WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Hello,

Thank you for contacting White Oak Counseling and Recovery for scheduling an appointment. We look forward to serving you. We are confident your time with us will prove encouraging and helpful.

Please fill out the enclosed forms and bring them along with you to your first appointment. This will save valuable time and give us more time to discuss your needs.

Our office is conveniently located at 4695 N M37 Hwy, Suite A, Middleville, MI 49333.

Payment is due before your scheduled appointment; you can prepay online through our website or bring your payment with you the day of your appointment.

We look forward to meeting you soon.

Sincerely,
Staff Counselor

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

CONSENT FOR SERVICES AND FEE AGREEMENT

To acquaint you further with the procedures and policies of our practice, we are providing you with the following information. Please sign at the bottom of this form indicating your acceptance of the following terms for client name: _____.

Office Hours: Our normal business hours are Monday and Thursday, 9:00am–5:00pm. You may leave a message via voicemail or email (*admin@wocounseling-recovery.com*). We will make every effort to return your call as soon as possible.

Appointment/Missed Appointments: Services are by appointment only by calling our office at (269)205-2402. To cancel an appointment, please **call** the office as soon as possible. **Appointments cancelled with less than 24 hour notice may be billed to you.** If you miss an appointment without notifying us, you will be charged a $25 fee. Please note that insurance companies **do not** cover missed appointments.

Confidentiality: Your trust in us is extremely important. Your client records are our personal property and shall be treated as highly confidential. Please note that all client charts are kept for seven years following your closing date from counseling, which after that time records will be destroyed. All information shared in sessions is confidential, except in circumstances governed by the laws, including the mandatory reporting of alleged harm to self or others. If we believe a consultation with another professional is important for your care, your confidentiality is protected under the "Privacy Practices" mandated by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Emergencies: In case of a **true** emergency/crisis situation, please call 911 and/or go to the emergency room of a local hospital.

Financial Responsibility: Presently the fees may vary for our counseling services; we will discuss the fee structure with you before your counseling session. Extended phone calls, letters or written documents may be charged as a separate fee.

At the time of your initial appointment, please be prepared to provide us with your insurance card(s) – both primary and secondary if applicable. You are fully responsible for payment of all balances not covered by your insurance company. As a courtesy to you, we will verify your mental health benefits and bill your insurance company. If we participate with your insurance plan, contracted insurance rates should apply. In the event of any insurance changes, please notify us via phone at (269)205-2402 or email *admin@wocounseling-recovery.com* within 24 hours of your next scheduled appointment so that your new insurance benefits can be verified and our system updated before your appointment time. Failure to follow this policy may result in a postponement of services. We accept cash, check, and credit cards. **Please make all checks payable to White Oak Counseling and Recovery.** Upon review, a service charge of $5.00 per month may be added to all unpaid balances over 30 days.

_____ Initial I understand that I am responsible to pay my insurance co-pay for counseling on the same day as the counseling session is given. If co-pay payment is not received within 30 days, White Oak Counseling will bill my credit card on file, or if no credit card is on file, my account will be turned over to collections.

We will be happy to answer any questions you may have concerning our policies. We are looking forward to serving you.

_____ _____
Client Signature Date

_____ _____
Signature of Person responsible for payment (If other than client) Phone number

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Authorization for Scheduling, Billing and Payment Purposes

This form, when completed and signed by you, authorizes the person(s) whom you have indicated below to contact us on your behalf for scheduling, billing and payment purposes only.

I authorize _____

Please indicate your relationship with this person:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

I authorize _____

Please indicate your relationship with this person:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

I authorize _____

Please indicate your relationship with this person:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

- This authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to White Oak Counseling and Recovery.

_____ _____
Client Signature Date

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Cancellation Policy

What if I need to Cancel or Postpone my Appointment?

Please call our office at 269-205-2402 to cancel an appointment

If for some reason you need to cancel or postpone the appointment, please be considerate of your therapist and other clients and give at least 48 hours notice.

Given the demand for appointment times, if less than 24 hours notice is given to cancel or reschedule your appointment, or if you fail to show up for your scheduled appointment, you will be charged $50.00 for the missed session.

Insurance does not pay for missed appointments. These charges are your responsibility.

Payment will be due in full before the beginning of your next session. Future appointments will not be made until the Cancellation Fee has been paid in full.

_____ _____
Client Signature Date

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

PF 1000 NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (AS A CLIENT IN THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Commitment to Your Privacy

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

II. Uses and Disclosures

Treatment. Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health care provider, such as your family physician or another professional counselor.

Payment. Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the clinical condition being treated.

Health care operations. Your PHI may be used as necessary to support the day-to-day activities and management of White Oak Counseling and Recovery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your PHI may be disclosed to federal, state or local law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointments. Your PHI will be used by White Oak Counseling and Recovery to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. The contact may be made by phone, U.S. mail, email, or texting.

Informative Information. Your PHI may be used to send you information on the treatment and management of your psychological/medical condition that you may find to be of interest. We may also send you information describing psychological/health-related goods and service that we believe may interest you.
**If there is ever a breach of your healthcare information and it comes to our attention, we will inform you as soon as possible.

III. Personal Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to a restriction you request.
- The right to receive confidential communications concerning your psychological/medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.
- The right to inspect and/or copy your PHI that may be used to make decisions about you, including client psychological/medical records and billing records, but not including psychotherapy notes. The client's provider can provide a summary of the client's PHI if in the professional judgment of the client's provider, providing the client with unlimited access to his/her PHI would cause emotional/mental distress or endanger the life or physical safety of the client or another person. A client does not have the right to access Psychotherapy Notes relating to him/her except (i) to the extent the client's treating professional approves such access in writing; or (ii) the client obtains a court order authorizing such access. A provider has 30 days to reply.

IV. Requests to Inspect PHI

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us at 269-205-2402. We may deny your access to PHI under certain circumstances, but in many cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

V. Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. We will post a copy of our current Notice in a visible location in our office at all times, and you may request a copy of our most current at any time.

VI. Complaints

If you are concerned that your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your concerns to:

Bret Hoxworth MA, LLP
White Oak Counseling and Recovery
4695 M37 Hwy, Suite A
Middleville, MI 49333

Or contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

VII. Contact Person

For further information concerning our privacy practices, you can contact:

Bret Hoxworth MA, LLP
White Oak Counseling and Recovery
4695 M37 Hwy, Suite A
Middleville, MI 49333
269-205-2402

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

PF 2000 CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Uses and Disclosure of Your Protected Health Information
Your protected health information will be used by White Oak Counseling and Recovery or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the "Notice of Privacy Practices" document for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of your Information
You may request a restriction on the use or disclosure of your protected health information. White Oak Counseling and Recovery may or may not agree to restrict the use or disclosure of your protected health information. If White Oak Counseling and Recovery agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
White Oak Counseling and Recovery reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and received a copy of the White Oak Counseling and Recovery "Notice of Privacy Practices" and give my permission to White Oak Counseling and Recovery to use and disclose my health information in accordance with it.

_____
Date

_____ _____
Name of Client (Print or Type) Signature of Client Representative

_____ _____
Client Signature Relationship of Client Representative

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

ADULT INTAKE FORM

To help your clinician understand your concerns, please answer the following questions on this form and bring it with you to your first appointment.

Client's Legal Name:_____ **DOB:** _____

Gender Identity (optional)

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Non-binary

Sexual Identity (optional)

☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Pansexual ☐ Undecided

RACE/ETHNICITY (optional)

Please check the box that best represents your race/ethnic background. Please check all that applies.

☐ African-American/Black ☐ Arab American ☐ Asian or Pacific Islander ☐ Hispanic ☐ Multi-racial ☐ Native American
☐ White/Caucasian ☐ Other: _____ or check all that apply

HISTORY OF PRESENT PROBLEM (symptoms, onset, duration, etc.)

What is your reason for seeking therapy today?_____

_____

_____

PAST PSYCHIATRIC HISTORY

Previous Counseling:

Outpatient (place and year)_____

Inpatient (place and year) _____

Intensive Outpatient Program/Partial (place and year)_____

TRAUMA HISTORY

Have you had a history of trauma, abuse, or neglect? ☐ Yes ☐ No

If yes, what type of abuse or trauma occurred? ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

FAMILY PSYCHIATRIC HISTORY

Do you have any family members that have been diagnosed with mental conditions (depression, attempted suicide)?

☐ Yes ☐ No If yes, what? _____

What is their relationship to you?_____

MEDICAL CONDITIONS & HISTORY *(Optional)*

Please check all medical issues for which you have had treatment:

☐ Allergies
(e.g., allergic reactions, seasonal allergies, etc.)

☐ Bone disease
(e.g., osteoporosis, arthritis, broken bones, etc.)

☐ Blood disease
(e.g., anemia, bleeding disorders, etc.)

☐ Digestive system disease
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc.)

☐ Endocrine disease
(e.g., diabetes, hypothyroid, low testosterone etc.)

☐ Genetic disease
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc.)

☐ Head and brain illness or injury
(e.g., fainting, concussion, seizures, dementia, etc.)

☐ Heart/cardiovascular disease
(e.g., heart arrhythmia, heart attack, high blood pressure)

☐ Immune disease
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc.)

☐ Lungs and breathing disease
(e.g., asthma, COPD, emphysema, etc.)

☐ Mouth and teeth disease
(e.g., gum disease, cold sores, canker sores, etc.)

☐ Muscle and movement disease
(e.g., tremors, tics, restless legs, Parkinson's, etc.)

☐ Poisoning & chemical exposure
(e.g., overdose, lead exposure, work fumes, etc.)

☐ Serious injuries and wounds
(e.g., burns, cuts, stabs, crushed limbs, etc.)

☐ Other: _____

Do you have problems with pain? ☐ Yes ☐ No

If yes: Severity of your pain? (low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high)

Location of your pain: _____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home?
☐ Yes ☐ No If yes, please explain: _____

_____

CURRENT MEDICATIONS

Please list all current medications and supplements you are currently taking:
(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)? ☐ Yes ☐ No If yes, list below:
Name of medication: _____ Explain reaction: _____

Name of medication: _____ Explain reaction: _____

SUBSTANCE USE

Do you use alcohol? ☐ Yes ☐ No If yes, number of drinks and frequency: _____

Do you use recreational/illicit drugs? ☐ Yes ☐ No

If yes, drug(s) of choice and frequency: _____

Have others viewed your use as a problem? ☐ Yes ☐ No

Have you ever tried to cut down on your alcohol or drug use or quit using? ☐ Yes ☐ No

If yes, please explain: _____

Has alcohol/drug use interfered with family, work, or interpersonal life? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any prior substance abuse treatment? ☐ Yes ☐ No If yes, list below:

When? **Where?**

_____ _____

_____ _____

FAMILY AND SUPPORTIVE RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Committed partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, Neighbor, Roommate, Parents)	Quality of Relationship?	Living with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

Please describe what life was like growing up (please include siblings, step-siblings, and birth order). _____

_____

_____

SOCIAL HISTORY

Were you sheltered/kept private? ☐ Yes ☐ No Did you relate well to others? ☐ Yes ☐ No

SPIRITUALITY/RELIGIOUS BACKGROUND AND PRACTICE

Religious upbringing: ☐ Nonexistent ☐ Attending Church ☐ Belief in God ☐ Other _____

Present practice: ☐ Inactive ☐ Active ☐ Searching ☐ Other _____

DEVELOPMENTAL HISTORY

Childhood diagnoses of ADHD? ☐ Yes ☐ No Autism? ☐ Yes ☐ No Other _____

_____

EDUCATIONAL / OCCUPATIONAL HISTORY

Highest level completed:

☐ High School ☐ Attended college or technical school ☐ College degree ☐ Graduate degree Other_____

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Stay-at-home Parent

Finances: Overall stress level: ☐ High ☐ Medium ☐ Low

LEGAL HISTORY

Involved with the legal system, Friend of the Court or Child Protective Services? ☐ Yes ☐ No

If yes, please explain:_____

_____

Do you currently have a probation or parole officer? ☐ Yes ☐ No

If yes, name:_____

Have you been involved with the legal system in the past? ☐ Yes ☐ No

If yes, please explain:_____

_____

SNAP (strengths, needs, abilities, preferences)

Strengths: _____

Needs: _____

Abilities: _____

Preferences: _____

DSM-5 – Rated Level 1 Cross-Cutting Symptom Measure – Adult

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4. Sleeping less than usual, but still have a lot of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	5. Starting lots more projects than usual or doing more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	7. Feeling panic or being frightened?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Avoiding situations that make you anxious?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Feeling that your illnesses are not being taken seriously enough?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VI.	11. Thoughts of actually hurting yourself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XII.	19. Not knowing who you really are or what you want out of life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	20. Not feeling close to other people or enjoying your relationships with them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	22. Smoking any cigarettes, a cigar, or pipe, using snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], or drugs like marijuana, cocaine, or crack, club drugs [like ecstasy], hallucinogens [like LSD], heroin, inhalants or solvents [like glue], or methamphetamine [like speed])?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

Are there other concerns (not listed above) that you want to discuss? _____

_____

_____

OTHER IMPORTANT INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature _____ **Date:** _____

THANK YOU!

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Notification & Coordination with Primary Care Physician / Psychiatrist

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information	
Client Name:	**Client DOB:**
Parent/Guardian (if applicable):	
Physician Name/Clinic: _____ Phone #: _____	Fax #: _____
Current Psychiatric Services ☐ **Yes or** ☐ **No** Treating Psychiatrist/Clinic: _____	
List All Current Medications: *If more room needed, please attach separate sheet Medication Name: _____ Dosage: _____ Reason: _____ Medication Name: _____ Dosage: _____ Reason: _____ Medication Name: _____ Dosage: _____ Reason: _____	

It is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, White Oak Counseling and Recovery its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

Extent of information to be disclosed: ☐ **Verbal Exchange or Written Summary or** ☐ **Other:** _____

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

----------OR----------

☐ My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

For Office Use Only:

Therapist Name: _____

Current Diagnosis: _____

_____

White Oak Counseling and Recovery Staff – Faxed by: _____ *Date:* _____

WHITE OAK Counseling and Recovery
Professionally Licensed Counseling from a Christian World and Life Perspective

EMERGENCY CONTACT AUTHORIZATION FORM

Client Name _____

Personal Contact Info:

Home Address_____

City, State, ZIP _____

Home # _____ Cell # _____ Work # _____

Emergency Contact Info:

Name_____ Relationship_____

Address _____

City, State, ZIP _____

Home # _____ Cell # _____ Work # _____

Name_____ Relationship_____

Address _____

City, State, ZIP _____

Home # _____ Cell # _____ Work # _____

Medical Contact Info:

Doctor Name _____ Phone #

☐ I have voluntarily provided the above contact information and authorize _____ and its representatives to contact any of the above named on my behalf in the event of an emergency.

Signature _____ Date _____

4695 N M37 Hwy, Suite A, Middleville, MI 49333 ◆ 269-205-2402 ◆ Fax: 269-205-2728
Email: info@wocounseling-recovery.com ◆ Website: WOCounseling-Recovery.com

WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Consent for Self-Pay Fee Sessions

Client's Name: _____

Initial Date of Service: _____ and all future appointments

Self-Pay Session Fee Rate: $_____per hour

I consent to pay the self-pay session fee rate for services rendered. I understand that these self-pay sessions are my responsibility and will not be billed to nor are the responsibilities of my medical insurance company.

_____ Initial I understand that I am responsible to pay for counseling on the same day as the counseling session is given. If payment is not received within 30 days, White Oak Counseling will bill my credit card on file, or if no credit card is on file, my account will be turned over to collections and the session rate will be increased to $170.00.

_____ Initial I understand that my Therapist does not participate with all or part of my insurance company. Therefore, I elect to:

☐ Pay the cash rate of $_____ towards either the deductible or copay*.

OR

☐ Be added to our Wait List for another Therapist who participates with my insurance.

*If deductibles are not met, the cash rate will reflect the amount required by your insurance company. If deductibles are met, this cash rate will reflect only the copay amount.

_____ Date: _____
Client/Parent/Guardian Signature

_____ Date: _____
Bret Hoxworth approval Signature