Tax ID# 26-1929537
Tax ID# 27-0681792
Tax ID# 27-1353163

Turning Point Counseling Services
315 5th Ave - Fairbanks - AK - 99701
Phone: 907-374-7776 Fax: 800-988-1650

Patient Registration

*Indicates information required for billing insurance

Legal Name*: _____Birth date*:_____

Preferred Name:_____

Legal Sex*: □ Male □ Female □ Not listed (specify):_____ Gender Identity:_____

Marital Status:□ Single □ Married □ Divorced □ Separated □ Widowed □ Not listed (specify):_____

Physical Address:_____
City State Zip Code

Mailing Address:_____
City State Zip Code

Phone Number: _____SSN: _____Language Preference: _____

Race: _____Ethnicity: _____Email Address: _____

Employer:_____ Referring Provider: (If Applicable) _____Medical Provider: _____

***INSURANCE INFORMATION MUST BE COMPLETED IN FULL: Please be sure we take a copy of your ID cards**

Primary Insurance*: _____ Address: _____

Phone #: _____ Group #*: _____ ID #*: _____

Subscriber's Name*: _____ Relation to Patient*: _____ DOB*: _____

Subscriber's Employer: (If applicable to plan) _____ Phone #: _____

Secondary Insurance: _____ Address: _____

Phone #: _____ Group #: _____ ID #: _____

Subscriber's Name: _____ Relation to Patient: _____ DOB: _____

Subscriber's Employer: (If applicable to plan) _____ Phone #: _____

I understand all payments for treatment received are my responsibility. I hereby acknowledge the release of any information to my insurance company that is required to process a claim on my behalf.

I hereby authorize my insurance company to remit payment for any medical benefits due, directly to my provider as noted above. This authorization shall expire in one year or upon my written notice.

I also acknowledge that I have received or read a copy of Turning Point Counseling Services' Notice of Privacy Practices, and I have been given an opportunity to ask any questions regarding these practices. I understand that I have a right to a copy of this Notice upon my request.

Signature of Responsible Party*: _____ Date:_____

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Turning Point Counseling Services

To Our Clients:

The following information is to familiarize you with Turning Point policies and practices. If you have any questions, we will be pleased to answer them.

CONFIDENTIALITY:

The maintenance of strict confidentiality is essential to the practice of clinical and counseling psychology. Your informed written consent is required for the release of any information about you (or your child) except in the follow circumstances:

1. We are legally obligated to inform the police if we have reason to believe a client is likely to inflict bodily harm on another person.
2. If we assess a client to be at high risk of suicide or gravely disabled due to a mental illness, we are legally obligated to arrange for protective services.
3. We are legally obligated to report suspected child abuse to the State Office of Child Protective Services (OCS). We are also required by law to report suspected abuse of handicapped or elderly individuals.
4. In certain legal situations, our treatment records may be ordered to be released by a court of law. Please discuss with us any concerns in this regard.
5. When an insurance claim is filed for our services the client (or legal guardian) gives their health insurance carrier the right to make inquiries regarding their mental condition. In certain cases, we may be asked to provide details concerning a client's presenting problem(s) and treatment needs. Insurance companies usually require a signed release form clients to pay benefits directly to a health service provider.
6. We may release a client's name to a collection agency if necessary. In these cases, no treatment related content would be associated.
7. At Turning Point Counseling Services, we use a team approach, which means we may consult with one or more clinical team members regarding your case. All team members are held to the same confidentiality outlined above.

In releasing confidential information, we will only disclose the details of a case that or legally or clinically necessary.

If you see someone leaving our office area that you recognize, please respect their confidentiality, as you would want them to do the same for you.

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YOUR HEALTH INFORMATION RIGHTS:

Your treatment file will be kept for seven years after your last date of service. After that time, it will be destroyed. Although your health records are the physical property of our practice, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) you have the right to:

1. Obtain a paper copy of this notice of request information.
2. Inspect and receive a copy of your health record.
3. Amend or supplement certain information in your health record.
4. Request communications of your health information by alternative means or at an alternative location.
5. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

Out practice is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice as to our legal duties and privacy practices concerning the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a request restriction.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at an alternative location.
6. Obtain all legal guardian(s) written consent to treat before initiating services unless legal documentation is provided stating otherwise.

We reserve the right to change out practices and to make new provisions effective for all protected health information we maintain. Should our information or practices change, we will mail a revised notice to your supplied address. We will not use or disclose your health information without your written authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization.

RISKS, BENEFITS, AND RESONSIBILITIES:

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may facilitate my ability to relate to others, enhance my academic performance, improve relationships with myself and others, expand my ability to deal with everyday stress and provide a clearer understanding of myself, my values, and my goals. Although counseling can be beneficial to many people, it may not be helpful for everyone. I understand that it is my responsibility to actively participate in the therapeutic process and treatment.

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TO REPORT A PROBLEM OR FILE A GRIEVANCE:

If you have questions or would like additional information, you may speak with your clinician or office staff. If you believe your privacy rights have been violated, or if you have any complaints regarding your services here at Turning Point, you may ask to speak with the clinical supervisor, administrative director, or program director. At that time, you may request a copy of our grievance procedure. This procedure clearly outlines the steps you can follow, and we will abide by them to resolve any grievance issues.

FEES:

Are subject to change at any time. Any fees that are due must be paid before the start of the appointment. We highly encourage leaving a Debit/Credit Card on file.

PAYMENT METHOD AND INSURANCE:

Payment is expected in full at the time of your initial appointment, except in cases where an advance arrangement with outside state and other agencies has been contracted. Your insurance will be billed for you as a courtesy unless you request otherwise.

Copays and deductibles for subsequent sessions must also be paid at the time of service. As a courtesy, your insurance will be billed for the balance; however, you are ultimately responsible for the amount owed regardless of what the insurance pays.

We accept most major insurances and/or cash payments. **WE DO NOT ACCEPT** Medicare, Medicaid, Tribal Insurance, Workers Compensation. We do not offer sliding scale fees or payment plans.

We accept most insurances; however, initial verification of benefits does not guarantee payment. Clients are considered the guarantors of all service charges, and you are ultimately responsible for the amount owed regardless of what the insurance pays. You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost.

Under the law, healthcare providers are required to give patients who do not have insurance, choose to not utilize their insurance, or have an out of network carrier, an estimate of the bill for medical items and services. These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length, or cost. If estimates or services are added or changed you will receive a new “Good Faith Estimate”. Your signature does not create a contract or require you to receive psychotherapy services from Turning Point, LLC. If the actual cost of services greatly exceeds the estimate, you may initiate a dispute resolution by contacting HHS at 1-800-985-3059 or you can visit http://cms.gov/nosurprises.consumers

COURT TESTIMONEY AND REPORTS:

Court testimony, depositions, and written reports to the court will be charged at the normal hourly rate of the provider Travel and waiting time will be included in the hourly rate. Please discuss with us in advance any court related services you may require.

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BROKEN APPOINTMENTS:

No-Show appointments will be defined as clients missing and/or canceling a scheduled appointment without providing a 24-hour notice.

The first no-show occurrence client will receive a reminder that a $100 fee will be applied to all future no-shows.

The third occurrence will result in the client being ineligible for services form Turning Point LLC for a minimum of six months and will be provided with a referral to continue services elsewhere.

PHONE CALLS:

If you need to call Turning Point, please call: 907-374-7776. During the weekends, after hours, and other times when we may be unavailable, we have voicemail and will always return your calls within one business day.

If you have a crisis and need immediate help after hours, you may go to the Emergency Room, call 911, or call Alaska Behavioral Health at 907-371-1300 and they will be able to assist you further. They have providers whom you will be able to talk to after hours.

INSPECTION OF RECORDS:

Federal law grants you the right to review any notes, psychological assessments reports, or other documents that are part of your treatment record. If you would like to review these records, please let us know. All medical record requests will be processed within 5 business days. Your treatment file will be kept for seven years after your last day of service. After that time, it will be destroyed.

MISCELLANEOUS:

If you would like to review the professional code of ethics that our agency abides by, go to our website, turningpointcounselingservices.com, and look for the link to the AMHCA codes of ethics.

If you are obtaining services for your child and the child is in an individual therapy session with us, we ask that a parent or guardian remain on the property.

Please keep us informed of any changes in your address or phone number so we may contact you in case any changes need to be made in scheduling.

By signing below, you state that you have received a copy of the above material. Additionally, your signature gives your consent to receive treatment and states that you agree to abide by the term's outlines above.

Client Signature*:_____ Date:_____

Staff*:_____ Date:_____

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Turning Point Counseling Services

FINANCIALY POLICY

Patient Name:_____

Last First MI

ACCEPTABLE METHODS OF PAYMENT:

We accept CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, AND DISCOVER for your convenience.

CASH PATIENTS: Payment for services is due at the time services are rendered, we do not offer payment plans or sliding scale fees.

We accept most insurance; however, initial verification of benefits does not guarantee payment. Clients are considered the guarantors of all service charges, and you are ultimately responsible for the amount owed regardless of what the insurance pays. You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, healthcare providers are required to give patients who do not have insurance, choose to not utilize their insurance, or have an out of network carrier, an estimate of the bill for medical items and services. These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length, or cost. If estimates or services are added or changed you will receive a new "Good Faith Estimate". Your signature does not create a contract or require you to receive psychotherapy services from Turning Point, LLC. If the actual cost of services greatly exceeds the estimate, you may initiate a dispute resolution by contacting HHS at 1-800-985-3059 or you can visit http://cms.gov/nosurprises.consumers

INSURED PATIENTS: We offer the courtesy of filing your insurance claims, but we require that copays, deductibles, and remaining balance be paid at the time services are rendered.

PAYMENT PLANS: Payment plans are available for extensive treatment plans for the IOP Program. Payment arrangements must be set up and signed before the date of service. A credit or debit card number must be provided and kept on file for payment plans.

RATES: Service rates are based on usual and customary for the geographic area and are subject to

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change without notice (we will do our best to inform you at the time of service of rate increases whenever possible). Each insurance company determines what they think is usual and customary, and the two may not agree, leaving the patient responsible for the remaining balance.

MISSED APPOINTMENT FEES: Missed appointments or appointments canceled with less than 24-hour notice will be charged a $100 fee.

DELINQUENT ACCOUNTS: Any account not paid within 30 days of receiving payment from the patient's insurance company will be considered delinquent. Any accounts sent to collections that incur attorney's fees will be the sole responsibility of the patient. Appointments will not be scheduled for patients who have accounts in collections until the balance is paid in full.

☐ I acknowledge that I have read the above policies and agree to the content.

Signature*:_____ Date:_____

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Consent for Electronic and Internet Communications

Patient Name (print clearly)*: _____

Last First

By utilizing out practice's electronic services, you agree that Turning Point LLC and its employees may send information about your specific mental health appointments or any information that you request regarding your account or mental health visits through the internet to an email address that you list below and/or by text message. You are responsible for providing our office any updates to your email address. You may withdraw your consent to electronic communication by call our office at 907-374-7776.

Email Address*:_____

I grant my permission to Turning Point LLC to upload and store confidential information (including account, appointments, and clinical information) to a secure website for Turning Point LLC. I understand that for security purposes the site requires a user ID and password for access and use. I also understand the mental health practice and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the mental health practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Turning Point LLC is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the mental health practice website with my ID and password. I also agree to immediately notify Turning Point LLC of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limits the ability to make use of certain services or to transmit certain information to third parties. I understand Turning Point LLC will represent and warrant that they will at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree Turning Point LLC has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient

information. I understand Turning Point LLC will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the mental health practice cannot and does not assume any responsibility for my use or misuse of patient

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information or other information transmitted, monitored, stored, uploaded, or received using the site or other services.

I ACKNOWLEDGE THAT I HAVE READ THE INFORMATION ABOVE AND AGREE TO THE CONTENT.

Signature*:_____ Date:_____

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Turning Point Counseling Services

Teletherapy Informed Consent

I _____ hereby consent to engage in teletherapy with a designated counselor/therapist with Turning Point LLC as part of my treatment. I understand that "teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications technology. I understand that with my signed consent, teletherapy also involves communication of my medical/mental information, both orally and visually, to healthcare practitioners located in Alaska or outside of Alaska.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also applies to teletherapy. As such I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child, elder, and dependent adult abuse; express threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the teletherapy interactions to researchers or other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from teletherapy including but not limited to the possibility despite reasonable efforts on the part of my counselor/therapist that the transmission of my medical information could be disrupted or distorted by technical failures the transmission of my medical information could be interrupted by unauthorized persons and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services and that cultural and/or language differences may affect service delivery.
5. I also understand that if my counselor/therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my area.
6. I understand that there are potential risks and benefits associated with any form of substance use treatment or mental health treatment and that despite my efforts and the efforts of my counselor/therapist my condition may not improve and in some cases may even get worse.

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7. I understand that it is customary for my counselor/therapist to respond within one business day but that is not a guarantee and that when my provider is not available in the event of an emergency, I have been directed to contact 911 or go to the nearest emergency room.
8. I understand that there may be a difference between Alaska and other time zones my provider may be in.
9. I understand that I may benefit from teletherapy but that results cannot be guaranteed or assured.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with Alaska State law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

Signature*:_____ Date:_____

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This confidential information is for use by your clinician. Please PRINT and complete all information.

Date:_____ Referred By:_____

Legal Name:_____ Date of Birth:_____ Age:_____

Preferred Name:_____ Preferred Pronouns:_____

TELEPHONE PRIVACY: Please answer the questions below. Federal HIPAA regulations require your signature.

Preferred Contact Number:_____

Please specify any calling instructions:_____

Print Name:_____ Signature:_____ Date:_____

Emergency Contact:_____ Phone#:_____

First MI Last

Your Primary Physician:_____ Phone#:_____

HEALTH INFORMATION: Please list any current medical conditions/problems that you have:

_____

_____

_____

_____

List Current Medication (including dose and schedule information):

_____

_____

_____

What is the concern that motivated you to seek services at this time?

_____

_____

_____

_____

Is this court ordered or required for you to complete? YES NO

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If yes, by whom?

Are you seeking services due to an accident? YES NO

If so, what kind of accident was it: Motor vehicle Work Other Please explain:

Are you willing to be referred for psychiatric medication evaluation? YES NO

What would you like to see change or what personal benefits would you like to receive as a result of participating in services?

Do you have a history of experiencing suicidal or homicidal thoughts? YES NO

If yes, please explain:

Are you experiencing suicidal or homicidal thought now or within the past 30 days? YES NO

If yes, please explain:

Is alcohol or other drug use causing social, relational, or legal problems in your life now or in the past? YES NO If yes, please explain:

Would you agree to abstain from alcohol or other drugs while receiving services? YES NO

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Instructions: Please rate your current levels of distress using the number scale below for the following symptoms and circumstances.

0	1	2	3	4	5	6
None	Minimal	Manageable	Moderate	Considerable	High.	Unbearable

_____ Depressed Mood _____

_____ Thought of Suicide _____

_____ Thoughts of harm to self or others. _____

_____ Thoughts of worthlessness _____

_____ Thoughts of hopelessness _____

_____ Difficulty falling asleep _____

_____ Frequent waking _____

_____ Loss of interest or pleasure _____

_____ Excessive worry _____

_____ Rapid thoughts _____

_____ Acting impulsively _____

_____ Eating/Nutritional Patterns _____

_____ Rapid Speech _____

_____ Excessive energy _____

_____ Feeling like you don't need sleep _____

_____ Feeling anxious or nervous _____

_____ Nightmares _____

_____ Frequent disturbing memories _____

_____ Seeing things others can't see _____

_____ Hearing things others can't hear_____

_____ Smelling things others can't smell_____

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_____ Legal Problems _____

_____ Financial problems _____

_____ Relationship problems _____

_____ Gender/sexual identity _____

_____ Death of a loved one _____

_____ Physical/sexual abuse _____

_____ Emotional/verbal abuse _____

_____ Health problems _____

_____ Parent/child conflict _____

_____ Problems managing anger _____

_____ Problems managing stress _____

_____ Problems with self-esteem _____

_____ Spiritual health _____

_____ Alcohol or drug use (self) _____

_____ Alcohol or drug use (others) _____

_____ Substance use withdrawal symptoms_____

Please circle any of the following symptoms that you have experienced in the last seven (7) days:

Irritable mood Nausea/Vomiting Muscle aches Diarrhea Excessive yawning Fever Insomnia Hand tremors Seizures Extreme mood swings Sweating without physical exertion

Please give any other information that you feel would be helpful for this evaluation and/or treatment planning:_____

_____

_____

_____

Print Name Signature Date Relation to patient

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Turning Point Counseling Services

Patient Self Report Survey

Name:_____ Date:_____

Please circle: which of the following services are you using at this time?

Initial Appointment Outpatient Counseling Intensive Outpatient Program

Please circle: How long have you been receiving services?

Admission/Just starting 1-30 days 31-60 days 61-90 days Other:_____

Please rate yourself in the following areas of your life	Excellent	Very Good	Good	Fair	Poor
1. Your ability to manage emotions and stress	5	4	3	2	1
2. Your relationship with family or significant others	5	4	3	2	1
3. Employment/School	5	4	3	2	1
4. Physical health	5	4	3	2	1
5. Social support	5	4	3	2	1
6. Practice self-care	5	4	3	2	1
7. Overall quality of life	5	4	3	2	1

Other comments you want to share:_____

_____

_____

_____

Signature*:_____ Date:_____