Oasis Counseling Services, LLC
1230 Slaughter Road
Suite E
Madison, Alabama 35758
256.694.0788

Oasis Counseling Services, LLC

Client Information

Today's Date:_____

Client's Name:_____Date of Birth:_____Age:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

May we call and/or leave a message at these numbers? Yes___No___

If no, specify restrictions_____

Email Address:_____

May I send emails to this address? Yes_____ No_____

Who should be contacted in case of an emergency? Name:_____

Relationship:_____Phone#:_____Alternate#:_____

How were you referred to Oasis Counseling Services, LLC? Please Circle:

Physician Friend Oasis Website Internet Insurance Company

Other_____

COUNSELING AGREEMENT & CONSENT FOR TREATMENT

My signature below indicates my understanding and agreement of the following:

**I have received a copy of the Information for New Clients and Notice of Privacy Practices and agree to abide by the policies stated therein.
** I agree not to voluntarily involve any Oasis Counseling Services, LLC owners, therapists, and staff in any legal matters or proceedings.
**I understand that all fees are due at the time of service, and I am responsible for late cancellation and no-show fees if I do not provide a 24 hour notice by phone.

**If using insurance, I authorize Oasis Counseling Services, LLC to release information related to my care including financial and medical data to my insurance company or any organization contracting with my insurance company that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations. I understand that a mental health diagnosis will be submitted to my insurance company. I am responsible for my co-pay, unmet deductibles, fees for services not covered by insurance and all fees that are not paid by my insurance company for any reason for more than 90 days.

**I understand that Oasis Counseling Services, LLC owners, therapists, and staff does not provide 24- hour assistance and in an emergency. I should seek help immediately by calling 911 or going to the nearest Emergency Room. I authorize Oasis Counseling Services, LLC to contact my Emergency Contact listed above if needed.

**I agree to enter therapy and give my consent to Oasis Counseling Services, LLC to provide me with counseling services.

Signature

Date

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Client Information

Marital Status: Married Divorced Separated Widowed Never Married

Number of children: _____

Current health problems:_____

Previous health problems:_____

Current medications:_____

Have you taken medication for a mental health condition (depression, anxiety, ADD etc)? Yes No

Is there a family history of mental health or substance abuse issues: Yes No

Have you been in counseling previously? Yes No

Have you ever experienced any of the following:

Attempted suicide: yes no If yes, when: _____

Abuse: Physical_____ Sexual_____ Emotional_____ Never_____

Recent loss (death of loved one, job loss, divorce etc): Yes No

Please check any of the symptoms you have experienced within the past 4 months:

_____Appetite Disturbances
_____Eating less or more
_____Weight loss or gain
_____Binging or purging
_____Sadness or tearfulness
_____Sleep Disturbances
_____Trouble falling asleep or staying asleep
_____Sleeping too much or too little
_____Nightmares
_____Fatigue/decreased energy

_____Decreased interest in activities
_____ Relationships Sexual disturbances
_____ Dissatisfaction Worry or Anxiety Mood
_____ Swings/Anger/Irritability
_____ Guilt, Shame or Regret
_____ Procrastination
_____ Feeling Paranoid
_____ Excessive Behaviors (spending sprees, etc.)
_____Feeling stressed
_____ Self-harming or Destructive Behaviors
_____ Fearful
_____ Work Related Problems
_____ Impaired Impulse Control
_____ Low Self Esteem
_____ Difficulty Getting Along w/Family/ Friends, etc.
_____Job Loss/Change or Retirement
_____Thoughts about hurting yourself
_____Thoughts about death or dying
____Do you feel you suffer from an eating disorder

____Isolating From Others
____Feeling Worthless
____Racing Thoughts
____Feeling Hopeless
____Difficulty Concentrating
____Distracted Hyperactivity
____Excessive Energy
____Financial Difficulties
____Panic Attacks
____Feeling Nervous
____Feeling Out of Control
____Obsessive/Compulsive Thoughts Perfectionism
____Addictive Behaviors
____Legal Problems/Involvement
____Hallucinations (Auditory or Visual)
____Marital/Relationship Conflicts Thoughts About
_____Hurting Someone Else
_____ Attempted Suicide

List of medications currently taking prescribed or over-the-counter and frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Policy Regarding Appointments

Appointment Information

Appointments are generally scheduled for 50 minutes in duration.

If your child is the client, please do not leave the waiting area during your child's session so that you are available in the event of emergency or in case your presence is needed in session. If you are not present at the end of your child's session, even if it ends early, your child will be left unsupervised in the waiting area.

In the event of inclement weather or an imminent threat thereof in North AL, please contact us before coming in to a scheduled appointment to make sure the office will remain open.

Cancellations and Missed Appointments

Please understand that when you schedule an appointment, that hour is reserved for you and unavailable to anyone else. If you miss an appointment or cancel an appointment without providing a 24 hour notice (one business day), you will be charged a $60 fee. These fees are not covered by insurance.

Please note that appointment reminders from us (usually by email) are a courtesy. You will still be responsible for missed appointments and late cancellation fees even if you do not receive a reminder from us.

Payment

Payment for session fees are due at the beginning of each session along with any balance on your account. If your child is the client and will be brought to session by someone else or if your teen client is coming alone, please remember to send payment. If payment is not made, the session may be cancelled, and you will be charged a missed appointment fee.

Services may not be rendered or scheduled if there is a balance on your account. Clients are expected to maintain a zero balance on their account.

Agreement

"My signature below indicates that I understand and agree to abide by the above stated policies regarding appointments with Oasis Counseling Services, LLC."

_____ _____

Signature of Client (or Parent if Client is under age 14) Date

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Oasis Counseling Services, LLC

Policy Regarding Confidentiality, Client Rights, Contact and Consent for Services

Confidentiality

In general, information shared in counseling is kept confidential and only released with the client's written consent. However, there are situations in which we are permitted or required by law to release private information to appropriate persons/authorities without consent. Situations include but are not limited to: if we believe there is a threat of harm to the client or another person; if we believe that physical/sexual abuse has occurred; if we receive a court order; if information is required for us to defend ourself in event of lawsuit; if information is required to collect payment; and if a medical provider has a legitimate need for information to provide competent care. For more information regarding privacy, please refer to the Notice of Privacy Practices available upon request.

Client Rights

Clients have a right to ask questions and be informed of all aspects of therapy, to discontinue treatment at any time and to seek other mental health consultation. Oasis Counseling Services, LLC may terminate therapy at any time. Common reasons for doing so include: lack of progress in therapy, client's needs outside scope of practice, failure to comply with clinical recommendations and administrative policies including excessive cancellations or non-payment. Counseling may include recalling unpleasant memories and experiencing intense emotions. Counseling may lead to changes in perspective, decisions and relationships. There is no guarantee that counseling will result in a certain outcome.

Contact and Emergencies

You can reach us by phone at (256) 694-0788. If we are unavailable to answer, please leave a message, and we will return your call at the first available opportunity. Phone calls (non-administrative in content) may be billed at the usual rate ($120 hourly). These fees are not covered by insurance, and you will be financially responsible.

You can reach us by email at: robin.malone@oasiscounselingservice.com. Please be advised that we cannot be held responsible for breaches in confidentiality that may occur in the electronic transmission of information to/from Oasis Counseling Services, LLC.

If you experience an emergency during or after hours, please immediately call 911 or go to your nearest emergency room. Please be advised that we do not provide 24 hour assistance.

Agreement and Consent for Treatment

"My signature below indicates that I understand and agree to abide by the above stated policies regarding appointments with Oasis Counseling Services, LLC. I have received or been made available a copy of the Notice of Privacy Practices for Oasis Counseling. Furthermore, I agree to receive counseling services from Oasis Counseling Services, LLC therapists. If my child (under age 14) is the client, I affirm that I am the guardian with legal right to consent to treatment for my child and I give my consent to Oasis Counseling Services, LLC therapists to provide counseling services to my child."

_____ _____

Signature of Client (or Parent if client is under age 14) Date

Policy Regarding Fees, Payment and Insurance

FEES

The standard fee for initial sessions and regular sessions (50 min) is $120, unless otherwise agreed upon. Sessions that last longer will be billed based on a pro-rated amount of $120 per hour.

The standard fee for all court-related work is $250 per hour. The standard fee for all other services rendered including but not limited to phone calls and email time (non-administrative in nature), report writing, consultations and authorized release of information requests will be billed at a rate of $120 per hour. Fees for these services are not covered by insurance and will be your responsibility.

The fee for missed appointments and cancellations not made within 24 hrs. is $60. These fees are not covered by insurance and are due no later than the beginning of the following session. The fee for insufficient checks is $50.

PAYMENT

Session fees along with any balance on your account is due at the beginning of each session. If payment is not made in full, the session may be cancelled and you will be charged a missed appointment fee. Payments may be made by cash, check or credit card.

Clients are expected to maintain a zero balance. A zero balance is required before services are rendered or scheduled. Balances that have not paid within 90 days may be sent to a collection agency. If collections proceedings become necessary, you will be required to pay all related costs.

INSURANCE

Oasis Counseling Services, LLC files insurance claims as a courtesy and reserves the right to discontinue doing so at anytime. If so, you will be expected to pay full fee for sessions at the time of service. You will be financially responsible for counseling fees not covered by your insurance company, regardless of the reason for denial.

Your copay is due at the time of service. If you have an unmet deductible, you will be required to pay full fee for sessions until we can determine your financial responsibility amount from your Insurance company.

A mental health diagnosis is required on all filed claims by insurance companies and will be included in your permanent health record.

AGREEMENT

"My signature below indicates that I agree to abide by the policies stated above. I authorize release of information to any insurance company or paying entity for all claims and permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to the parties who accept assignment.

_____ _____

Signature of Financially Responsible Party Date

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Agreement Regarding Court Testimony and Records Policy

It is essential to the therapeutic process that information discussed in therapy be kept confidential with exceptions being made for matters related to safety. In an effort to provide quality services, I prefer not to be requested to testify in court, Furthermore, please note that court testimonial services is not in my area of expertise. If you suspect that you may be going to court and/or need a therapist's forensic testimony, you are advised to seek the services of a provider who has court experience. Nevertheless, I realize that there are cases in which records and/or my presence in court is ordered. A considerable amount of time is involved in court preparation and testimony which impacts my availability to provide therapeutic services to others. As a result, clients are required to sign the following agreement before beginning treatment. Please be advised that this contract is binding if a Subpoena, Court Order and/or request for court appearance is processed and received, citing you or your child as litigant in court proceedings.

Being sufficiently advised of this Notice, I understand and agree to the following conditions in relation to Oasis Counseling Services, LLC:

I understand that contingencies required by my therapist's involvement in litigation can be contra- indicative to the therapeutic relationship. I understand that confidentiality of therapy at Oasis Counseling Services, LLC is governed by the statutes set forth by AL Code 1975 34-8a-1 and Regulations Governing Professional Counselors, Chapter 255-X-2-06 relative to Privileged Communication. This privilege is considered the same as that existing between client and attorney and can only be waived by authorization from the client to release information or when the client is considered dangerous to self or others, or by judicial order.

I agree to pay an advanced deposit of $l,000 for court testimony and related activities. The amount of the deposit will commensurate with the date that the Subpoena or Court Order is received. The deposit of $ 1,000 is not refundable, as our therapist has left this day open to appear in court.

I also agree to pay the rate of $250 per hour for our therapist's time involved in court-related tasks including but not limited to court appearance, testimony, deposition, administrative and court preparation, consultation with attorneys or other professionals, time in court, wait time, total time out of office (departure until return) plus all expenses (i.e., travel, "on call" professional coverage), in order for her to satisfy contingencies of the Subpoena/Order. I agree to pay the fee of $500 for being placed "on call" for court testimony which will cover up to two hours in actual court time, but I understand I will be billed at $250 hourly beyond two hours. I understand some counseling services regarding court related matters cannot be billed to insurance and will be billed at the standard hourly rate.

I understand that my attorney is responsible for scheduling my therapist as a witness in proceedings. Whether or not he/she testifies in a timely fashion or not, within 48 hours from schedule, I will be billed and agree to pay the total amount for my therapist's time. I understand that I will be responsible for payment of all court fees even if my attorney did not issue the Subpoena/Order due to my name or my child being listed as litigant. I understand that insurance cannot be filed for any portion of the above expenses, relative to the Subpoena/Order served to my therapist, and I am financially responsible for any portion of the fees relative to the subpoena/order.

I agree to pay the deposit of $1,000 no later than 48 hours after Oasis Counseling Services, LLC receives a Subpoena/Court Order listing myself or my child as litigant. Additionally, I agree to pay the balance for court related expenses within 30 days from the time services are rendered. I agree to all terms and conditions of payment and collections, and in case of default, to pay all costs of collections or attempts to

collect including but not limited to reasonable attorney fees and court costs. Oasis Counseling Services, LLC retains the right to retain a Collection Agent, to notify the Credit Bureau and to initiate proceedings in Small Claims Court. This agreement is governed by the laws of Alabama.

I understand that no civil or criminal action may be brought against Oasis Counseling Services, LLC owners, therapists, or administrative staff of Oasis Counseling Services, LLC for providing records, reports, testimony, recommendations or data (verbal or written), which resulted as consequences of a request for or response to a Subpoena/Court Order or ligitative proceedings. I understand that this release has no expiration and will remain active even after my case is closed for services with Oasis Counseling Services, LLC. I authorize Oasis Counseling Services, LLC to release confidential information in court testimony and written reports to the Court if legally requested by the Court.

_____ _____

Client's Signature (or Legal Guardian Signature if client is under age 18) Date

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NOTICE OF PRIVACY PRACTICES

This Notice describes how Oasis Counseling Services, LLC may use and disclose Personal Health Information (PHI) about you and how you can get access to this information. Please review it carefully. I am required by law to maintain the privacy of protected health information regarding you and to provide you with the notice of my legal duties and privacy practices with respect to PHL PHI refers to information in your health record that could identify you, including demographic, financial, past and current physical or mental health condition and treatment and related health care services.

How I May Use or Disclose Your Health Information Without Your Consent

TREATMENT: I may use and disclose your PHI to provide, coordinate or manage your health care and other services related to your healthcare. Examples of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional and when I give your PHI to a hospital in order to obtain approval for admission.
PAYMENT: I may use and disclose PHI to obtain payment for services that you receive from me. For example, I may disclose your PHI to your insurance company to verify eligibility, obtain approval for treatment, file claims and obtain payment. While insurance companies are required to keep your PHI confidential, I am not responsible for breaches of confidentiality.
HEALTH CARE OPERATIONS: I may use and disclose PHI in order to support activities related to the performance and operation of my practice. Examples of health care operations include quality assessments, improvement activities, business matters such as audits and administrative services, and care coordination. I may share your PHI with administrative service providers that perform activities for my practice provided that they have signed a confidentiality agreement stating that they agree not to release PHI.
We may also use and disclose your PHI as follows:
Child, Elderly, or Disabled Adult Abuse - If I know or suspect that a child under age 18, an elderly person or disabled person has been a victim of abuse or neglect, I am required by law to report this to the appropriate authorities and may be required to provide PHI.
Safety- I may disclose PHI in order to reduce or prevent an imminent or serious threat to the health and safety of you or others. If a client threatens to harm himself/herself or others, I may be obligated to seek hospitalization for him/her, contact person who's safety has been threatened and/or contact others who are reasonably able to prevent or lessen the threat.
Legal and Law Enforcement - I am required to release PHI in compliance with a court order or subpoena. If a client files a complaint or lawsuit against me, I may disclose relevant PHI in order to defend myself. I may disclose PHI to a law enforcement official for law enforcement purposes when federal, state or local law requires disclosure.
Inmates: If you are an inmate of a correctional facility, I may use or disclose PHI created or received in course of providing care to you.
Worker's Compensation- I may disclose PHI as necessary to comply with worker's compensation laws. Military Activity and National Security: If you are a member of the U.S. Armed Forces, I may disclose PHI as required by military command authorities. I may also disclose PHI to authorized federal officials for national security reasons and intelligence activities.
Vocational Rehabilitation Services and Similar Agencies- I may disclose PHI to agencies from which you are requesting assistance.

Health Oversight Activities- I may disclose PHI if requested by a government agency for health oversight activities.
Disaster Relief- I am permitted under Privacy Rules to provide PHI to disaster relief agencies.
Public Health: I may disclose PHI for public health activities to an appropriate authority. The disclosure will be made for the purpose of controlling disease, injury or disability. I may disclose PHI if I believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I may disclose PHI to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading disease. If a client admits prenatal exposure to controlled substances that are potentially harmful, I may disclose PHI to the appropriate authorities.
Professional Misconduct: If I am aware of professional misconduct by another health provider, I must report this to the appropriate authorities and release related information if a professional or legal disciplinary meeting is held regarding the provider's actions.
Food and Drug Administration: I may disclose PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, to enable product recalls or to make repairs or replacements.
Death: In the event of a client's death, the spouse and/or parents of the client has a right to their child or spouse's records.

Uses and Disclosures of PHI with Your Permission

I may use or disclose PHI for purposes outside of treatment, payment or health care operations. When your authorization is obtained, an "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Mental Health Notes.
You may revoke all such authorizations at any time, provided each revocation is in a written statement submitted to me. You may not revoke an authorization to the extent that 1) I have relied on that authorization; 2) the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

CLIENT'S RIGHTS

You may request to us in writing that we do one or more of the following concerning your PHI that we maintain:
Access- You have the right to inspect and request a copy of your PHI in my records for as long as the PHI is maintained in the record. In some cases, we do not have to agree to your request. You may inspect and copy Mental Health Notes unless I make a clinical determination that access would be detrimental to your health. Records are not kept indefinitely and will be destroyed in a manner consistent with upholding client confidentiality.
Amendment- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This request must be made to me in writing and include the reason for the request. In certain cases, I may deny your request. I may deny the request if the information was not created by me (unless you prove that the creator of the information is no longer available to amend the information), the information is not part of the records used to make decisions about you, if I believe the information is correct and complete, if I feel the information could be harmful to you or to another person or if you would not have the right to see and copy the information as described above. On your request, I will discuss with you the details of the amendment process.
Restrictions- You have the right to request restrictions on certain uses and disclosures of your PHI. I am not required to agree to your request.

Alternative communications- You have the right to request and receive confidential communications of your PHI by me by alternative means or at alternative locations. For example, you may request that I use a specific phone number or address to communicate with you. Requests must be made in writing to me and must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location.

Disclosure accounting- You generally have the right to receive an accounting of certain disclosures of your PHI made by me. On your request, I will discuss with you the details of the accounting process. This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures I may have made to you, family members or friends involved in your care, or for notification purposes. You may ask for disclosures made up to 6 years before the time of your request.

Paper Copy: You have a right to obtain a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints:

If you believe we have violated your privacy rights, you have the right to discuss this with us or to complain in writing to the Secretary of the U.S. Dept of Health and Human Services at 200 Independence Ave. SW, Washington, D.C. 20201. Complaints must be filed within 180 days of the time you knew or should have known of the violation. I support your right to privacy of PHI and will not retaliate against you for exercising the right to file a complaint.

Contact:

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following: by phone at (256) 694-0788: by email at robin.malone@oasiscounselingservice.com: or by mail to: 1230 Slaughter Rd., Suite E, Madison, AL 35758.

Effective Date: Restrictions and Changes to Privacy Policy

The effective date of this notice is September I, 2019. We are required to follow the terms of this notice until we replace it, and we reserve the right to change the terms of this notice at any time. If we make changes, we will revise it and send a new Privacy Notice to all persons to whom we are required to give the new notice. We reserve the right to make the new changes apply to all your PHI maintained by us before and after the effective date of the new notice.

_____ _____

Signature Date

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CONSENT TO CHARGE CREDIT/DEBIT CARD

Client's Name: _____

Amount to be Charged Per Session: _____

Credit Card Information:

Circle Credit Card Type: Visa Master Card Discover American Express

Credit Card Number: _____

Expiration Date: _____

3 digit code: _____

Card Holder's Name (as listed on card): _____

Card Holder's Billing Address: _____

_____

_____

Card Holder's Phone #: _____

Card Holder's
EmailAddress: _____

Card Holder's
Signature: _____

"'By signing below, I, authorize Oasis Counseling Services to charge my credit card without my physical presence at Oasis Counseling Services, LLC in the amount of my copay/self-pay fee following each session. I understand that I may withdraw the authorization to charge my credit card in the future by providing the revocation of authorization in writing to Oasis Counseling Services."

_____ _____

Card Holder's Signature Date

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256.694.0788
www.oasiscounselingservicesllc.com

Insurance Worksheet

If you plan to use insurance, it is very important that you know the terms and coverage of your plan.You are advised to call your insurance company prior to your first appointment in order to verify coverage and obtain authorization, if necessary. (The phone number is usually on the back of your card.)

Name of Client:_____Client's Birthday_____

Insurance Company:_____

Contract#:_____Group#:_____

Name of Insured:_____ Insured's Birth Date:_____

Name of Insured's Employer_____

The following questions will help guide you when you call.

1) Are out-patient mental health services covered? _____

2) If so, is the therapist a covered provider?_____

Oasis Counselors are Licensed Professional Counselors; Master's Level Therapists

Robin Malone, LLC, NCC, CHt -National Provider # 1538705124

Glynn Cannon, M.Ed, LPC - National Provider # 1225676034

3) What is the coverage amount per session?_____%

4) Do I need authorization before beginning counseling? _____

If yes, Authorization #: _____

5) How many sesions are authorized?_____Does this include visits with a psychiatrist?_____ How mant sessions have been used to date?_____

6) Do I have a deductible that will apply?____If so: $_____yearly

How much has been met to date?_____

7) What will my co-pay be per session?_____