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

315 5th Ave ~ Fairbanks ~ Alaska ~ 99701
Phone: 907-374-7776 Fax: 800-988-1650

Patient Registration

*Indicates information required for billing insurance

Legal Name*: _____ Birth date*: _____
Last First MI

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: _____

Race: _____ Ethnicity: _____ Language Preference: _____

Email Address: _____ Employer: _____

Referring Provider: (If Applicable) _____ Medical Provider: _____

Parent/Guardian: _____
(If Patient is a Minor) Last First MI

Birth date: _____ SSN: _____ Relationship: _____

_____
Mailing Address if different from child

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

Primary Insurance: _____ Address: _____

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

Insured's Name: _____ Relation to Patient: _____ **DOB** _____
Insured's Employer:(If applicable to plan) _____ Phone # _____

Secondary Insurance: _____ Address: _____

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

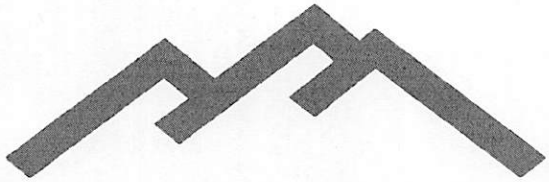
Insured's Name: _____ Relation to Patient: _____ **DOB** _____
Insured's Employer:(If applicable to plan) _____ Phone # _____

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: _____



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 following 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 hospitalization.

3. We are legally obligated to report suspected child abuse to the State Office of Children's Services (OCS). We are also required by law to report suspected abuse of handicapped or elderly persons.

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 from 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 disclosed.

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 are 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.

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 record is the physical property of our practice, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) you have the right to:

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

OUR RESPONSIBILITIES:

Our practice is required to:

Maintain the privacy of your health information.
Provide you with this notice as to our legal duties and privacy practices concerning the information we collect and maintain about you.
Abide by the terms of this notice.
Notify you if we are unable to agree to a requested restriction.
Accommodate reasonable requests you may have to communicate health information by alternative means or at an alternative location.
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 our practices and to make new provisions effective for all protected health information we maintain. Should my 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 RESPONSIBILITY:

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.

FOR MORE INFORMATION, TO REPORT A PROBLEM OR TO 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 issue.

FEES:

Are subject to change at any time. Any fees that are due must be paid before the start of the appointment. We highly suggest leaving a credit card on file.

PAYMENT METHOD AND INSURANCE:

Payment is expected in full at the time of your initial assessment, 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.

Co-Pays & 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, Chief Andrew Isaacs, or Workmen's Compensation. We do not offer payment plans or sliding fee scales.

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 costs of services greatly exceed the estimate, you may initiate a dispute resolution by contacting HHS at 1.800.985.3059 or you can visit https://cms.gov/nosurprises/consumers

COURT TESTIMONY 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.

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 from Turning Point LLC for a minimum of 6 months and will be provided with a referral to continue services elsewhere.

PHONE CALLS:

If you need to call us, please call: 907-374-7776. During weekends, after hours, and other times when we may be unavailable, we have voice mail and will always return your call within one working 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. 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 assessment 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 records requests will be processed within 5 working days. Your treatment file will be kept for seven years after your last date 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 code 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 terms outlined above.

Client's Signature	Date
Parent/Legal Guardian's Signature (if the client is under 18)	Date
Parent/Legal Guardian's Signature (if the client is under 18)	Date
STAFF	Date

Turning Point Counseling Services

FINANCIAL 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 fee scales.

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 costs of services greatly exceed the estimate, you may initiate a dispute resolution by contacting HHS at 1.800.985.3059 or you can visit https://cms.gov/nosurprises/consumers

INSURED PATIENTS: We offer the courtesy of filing your insurance claim, but we require that co-pays, deductibles, and remaining balances 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 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.

315 5TH AVENUE • FAIRBANKS, AK • 99701
PHONE: (907) 374-7776• FAX: (800) 988-1650

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 patient's sole responsibility. 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: _____

Turning Point Counseling Services

Building Recovery Foundations Together

Consent for Electronic and Internet Communications

Patient Name: _____ _____
Last First

By utilizing our 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 messaging. You are responsible for providing our office any updates to your email address. You may withdraw your consent to electronic communication by calling our office at (907) 374-7776.

Email Address: _____

I grant my permission to Turning Point, LLC to upload and store confidential information (including account information, appointment information, 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 Turing 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 that 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 INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I acknowledge that I have read the information above and agree to the contents.

Signature: _____ Date: _____

315 5th Avenue Fairbanks, AK 99701 / (907) 374-7776 Fax: (800) 988-1650
staff@turningpointcs.org / www.turningpointcounselingservices.com

Turning Point Counseling Services

Teletherapy Informed Consent

I hereby consent to engage in teletherapy with a designated counselor or 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, telemedicine also involves the 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 apply 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; expressed 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 interaction 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 or 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 or 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 or 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 or therapist, my condition may not improve, and in some cases may even get worse.

(7) I understand that it is customary for my counselor or 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 the nearest emergency room.

(8) I understand that there may be a difference between Alaska and other time zones.

(9) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

(1) 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 or therapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

Client Signature_____ Date_____

Turning Point Counseling Services

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:_____ Pronouns:_____

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

Preferred contact number:_____

Please specify other calling instructions:

_____

Print Name:_____ Signature:_____ Date:_____

Emergency Contact/Relation:_____ Phone #:_____
(first) (middle) (last)

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

_____

_____

_____

_____

List current medications (*include dose and schedule information*):_____

_____

_____

Your primary physician:_____ Address:_____ Phone:_____

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

_____

_____

_____

Is this visit court-ordered or required for you to complete?_____ If yes, by whom?_____

Is your visit 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 thoughts 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:_____

_____

_____

If asked, would you agree to abstain from alcohol or other mood-altering drugs while receiving services? **yes** **no**

Print Name	Signature	Date	Relation to Client

Instructions: Please rate your current level 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
_____ Rapid Speech
_____ Excessive Energy
_____ Feel Like Don't Need Sleep
_____ Feeling Anxious or Nervous
_____ Nightmares
_____ Frequent Disturbing Memories
_____ See Things Others Can't See
_____ Hearing Things Others Can't Hear
_____ Smelling things Others Can't Smell
_____ Legal Problems
_____ Relationship Problems
_____ Gender/Sexual Identity
_____ Death of a Loved One
_____ Physical Abuse
_____ Sexual Abuse
_____ Emotional or Verbal Abuse
_____ Health Problems
_____ Parent-Child Conflict
_____ Problem Managing Anger
_____ Problem Managing Stress
_____ Problems with Self-Esteem
_____ Spiritual Health
_____ Alcohol or Drug Use (Self)
_____ Alcohol or Drug Use (Others)
_____ Substance Use Withdrawal Symptoms (*if applicable*)

Place a checkmark for any of the following symptoms that you have experienced in the last seven days:

Irritable Mood Nausea or 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_____

Turning Point
Patient Self-Report Survey

Name:_____ **Date**_____

Which of the following services are you using at this time?
Initial Appointment Outpatient Counseling Intensive Outpatient

How long have you been receiving services?
Admission 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.Your physical health:	5	4	3	2	1
5. Your social supports:	5	4	3	2	1
6. Your practice of self-care:	5	4	3	2	1
7. Overall quality of your life:	5	4	3	2	1

Other Comments: _____
_____
_____

Signature _____

FOR STAFF USE ONLY
ID #:_____
Clinician:_____