Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy Suite 220, Wasilla, AK 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 8-14) 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- Adult
   D. Adult Agreement Not to Request Therapist Information for Court and / or Child Oriented Agreement Regarding Information of Court
   E. Agreement to Pay for Professional Services
   F. Acknowledgement of Receipt of Intake Forms

Thank you

Shelly J. Thomas, LMFT
Rae Ann Hendrickson, LPC
Derek Sandlin, LPC
Holly Hoff, LPC
Brittney Punt, LCSW

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 or 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 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 friend, or any other person with whom 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 provide 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 at the end of this document. 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. Exceptions apply when the law requires us to share information. 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 disclose something as a "secret" that we cannot keep secret.

1. When you or another person is in physical danger, we are required by law to report 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 call on your family members who can help protect you. If such a situation does occur, we will attempt to fully discuss the situation with you before acting unless there is an exceptional 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 or 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 disclose anything about these topics. Consider speaking with a 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 your treatment:
    a) We may sometimes consult with another professional about your treatment without providing your name. This professional is also required by law to keep your information confidential. Likewise, when we are unavailable, another therapist may be available to help our clients, at their request, and will have access to their 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 thus need special advice, we urge you to speak with 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 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

While parents have the legal right to receive the information their children share in therapy, for children to feel safe with us, we ask that parents do not request information from us or from the children. We may encourage children to share information and assist them in doing so, but we will not share information 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 us 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 feel safe if their information is passed on to other family members or if information from therapy is used in court proceedings. Therefore, any request for records that where compliance is not lawfully required may indicate that the requestee has his or her own best interest in mind, rather than that of the clients or children.

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 not usually in the best interest of an individual

to obtain therapeutic records—any request for records with which we are legally obligated to comply will include a written statement declaring that you were informed as such.

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 listed at the end of this document.

- 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 listed at the end of this document stating how or where you wish to be contacted.

- Inspect or copy your health information in paper or electronic form. You must submit your request in writing to the address listed at the end of this document. If you request a copy of your health information, we may charge you a fee for the cost of copying, mailing, and other supplies. In certain circumstances, we may deny your request to inspect or copy your health information. However, 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.

- Amend health information. If you feel that your health information that we have on record is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to the address listed at the end of this document. 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 a reason to support your request is not provided. We may also deny your request if:
    a) The information was not created by us, unless the person that created the information is no longer available to make the amendment;

    b) the information is not part of the health information kept on record by or for us;

    c) it is not part of the information you are permitted to inspect or copy; or

    d) it is accurate and complete.

- To receive an accounting of disclosures of your health information. You must submit a request in writing to the address listed at the end of this document. Not all health information is subject to this request. Your request must state a time no longer than 6 years and may not include dates before April 14, 2003, and 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 this service. We will notify you of this cost, and you may choose to withdraw or modify your request before any charges are made.

- 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 listed at the end of this document.

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 at the end of this document.

Other Clients' Rights

As our client, you have the right to:

1. Be treated with respect regarding psychosocial, spiritual, and cultural variables that influence perceptions of problems.
2. Have a safe treatment setting, free of discrimination from race, color, religion, gender, 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 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 that 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 is not 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, and marriage and family counselors). You are encouraged to 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. Sometimes, changes made because of therapy may have consequences that some people might consider bad, such as the 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 office 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, AK 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

Olive Tree Counseling, Inc.

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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.

_____

_____

_____

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Authorization for Treatment

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. I have had all my questions answered fully.
I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
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 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 understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.
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 agree to pay for services to me up until the time I end the relationship.
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 I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.
In the event of an emergency (i.e. I become sick while on the premises, I pass out or fall, an ambulance is called to transport me to a hospital, or I become suicidal and do not wish to go to an emergency room) I hereby give permission for the staff at Olive Tree Counseling, Inc. to contact and provide information about the emergency and where I am to the following individual:
_____ (Name) at this phone number _____
or _____.

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

_____	_____	_____
Printed name of Client	Signature of Client	Date
_____	_____	_____
Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

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, CDCII _____Brittney Punt, LCSW _____Derek Sandlin, LPC _____Holly Hoff, LPC

_____	_____
Signature of therapist	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.**

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

_____Shelly J. Thomas, LMFT _____Rae Ann Hendrickson, LPC, CDCII _____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 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 Signature: _____ Date: _____

Parent Signature: _____ Date: _____

_____Shelly J. Thomas, LMFT _____Rae Ann Hendrickson, LPC, CDCII _____Brittney Punt, LCSW _____Derek Sandlin, LPC _____Holly Hoff, LPC

Therapist Signature: _____ 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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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

_____ _____ _____
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, CDCII _____Brittney Punt, LCSW _____Derek Sandlin, LPC _____Holly Hoff, LPC

Therapist Signature: _____ Date: _____

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PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Olive Tree Counseling Employees will not routinely use electronic communication with clients. Any use of electronic communication with clients must be pre-approved by owners of OTC and the reasons for this choice will be documented in the client records.

Communication Consent

If you personally wish for Olive Tree Counseling, Inc to review your need to communicate via Email and/or Fax, please indicate the necessity and provide a valid email address and/or fax number.

_____

_____

_____

Please initial the appropriate lines below.

_____ I do **NOT** need to communicate with Olive Tree Counseling via E-mail or Fax

_____ I do wish to communicate via email. Email address:_____

_____ I do wish to communicate via fax. Fax number: _____

I have received, read and understand the Email and Other Electronic Communications Policy and have initialed my communication preferences above. If I have authorized email communications, I do so with the following understanding:

E-MAIL CAN BE MISDIRECTED TO OR INTERCEPTED AND DISCLOSED BY UNINTENDED THIRD PARTIES AND THUS MAY NOT A CONFIDENTIAL MEDIUM OF COMMUNICATION. PATIENTS WHO HAVE CONCERNS SHOULD CONSIDER USING ANOTHER MODE OF COMMUNICATION. PATIENTS UNDERSTAND AND AGREE THAT E-MAIL TRANSMISSION IS BEING USED FOR THE CONVENIENCE OF PATIENTS AND OLIVE TREE DOES NOT WARRANT THE CONFIDENTIALITY AND SECURITY OF THIS TRANSMISSION. PATIENTS, AND IN PARTICULAR, THOSE PATIENTS WHO HAVE MULTI-USER E-MAIL ACCOUNTS, ARE RESPONSIBLE FOR MAINTAINING THE CONFIDENTIALITY AND SECURITY OF THEIR OWN E-MAIL ACCOUNTS.

Telehealth Consent

Using telehealth services is entirely voluntary and will not impact the quality of care you receive from Olive Tree Counseling, Inc should you decide not to use these services. This office will not condition treatment or payment for health care on whether or not you use telehealth services or sign this agreement.

Olive Tree Counseling Inc is not liable for any claims and/or damages arising from the use of telehealth services.

_____ I do wish to use telehealth services. Email address:_____

_____ I do not need to use telehealth services.

By signing below, you acknowledge that you have read and fully understand the Olive Tree Counseling, Inc Electronic Communications Policy. You have been given the risks and benefits of such services and technologies, and understand the risks associated with online communications with Olive Tree Counseling, Inc and consent to the conditions as indicated herein. In addition, you agree to adhere to the policies set forth above, as well as any other instructions or guidelines that Olive Tree Counseling may impose for using the electronic communications.

Print Name	Patient Signature	Date
Print Name of Parent/Guardian	Signature	Date

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Consent for Telehealth/Telemedicine

Alaska Telehealth/Telemedicine Definition
Alaska policy and regulations telemedicine references
Senate Bill 74

Defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other.

As a client receiving behavioral health services through technologies, I understand:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to said in protecting against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct face to face communication. There are benefits and limitations to this service.
    a. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. These services rely on technology, which allows for greater convenience.
    b. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
    c. In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means: i.e. through the cell phone number provided by your provider.
    d. In the event of disruption of services, I will attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner, or practitioners in my area such as another provider in my behavioral practitioner's office or obtain an appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening my not be immediately available in other offices.
7. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today and modify our plan as needed.

Consent for Telehealth

8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications
9. I will take the following precautions to ensure that my communications are directed only to my behavioral health provider or other designated individuals:

   a. _____

   b. _____

10. I may decline any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
11. Records of my communication/sessions will be stored in the same manner that face to face records are stored.
12. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I have read this document carefully, and my questions have been answered to my satisfaction.
My signature below shows that I understand and agree with all these statements.

_____	_____	_____
Printed name of Client	Signature or client	Date
_____	_____	_____
Printed name of Parent/Guardian	Signature	Date

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

_____	_____
Signature of therapist	Date

2020 Olive Tree Counseling, Inc.
1981 E. Palmer-Wasilla Hwy. Suite 220, Wasilla, Alaska 99654
Phone: 907-357-6513 Fax: 907-357-6514

Name: _____ Date: _____

Please mark all of the items below that apply. Write in any clarifying remarks

☐ Anger, Rage_____
☐ Anxiety, nervousness, worry _____
_____
_____ I feel restlessness or keyed up on edge frequently _____ I have feelings of irritability
_____ I am easily fatigued _____ I have muscle tension
_____ I have difficulty concentrating or my mind going blank _____ I experience sleep disturbance
_____ I fear or avoid social situations
I have experienced these feelings for _____ 6mo _____1year _____2 years _____since childhood
☐ Attention, concentration, distractibility
☐ Career concerns, goals, and choices
☐ Codependence
☐ Confusion
☐ Custody of children
☐ Decision making, indecision, mixed feelings, putting off decisions
☐ Delusions (false ideas)
☐ Depression _____
_____I feel sad most of the day, nearly every day _____ I feel low energy or fatigue
_____I have a poor appetite, or I overeat _____ I experience feelings of low self esteem
_____I have trouble sleeping or I sleep a lot _____ I experience feelings of hopelessness
_____I have poor concentration or difficulty making decisions _____ I have had a significant weight loss or gain
_____I have feelings of committing suicide _____ I feel like dying
I have experienced these feelings for _____6mo _____1yr _____years _____since childhood
☐ Eating problems – Overeating, under eating, no appetite (see also "Weight and diet issues")
☐ I have used diuretics, laxatives, or induced vomiting ☐ I have been diagnosed with an eating disorder
☐ I have difficulty maintaining my body weight ☐ I eat food for comfort when I am upset or lonely
☐ I am often disturbed by my body's shape or weight ☐ I binge eat
☐ Emptiness
☐ Exercise: How often/What type_____
☐ Envy
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money troubles, debt, impulsive spending, low income
☐ Friendships – None or limited supportive friendships
☐ Forgiveness- I have a difficult time forgiving others
☐ Gambling
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Headaches, other kinds of physical pains_____
☐ Housework/chores - quality, schedules, sharing duties
☐ I pull out my hair and there is noticeable hair loss
☐ I sometimes feel a sense of tension until I pull out my hair and/or I feel a sense of relief after I pull out my hair

☐ Inferiority feelings
☐ Interpersonal conflicts
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Loneliness
☐ Marital conflict:

____ Distant/coldness	____ Infidelity/Affair	____ Remarriage
____ Disappointments/Discontent	____ Lack of communication	____ Value/Belief System differences
____ Parenting style differences	____ Difference in sexual desire	____ Pornography issues
____Physical or Emotional Intimacy	____ Emotional Neglect or Abuse	____ Domestic Violence

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☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Obsessions/ Compulsions

_____I have recurrent or persistent thoughts	_____I experience images or impulses that are intrusive
_____I feel anxiety	_____I ignore or suppress thoughts, urges, or images
_____I repeat behaviors (i.e. washing hands, checking, ordering)	_____I experience anxiety if I don't repeat behaviors

☐ Oversensitivity to rejection
☐ Panic or anxiety attacks
_____palpitations, pounding of or increased heart rate ____Sweating ____trembling or shaking ____nausea ____fear
_____shortness of breath _____feeling of choking ____chest pain/discomfort ____dizziness ____fear of losing control
☐ Parenting, child management, single parenthood
☐ Perfectionism
☐ Pessimism
☐ Pregnancies: How many_____ Losses_____ Terminations _____ Difficulties _____
☐ Problems associated with prescriptions medications, over-the-counter medications
☐ Procrastination, work, inhibitions, laziness
☐ Relationship problems (with friends, with relatives, or at work)
☐ Self-centeredness
☐ Self-esteem, Self-neglect, poor self-care
☐ Sexual issues, dysfunctions, conflicts, desire differences
☐ Shyness, oversensitivity to criticism
☐ Sleep problems—too much, too little, insomnia, nightmares
☐ Smoking and tobacco use
☐ Sometimes I see or hear things others do not hear or see
☐ Spiritual, religious, moral, ethical issues
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Suspiciousness
☐ Suicidal thoughts: Describe_____
Suicide attempt: Describe_____
Homicidal thoughts or attempts: Describe_____
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization
☐ Threats, violence
☐ Withdrawal, isolating
☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
☐ No one could really love me as I am
☐ I must be right or perfect to be ok

☐ I am basically a bad, unworthy person
☐ Internet use: How much time/day do you engage in _____gaming _____surfing _____Surfing _____Facebook/blogging
☐ Sex is my most important need or sign of love
☐ My needs are never going to be met if I have to depend on others
☐ I have trouble with authority figures
☐ I dislike taking instructions or having someone tell me what to do
☐ I have in the past or am currently cutting myself
☐ Alcohol or drug use over the past 12 months:
  ☐ Have you gotten into trouble at home, at school or in the community, because of your drinking, using drugs or inhalants?
  ☐ Have you missed school or work because of using alcohol, drugs or inhalants?
  ☐ In the past year have you ever had 6 or more drinks at any one time?
  ☐ Have you done harmful or risky things when you were high?
  ☐ Do you think you might have a problem with your drinking, drug or inhalant use?
  ☐ When using alcohol, drugs or inhalants have you done things without thinking, and wished you had not done them later?
  ☐ Do you miss family activities, after school activities, community events, traditional ceremonies, potlatches, or feasts because of using alcohol, drugs or inhalants?
  ☐ Does anyone close to you worry or complain about your using alcohol, drugs or inhalants?
  ☐ Have you lost a friend or hurt a loved one because of your using alcohol, drugs or inhalants?
  ☐ Do you use alcohol, drugs or inhalants to make you feel normal?
  ☐ Does it make you mad if someone tells you that you drink or use drugs or inhalants too much?
  ☐ Do you feel guilty about your alcohol, drug or inhalant use?

Medical: Personal and Family of Origin

Name of Personal Family Physician _____

☐ Do you have any allergies? No Yes if yes, please describe_____

☐ How would you describe your health/medical status? Excellent good fair poor

☐ Please describe any chronic / current medical conditions_____

_____

Please list any medications you are taking for these conditions_____

_____

☐ Please describe any past or present psychiatric, counseling or drug / alcohol treatment you have received

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

☐ Please list any psychiatric medications you have taken in past or are currently taking

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

☐ I am at low medium high risk for HIV ☐ I am at low medium high risk for Hepatitis
☐ I have been diagnosed with TB ☐ I have been treated for TB
☐ I have had a blow to the head that caused me lose consciousness ☐ I have had a blow to the head that caused a concussion
☐ I have received an injury that caused vision and / or hearing loss
☐ Did your father or his parents have any medical or psychological problems? No Yes if yes, please describe

_____

☐ Did your mother or her parents have any medical or psychological problems? No Yes if yes, please describe

_____

Your Children:

Name	Gender	Age	Who do they live with	Describe your relationship with them
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Family History:

1. Where were you born and raised? How many siblings do you have?
   _____
2. Which of these words best describes your relationship with your parents as a child?
   Mother: ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Father: ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

3. Which of these words best describes your relationship with your Siblings?
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

4. List two positive things your parents taught you when you were growing up: _____
5. List two negative things your parents taught you: _____
6. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Who? _____ _____ Yes _____No
7. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Who? _____ _____Yes _____No
8. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? Who? _____ _____ Yes _____ No
9. Did you often feel that… no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? _____Yes _____No
10. Did you often feel that… you didn't have enough to eat, had to wear dirty clothes, had no one to protect you Or your parents were too drunk or high to care for you or take you to the doctor if needed? _____Yes _____No
11. Were your parents ever separated or divorced? How old were you? ____ _____Yes _____No
12. When you were a child were any of your caregivers treated violently, often pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? _____ _____Yes _____No
13. Did you live with anyone who was a problem drinker or used street drugs? Who? _____ _____Yes _____No
14. Was a household member depressed or mentally ill or did a household member attempt suicide? Who? _____ _____Yes _____No
15. Did a household member go to prison? Who? _____ _____Yes _____No

Additional Lifetime losses / Adult OR Teen Traumas NOT previously noted.(Briefly describe)

____ Abandonments _____
____ Assaults / Violent Events (including date or stranger rape)_____
_____
____ Betrayals_____
____ Deaths_____
____ Separation or Divorces (How many? Briefly describe cause) _____
_____
____ Threats / Intimidation (Briefly describe)_____

☐ Please comment on any additional information In space below