Olive Tree Counseling, Inc.
1981 E. Palmer-Wasilla Hwy Suite 220, Wasilla, Alaska 99654
Phone: 907-357-6513 Fax: 907-357-6514

INSTRUCTIONS

I. Please read the important Notice Regarding Privacy Practices and Client Rights before printing any of your Intake documents. You will have an opportunity to discuss any questions about this notice and all of your intake forms at your first appointment.

II. Complete Print, Sign, and bring the following forms (pages 2 and 7-13) with you to your first session

A. Intake General Information
B. Acknowledgement of Receipt of Notice of Privacy Practices and Client Rights
C. Authorization for Treatment- Minor
D. Acknowledgement of Receipt of Intake Forms
E. Child Oriented Agreement Regarding Information of Court
F. Agreement to Pay for Professional Services
G. Family Consent

Thank you

Shelly J. Thomas, LMFT
Rae Ann Hendrickson, LPC

OLIVE TREE COUNSELING, INC.
NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

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

Because Olive Tree Counseling, Inc. ("Olive Tree") frequently serves children under the age of 18, all references to "you" are meant to include your child, if you are reading this as the parent or guardian of the child. In most cases, a parent or guardian may exercise the rights of the individual minor child.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.

Our Duties

We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect.

How We May Use And Disclose Health Information About You

We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We may use and disclose your health information while providing, coordinating or managing your health care. For example, information obtained by a member of your counseling team will be recorded in your record and used to determine the course of treatment that should work best for you. We may also provide other healthcare providers with your information to assist him or her in treating you.

Payment: We may use and disclose your medical information to obtain or provide payment for providing your health care. For example, we may send a bill to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As another example, we may disclose information about you to your health plan so that the health plan may determine your eligibility for payment for certain benefits. Please note: some insurance companies request detailed information and others request only diagnosis and office visit codes. It is your responsibility to know what personal information is required by your insurance company.

Health Care Operations: We may use and disclose your health information to deal with certain administrative aspects of your health care, and to manage our business more efficiently. For example, members of our medical staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. We may disclose your health information to our business associate so they can perform the job we've asked them to do, such as accounting or legal analysis. However, we require the business associate to take precautions to protect your health information.

Notification of Family: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition, in the event of an emergency.

Communication With Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

Court Proceeding: We may disclose your health information in response to requests made during judicial and administrative proceedings, such as court orders or subpoenas, as required by law.

Other Uses: We may also use and disclose your personal health information for the following purposes:

- Olive Tree Counseling may leave messages for patients regarding upcoming appointments or other administrative matters at the contact numbers on file;
- To describe or recommend treatment alternatives to you; or

- To furnish information about health-related benefits and services that may be of interest to you.

On rare occasions, we may disclose information for the following purposes: Food and Drug Administration (FDA), Public Health, Reporting Abuse, Neglect or Domestic Violence, Health Oversight, Law Enforcement, Threats to Public Health or Safety, and Specialized Government Functions (military, national security).

Prohibition on Other Uses or Disclosures

We may not make any other use or disclosure of your personal health information without your written authorization. Your name and identity will only be disclosed in accordance with AS 08.29.200. Once given, you may revoke the authorization by writing to the contact person listed below. Understandably, we are unable to take back any disclosure we have already made with your permission.

Olive Tree Counseling Position on Confidentiality and Privacy

Confidentiality at Olive Tree Counseling is maintained according to the AAMFT Code of Ethics, State Professional Counseling regulations and HIPAA regulations. We cannot promise everything you tell us will never be revealed to someone else. There are times when the law requires us to tell things to others. There are also some other limits on our confidentiality. We want you to understand clearly what we can and cannot keep confidential. You need to know about these rules now, so that you do not tell me something as a "secret" that we cannot keep secret.

1. When you or another person is in physical danger, the law requires use to tell others about it. Specifically:

   a) If we come to believe that you are threatening serious harm to another person, we are required to try to protect that person. We may have to tell the person and the police, or perhaps try to have you placed in a hospital.

   b) If you seriously threaten or act in a way that is very likely to harm yourself, we may have to seek a hospital for you, or to call on your family members who can help protect you. If such a situation does come up, we will attempt to fully discuss the situation with you before we do anything, unless there is a very strong reason not to.

   c) In an emergency where your life or health is in danger, and we cannot get your consent, we may give another professional some information to protect your life. We will try to get your permission first, and we will discuss this with you as soon as possible afterwards.

   d) If we believe or suspect that, you are abusing a child, an elderly person, or a disabled person we must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. We do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

   * In any of these situations, we would reveal only the information necessary to protect you or the other person.

2. There are a few other things you must know about confidentiality and you treatment:

   a) We may sometimes consult with another professional about your treatment without providing your name. This other person is also required by professional ethics to keep your information confidential. Likewise, when we are out of town or unavailable, another therapist may be available to help our clients, at their request, and will have access to your records.

   b) We are required to keep records of your treatment, such as notes we take when we meet. The laws and rules on confidentiality are complicated. Please bear in mind that we are not able to give you legal advice. If you have special/unusual concerns, and so need special advice, we strongly suggest that you talk to your own attorney.

We see people individually as well as in couples or families. We will keep information confidential except for the previously listed situations. However, if we believe that others need to have the information in order for us to continue progressing in therapy; we may encourage you to disclose the information and will work with you to do so.

Records Requests for Minors

Parents have the legal right to receive information that their children share with us in therapy. However, in order for them to feel safe with us, we may ask that parents not request information from us or from the children. We may encourage children to share information and help them to do this, but will not do so ourselves unless we believe it is necessary to protect the life and wellbeing of the child or someone else. We do not believe it is in the child's best interest to release their therapeutic records in most cases. Our code of ethics prohibits use from doing anything that will bring harm to our clients; therefore we will not willingly release these records unless required by law. In general, people do not believe it is safe if what they say is passed on to other family members or if information from therapy may be used in court proceedings. Therefore, any request for records that we are required to comply with

may indicate that the person requesting information has their own purpose rather than the best interest of the client or their children in mind.

Other Records Requests

We do not release marriage and family therapeutic records to spouses without both spouses written consent. Only your own individual records are available for you to request individually. However, it is our belief that it is frequently not in the best interest of an individual to obtain therapeutic records, therefore any request for records with which we must comply legally will include a statement saying that you were informed that we believed releasing the records was not in your best interest.

Individual Privacy Rights

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment, and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to the address below.

- To receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the address below, and tell us how or where you wish to be contacted.

- To inspect or copy your health information in paper or electronic form. You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if:

    - The information was not created by us, unless the person that created the information is no longer available to make the amendment,

    - The information is not part of the health information kept by or for us,

    - Is not part of the information you would be permitted to inspect or copy, or

    - Is accurate and complete

- To receive an accounting of disclosures of your health information. You must submit a request in writing to the address below. Not all health information is subject to this request. Your request must state a time period, no longer than 6 years and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically). The first accounting you request within a 12-month period is free. For additional accountings, we may charge you the cost of providing the accounting. We will notify you of this cost and you may choose to withdraw or modify your request before charges are incurred.

- To receive a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically. You must submit a request for a paper notice in writing to the address below.

All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed below.

Other Client Rights

1. Be treated with respect at all times which includes consideration of psychosocial, spiritual, and cultural variables that influence perceptions of problems.
2. Have a safe treatment setting free of discrimination from race, color, religion, sex, handicap, national origin or political beliefs. We treat each person as a unique individual in a way that recognizes basic human rights.

3. Ask for and receive information about the therapist's qualifications, including his or her license, education, training experience, membership in professional groups, special areas of practice, and limits of practice.
4. Have written information, before entering therapy, about fees, methods of payment, insurance coverage, and number of sessions the therapist thinks will be needed, and cancellation policies.
5. Have informed consent to procedures, benefits and risks, and alternative options for your care.
6. Privacy and confidentiality of your assessment and records, with exceptions noted in this document.
7. Refuse audio or video recordings of sessions.
8. Ask the therapist to inform you of your progress.
9. Report any illegal or immoral behavior by a therapist.

Proper and Improper Therapist Conduct

First, a therapist should never use threatening or coercing behavior as part of your treatment plan. If you feel as if your therapist is engaging in this behavior, discuss it with them immediately. Second, it is normal for people in therapy to develop positive feelings, such as love or affection, toward a therapist who gives them support and caring. These feelings can be strong and may take the form of sexual attraction. Though these feelings may sometimes occur, sexual contact with your therapist cannot be helpful and in fact has been found to be harmful to the client in many ways, including damaging the client's ability to trust. The harmful effects may be immediate, or they may not be felt until later. Sexual contact is against the professional code of conduct for all professional groups of mental health workers (i.e. psychologists, psychiatrists, licensed counselors, marriage and family counselors). You may contact the professional organization for any therapist to obtain more information or file a complaint.

No Guaranteed Outcome

While it would be wonderful for everyone who attends therapy to reach the goals they desire, we cannot guarantee success. We will do our best to help you or to refer you to someone who can help you. Sometimes, changes made as a result of therapy may have consequences that some people might consider bad; for example, a decision to divorce. We will do our best to help everyone leave therapy with the best possible outcomes with the least amount of discomfort. If therapy does not seem to be helping, we will talk about alternative methods in therapy or alternative resources for you.

Complaints

If you believe that your privacy rights have been violated, a complaint may be made to our privacy officer at 907-357-6513 or the address listed below. You may also submit a complaint to the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Contact Person

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Shelly J. Thomas, LMFT
1981 E. Palmer-Wasilla Hwy. Suite 220
Wasilla, Alaska 99654
Attn: Privacy Officer

Changes to This Notice

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.

Notice Effective Date: January 5, 2015

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INTAKE GENERAL INFORMATION

A. Date:_____

B. Your Name: _____ Date of Birth: _____ Age: _____ Soc Sec#_____

Spouses Name: _____ Date of Birth: _____ Age: _____ Soc Sec#_____

Home Address: _____ City, State, Zip: _____

Mailing Address: _____

Home Phone: _____ Cell Ph: _____ Email address: _____

Current Employer: _____ Work Phone: _____

Insurance Carrier_____ Group #_____ ID# _____

Primary Language: _____

Your Education, Training, or Military experience: _____

If client is a Minor:

Child's Name: _____ Date of Birth: _____ Age: _____ Soc Sec#_____

Name of Child's Biological Parent if different than above: _____

Biological Parent Date of Birth: _____ Biological Parent Social Security # _____

Home Address: _____

Mailing Address: _____Phone:_____

C. Referral Information

Name: _____ Relationship_____ Phone: _____

How did this person explain I might be of help to you? _____

D. Chief Concern

Please describe the main difficulty that has brought you to see me:

_____

_____

D. Your two most important goals _____

_____

E. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

_____NO _____ YES if yes, Please indicate:

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

F. Have you ever taken medications for psychiatric or emotional problems? No___ Yes_____

Medication Name	When/From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

By my signature below, I acknowledge that I have received Olive Tree Counseling, Inc.'s Notice of Privacy Practices and Client Rights, and that I understand and have had an opportunity to ask questions about the Notice, rights, therapist conduct, and other information in the Notice.

_____
Name

_____
Signature

_____
Date

_____
Name of Parent/Guardian/Personal Representative

_____
Signature of Parent/Guardian/Personal Representative

_____
Date

This acknowledgement page should be retained in patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

_____

_____

_____

Olive Tree Counseling, Inc.
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Authorization to Treat Minor

I acknowledge that I have received, read (or have had read to me), and understand the information provided to me about the therapy I am considering for my child. I have had all my questions answered fully.

I do hereby seek and consent to allow my child _____ take part in the treatment by Rae Ann Hendrickson, LPC, Brittney Punt, LCSW, Shelly J. Thomas, LMFT, Derek Sandlin, LPC, or Holly Hoff, LPC. I understand that a treatment plan will be developed with this therapist and a regular review of progress toward meeting the treatment goals are in my child's best interest.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that as the parent or legal guardian I may stop treatment with this therapist at any time. The financial obligation for the services received shall fall under the responsibility of the parent who is initially seeking treatment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments my child receives.

My signature below shows that I understand and agree with all of these statements.

_____ _____ _____
Printed name of client | Signature of Client | Date

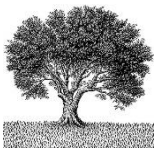
_____ _____ _____
Printed name of parent or legal guardian | Signature of parent or legal guardian | Date

_____
Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the parent or legal guardian. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC __Holly Hoff, LPC

_____ _____
Signature of therapist | Date



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Acknowledgement of Receipt of Intake Forms

I, _____, acknowledge I have read or have had read to me and been offered copies of my Intake forms which includes:

1. Notice of Privacy Practices
2. Client Rights
3. Fees for Professional Services
4. Fees for Administrative Services
5. Disclosure Statements for my Therapist
6. Authorization to Treat
7. E-communications
8. Custody / Court policy agreement

_____ _____ _____
Printed name of Client Signature of Client Date

_____ _____
Signature of parent or guardian if applicable Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC ___Holly Hoff, LPC

_____ _____
Signature of therapist Date

OLIVE TREE COUNSELING AND MINISTRIES

1981 Palmer-Wasilla Hwy, Ste 220, Wasilla, Alaska 99654
Ph: 907-745-6557 Fax: 907-745-6514
Shelly J. Thomas, LMFT Rae Ann Hendrickson, LPC

September 1, 2022 Fee Schedule

Olive Tree Counseling, Inc. Fee Schedule:		**Specialty Services**	
Initial Assessment	$350.00	Group Therapy	$ 75.00
Individual session 55 min	$200.00	Multi-Family Group Therapy	$ 75.00
Family session 55min	$200.00	Play Therapy	$200.00
Brief session 45 min	$160.00		

Olive Tree Counseling, Inc. Administrative / Court Fee Schedule:

Copies per page	$ .50
Summary of Care Reports	$ 100.00
Court appearances are hourly (Point to point)	$ 2000.00

I agree that I am responsible for the charges for services provided by this therapist to me although other persons or insurance companies may make payments on my account. I am also aware that should I not comply with my responsibility to pay for services, Olive Tree Counseling, Inc. reserves the right to provide my demographic data and financial information to a collection agency.
I understand that OTC will bill my primary insurance as a courtesy**.** If I request Olive Tree Counseling, Inc. to bill my primary insurance company, the company will be provided with personal information regarding services received at Olive Tree Counseling, Inc. I have been informed and understand that Olive Tree Counseling, Inc. does not bill any Secondary Insurance Companies for services received in Olive Tree Counseling, Inc. offices and that if requested, Olive Tree Counseling, Inc. will provide clients the claim forms to submit to any secondary insurances.
I understand that I will be responsible for anything that is not covered by my primary insurance company. I request Olive Tree Counseling, Inc. to bill my insurance company for services I receive.
I also understand that Olive Tree reserves the right to change the Fee Schedule and terms of payment at any time, and if there is a change, I will be provided with the new Fee Schedule and terms at the next applicable visit.
I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I _____ acknowledge that I received
(Print Name)
a copy and read the new Fee Schedule of Olive Tree Counseling which goes into effect September 1, 2022.

_____ _____ _____
Signature of Client (or person acting for client) Printed Name Date

___ Jody Rossing, ____S.J Thomas, LMFT ____RA. Hendrickson, LPC ____Brittney Punt, LCSW ____Derek Sandlin, LPC ___ Holly Hoff, LPC

_____ _____
Staff Signature/ Credentials Date

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Adult Agreement Not to Request Therapist Information for Court

As a therapist I do not make recommendations to the court concerning divorce, custody or parenting issues. The court can appoint professionals to conduct custody evaluations and you may request an evaluation through your attorney if necessary. Therefore, it is my policy to notify and discuss with all couples of the following:

Please initial before each premise acknowledging your understanding and agreement.

_____ I understand that the information the therapist gains from working with me or my family is confidential.

_____ I understand that the therapist will not give information about me or my family to anyone else without my written authorization.

_____ I understand that it is not the role of my therapist to make recommendations to the judge or to express opinions concerning divorce or custody issues. Therefore, I agree **not** to request my therapist provide any information for **any court related reason whatsoever, including but not limited to divorce or custody issues.**

_____ _____
Print Name Date

_____ _____
Signature Date

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC ___Holly Hoff, LPC

Therapist Signature: _____ Date: _____

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Child Oriented Therapy Agreement Regarding Information for Court

I am working with your child to assist him/her to cope with and adjust to the separation/divorce of his/her parents, and or other issues of which one or both parents have informed me. The purpose of the following agreement is to avoid harming the clinical relationship between the child and his/her therapist as well as with the family.

As a therapist I do not make recommendations to the court concerning custody and parenting issues. The court appoints professionals to conduct these evaluations. Therefore, it is my policy to notify and discuss with all couples who have children of the following:

Please initial before each premise acknowledging your understanding and agreement.

_____ I understand that the information the therapist gains from working with my child is confidential. With the child's permission the therapist will share information that they believe is important with his/her parents.

_____ I understand that the therapist will not give information to anyone else without my written authorization.

_____ I agree, as the parent(s) not to request any information for **any** court related reason whatsoever, including but not limited to custody issues.

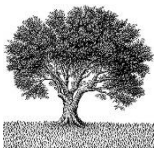
_____ I understand that it is not the role of the therapist to make recommendations to the judge or to express opinions concerning divorce or custody issues.

_____ _____
Parent(s) Name: Print Date

_____ _____
Parent(s) Signature Date

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC ___Holly Hoff, LPC

Therapist Signature: _____ Date: _____



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Authorization for Family Therapy

We acknowledge that we have received, have read (or have had read to us), and understand the Information provided to us in the Intake Packet. We have had all our questions answered fully.

We do hereby seek and consent to take part in the treatment by the therapist named below. We understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. We agree to plan an active role in this process.

We understand that no promises have been made to us as to the results of treatment or of any procedures provided by this therapist. We are aware that we may stop our treatment with this therapist at any time. The only thing we will still be responsible for is paying for the services already received.

We know that we must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If we do not cancel and do not show up, we will be charged for that appointment.

We plan for the following family members to participate in family therapy.

Name	Relationship	Birth date
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____
5_____	_____	_____
6_____	_____	_____

Our signatures below indicate that we understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Signature of client (or person acting for client) Date

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC ___Holly Hoff, LPC

_____ _____
Signature of therapist Date