED NAME	DATE

Another Road Counseling
Authorization for Electronic Communication

_____I execute this authorization on my own behalf.
_____I execute this authorization on behalf of child / ward as his / her / other parent / guardian / conservator.

I am aware that my privacy is protected and that legally no information can be sent by electronic means unless I waive this right. As a convenience to me, I hereby request that Another Road Counseling LLC electronically communicate with me regarding my treatment by Another Road Counseling LLC via any form of electronic communication. I understand that this means Another Road Counseling LLC and/or my treating providers will transmit my protected health information such as information about for example, my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to unintended disclosure or access by unauthorized parties, Another Road Counseling LLC shall not have any responsibility or liability with respect to any error, omission, claim or loss or other consequence arising from or in connection with the electronic communication of information by Another Road Counseling LLC.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Another Road Counseling LLC to communicate electronically, which will include the transmission of my protected health information. I understand that in the event I no longer wish to allow electronic communications from Another Road Counseling LLC, I may revoke this authorization by providing written notice to Another Road Counseling LLC at 31580 Schoolcraft Rd, Livonia, MI 48150 or fax at 734-422-1330 or phone or text at 248-779-6364 or any subsequent address or phone number.

I agree that Another Road Counseling LLC may communicate electronically unless and until I revoke this authorization by submitting notice in writing. This authorization does not allow for knowing electronic transmission of my protected health information to unspecified parties and I understand I must execute a separate authorization for my protected health information to be disclosed to each specified party and/or parties.

I hereby authorize the transmission of my protected health information electronically as described above.

____________________	____________________	________
CLIENT SIGNATURE	PRINTED NAME	DATE
____________________	____________________	________
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE
____________________	Abigail DuPree LMSW	________
CLINICIAN SIGNATURE	PRINTED NAME	DATE

Another Road Counseling llc
Teletherapy Informed Consent Form

I understand that my therapists video conferencing software is secure and HIPAA-compliant and they will do everything to ensure the security.

I will ensure that I am in a private location that allows me to have the same level of concentration and openness I show in the in-person sessions. If another person is present or enters the room, I will notify my therapist immediately.

I understand that while many insurance providers are approving these practices and are covering them in much the same way they would cover my in-office or face to face sessions, my therapist cannot guarantee that all insurances will cover all of these alternative services. My therapist has encouraged to call and find out my benefits. If telehealth services that I engage with are not covered by insurance, I acknowledge my therapist will have to bill me directly for those services.

The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above.

______________________	______________________	______
Client's Signature	Client's Printed Name	Date

If service is for a minor child, Print Client's name here ______________________

______________________	______________________	______
Parent's Signature	Parent's Printed Name	Date

______________________	Abigail DuPree LMSW	______
Therapist's Signature	Therapist's Name	Date

Another Road Counseling LLC

Clinician: Abigail DuPree LMSW
31580 Schoolcraft Rd, Livonia, MI 48150
Phone: 248-779-6364 Fax: 734-422-1330

Coordination of Care with Provider

Patient Name:	DOB:

_____ Authorize _____ Do Not Authorize

The release of information between Another Road Counseling LLC and:

Provider Name:	Phone:	Fax:	
Address	City:	State:	Zip:

OPTIONAL: The following additional PHI can be discussed ONLY if you initial by each of the following:
I understand that this information may include HIV-related information and/or information relating to the diagnosis or treatment of other communicable diseases and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

____HIV Related information
____Alcohol and drug treatment information (Protected under 42CFR Part 2)
____Sexually transmitted diseases (Specify)______________________________________
____Hepatitis
____Tuberculosis "TB"

To exchange information regarding mental health treatment. The information exchanged may include diagnosis, psychiatric evaluation, treatment goals, medications prescribed, symptoms reported, safety information, and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between Another Road Counseling LLC and my psychiatrist. This release expires upon termination of my treatment with Another Road Counseling LLC or upon my written request.

______________________________ ______________________________ ________
PATIENT SIGNATURE PRINTED NAME DATE

______________________________ Abigail DuPree LMSW__________ ________
CLINICIAN SIGNATURE PRINTED NAME DATE

OFFICE USE ONLY		
TREATMENT INFORMATION		
Admission:	Diagnosis:	
Treatment Frequency:	Potential medical concerns reported by client:	
Relevant treatment information:		
Signature of Clinician:	Printed Name of Clinician: Abigail DuPree LMSW	Date:

No response is required; however, I would appreciate contact if there is any information you feel would be appropriate to support this client's medical or mental health treatment.

Another Road Counseling LLC
Notice of Privacy Practices

In accordance with the requirements of the HIPAA Privacy Rule
The Health Insurance Portability and Accountability Act of 1996

Effective January 1, 2015

Another Road Counseling LLC
31580 Schoolcraft Rd
Livonia, MI 48150
Phone: 248-779-6364
Fax: 734-422-1330

Acknowledgement of Review and Receipt:
Please review our Notice of Privacy Practices and sign below.

I acknowledge that I have reviewed the Another Road Counseling LLC notice of privacy practices and have been provided a copy of the notice.

________________________	________________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE
CLINICIAN SIGNATURE	Abigail DuPree LMSW PRINTED NAME	DATE

Note: Another Road Counseling LLC has the right to change the terms of this notice at any time. You will be provided with a copy of changes if they occur while you are receiving services.

ANOTHER ROAD COUNSELING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This is called Protected Health Information (PHI) and it refers to information in your health record that could identify you. This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

WITHOUT AUTHORIZATION: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect:** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings:** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients:** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
- **Medical Emergencies:** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care:** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight:** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement:** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions:** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health:** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety:** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research:** PHI may only be disclosed after a special approval process or with your authorization.
- **Fundraising:** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
- **Verbal Permission:** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to 31580 Schoolcraft Rd, Livonia, MI 48150:

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make