The Center for Life Changes

In order to serve you properly I will need the following information and your signatures where indicated.

Client information

Name: _____ DOB: _____ Age: _____

Gender Identification: _____

Pronoun Preference: _____

Self-Identified Race and/or Ethnicity: _____

Address: _____ NM _____
Street State Zip Code

Phone Number: _____ ___Email: _____

Responsible Party Other Than Self/Relationship:

Name: _____ Relationship: _____

I give permission for the Center for life Changes and/or associates to contact the below listed person in case of emergency.

Emergency Contact: _____ Phone:_____

Relationship/Insurance Information **Insurance Carrier: _____**

Member ID: _____ Group: _____

Additionally, we will need a copy of your insurance card (front/back) and a copy of your driver's license.

By signing this form I am authorizing The Center for Life Changes and/or associates who accepts assignment, to release information necessary to process claims to the medical insurance company. My signature on this form and the attached forms also indicates that I understand that insurance matters are between myself, the client, and the insurance company and not between The Center for Life Changes and the insurance company. Therefore any claims not paid by the insurance company will be my responsibility.

Signature: _____ Date: _____

The Center for Life Changes

WELCOME to The Center for Life Changes, as you embark on this journey seeking clarity, change, and a different direction for your life. I am honored that you have chosen us, and me as your counselor.

Informed Consent for Treatment - Client-Counselor Services Agreement

At The Center for Life Changes, we are here to support your path in therapy. This document contains important information about professional services offered and our policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although this document is long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Professional Counseling

The goal of therapy is to offer a safe place for growth and change. The stressors and transitions of life can often make us feel isolated and vulnerable. A therapist can offer you with nurturing and strength-based guidance, resources that can enrich your inner life, and a nourish relationship to allow you to resolve those difficulties. The therapeutic relationship will provide you with a safe place to grow and cope with stressors in your life along with the transitions that come, and ultimately *Change* itself.

Our goal is to provide you with compassionate and competent therapeutic services in an informal setting and to see that you receive treatment with respect and dignity. In addition, we desire to help you face the challenges of life with a clearer sense of vision, inspiration, and strength.

Please explore our website at www.thecenterforlifechanges.com to learn more about the ways we can partner to explore your ideas or thoughts about therapy. Please ask me questions about your particular needs. I encourage and welcome individuals who express themselves in diverse ways, so as we work in your most effective form – even during difficult times. Because we are so diverse, sometimes the "It Takes a Village" approach works. Our partnerships with a variety of colleagues offer different types of services to address Mind-Body-Soul and encourages exploration of the different facets of your life.

Counseling Services

The Center for Life Changes

Therapy is a relationship between people that works when rights and responsibilities between the client and the therapist are clearly defined. Therapy is not easily described in a general statement. It may vary depending on the personalities of the counselor and the client, and the evolution of the therapeutic process and the therapeutic relationship. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you.

There are many methods that can be used to help you address the current reason(s) you are seeking therapy. *These methods usually call for a very active effort on your part*. For the therapy to be effective and successful, you are invited to work on the things we talk about during our sessions and, also out of session. These techniques have benefits and risks. The risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. In many instances, these feelings may cause additional triggers and/or urges. It is important that you share feelings with me during the therapy process.

Counseling provides many benefits for individuals who engage in therapy and can often lead to significant decrease in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, triggers, and urges. This may include improvement of physical health and well-being. There are no guarantees of what you may experience, and I encourage you to be honest and forthright with me. You are entitled to receive information from me about the methods of therapy, the techniques for use in treatment planning progress, and the duration of therapy needed. A treatment plan is necessary to mark progression in therapy and will be developed and used to direct the steps in your personal work. Please ask me if you would like to receive this information or if you have questions about the therapeutic process so we can discuss them as those questions arise.

I consider myself as a seasoned counselor with a background in multiple areas, and as such, I will not practice outside of my scope of practice. If we find ourselves outside my scope of practice, I will offer appropriate recommendations to include possible referral for services elsewhere. Any questions, concerns, or complaints regarding our work together should be discussed between us, and if you deem it necessary, it is within your rights to contact the state licensing board. You may seek out a second opinion from another counselor or terminate therapy at any time. The practice of professional counseling is regulated by the New Mexico Counseling and Therapy Practice Board New Mexico located at 2550 Cerrillos Road, 2nd Floor Santa Fe, NM 87505 (505-476-4622).
I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

Individual Appointments

Appointments are ordinarily 45-50 minutes in duration, once per week at a time we agree upon, some sessions may be more frequent or less, as is needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session. A 24-hour notice is required. If you miss a session without canceling or cancel without the 24-hour notice, my policy is to collect a missed session fee of $50.00. I will work with you to find another time to reschedule your appointment, however this will be based upon scheduling availability. In addition, you are responsible for arriving to your session on time and ready to work. If you are late for your appointment I will still need to close by the end of your scheduled time. Should you fail to cancel or show for an appointment without the required notice for 3 times, for legal and ethical reasons, we must consider the professional relationship discontinued and renewal of services will be evaluated based on availability.

Couples and Family Session Appointments

In order to facilitate couples and family sessions, it is important that all members attend. If one member is unable to attend, the session will need to be rescheduled, as all clients must be in attendance. A 24-hour notice is required. If you miss a session without canceling or cancel without the 24-hour notice, my policy is to collect a missed session fee of $50.00.

I have read and understand this statement:

Signature: _____ **Date:** _____

Employee Assistance Programs (EAP)

Employee Assistance Affiliate Statement of Understanding. The Center for Life Changes is a licensed behavioral health affiliate credentialed by the EAP that referred you. Services from an EAP affiliate begin with an assessment. The purpose of an assessment is to clarify what your issues and goals are, and to find the best way to help you reach a resolution within that timeframe.

1. Brief EAP Counseling: If it appears likely that your concern can be fully resolved within the number of sessions allowed by your employer's EAP contract, your counselor will, in most cases, recommend that you continue counseling with your private insurance after the contracted number of sessions through EAP. In this case, it is important to know what your private insurance is, and is also requested when you begin, in order to determine continuity of services after EAP sessions.
2. Cost of EAP Counseling: You are never charged for EAP counseling. If you are referred for counseling or treatment outside of EAP, you will be responsible for any costs incurred.

3. Non-Attendance: If you need to cancel an appointment, it is required that you provide at least 24-hours advance notice. If you do not cancel with the 24-hour advance notice, one session will be deducted from the number of sessions allowed by your employer's EAP contract.

4. Example: If you have 6 available sessions, and do not attend a scheduled appointment with a 24-hour advance cancellation notice, you will only have 5 available sessions.

I have read and understand this statement:

Signature: _____ **Date:** _____

Fees and Forms of Payment

In order to set treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are ultimately responsible for knowing your policy coverage and for letting me know if or when your coverage changes.

The standard fee for the initial intake is $180.00 and each subsequent session is $150.00, couples or family sessions are $175.00, crisis calls are $160.00 for the first hour then $82.50 for an additional 30 minutes. This time cannot exceed one and a half hours. These rates will apply to Insurance and the contract I have with the insurance company.

Insurance Prior Authorization Advisory: If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If authorization is not obtained and it is required, you may be responsible for full payment of the fee. Prior authorization request may vary between insurance companies as to how and who requests that authorization. Many policies have a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by you. Either amount is to be paid at the time of your appointment.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If authorization is not obtained and it is required, you may be responsible for full payment of the fee. Prior authorization request may vary between insurance companies as to how and who requests that authorization. Many policies have a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by you. Either amount is to be paid at the time of your appointment.

Some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by you before the insurance company is willing to begin paying any amount for therapy services. This will typically mean that you will be responsible to pay for initial sessions until your

deductible has been met. The deductible amount begins at the start of each calendar year or with some insurance companies may have different eligibility dates. It is important to know that you always have the right to pay for therapy services yourself to avoid the problems described above unless prohibited by my provider contract with your insurance company**.** If I am not a participating provider for your insurance company, I will supply you with a receipt of payment for services for you to submit to your insurance company, and you will need to be informed if your insurance company accepts out-of-network providers. Please note: The Center for Life Changes does not provide end of year statements. If you use your insurance, The Center for Life Changes will submit your claims electronically due to required insurance company processes.

Self-payment sessions are $95.00 for a 50-minute session and will be based on a three-month period. This fee schedule is subject to change. An additional informed consent agreement form will be filled out for each period of time.

Please understand that a cancelled appointment without 24-hour notice or a missed appointment are not covered by the insurance company and as such, are your responsibility to pay at the time of the missed appointment. The ONLY exception is if the missed appointment is due to a critical emergency or other circumstances that are discussed with me ***before*** the scheduled session.

Some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by you before the insurance company is willing to begin paying any amount for therapy services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met. The deductible amount begins at the start of each calendar year or with some insurance companies may have different eligibility dates. It is important to know that you always have the right to pay for therapy services yourself to avoid the problems described above unless prohibited by my provider contract with your insurance company**.** If I am not a participating provider for your insurance company, I will supply you with a receipt of payment for services for you to submit to your insurance company, and you will need to be informed if your insurance company accepts out-of-network providers. Please note: The Center for Life Changes does not provide end of year statements. If you use your insurance, The Center for Life Changes will submit your claims electronically due to required insurance company processes.

I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

The Center for Life Changes accepts exact cash, major credit cards, Health Savings Accounts, and Flexible Savings Accounts. In some cases, checks will be accepted with the understanding that if your check does not clear for payment, you will incur a $25.00 fee payable to The Center for Life Changes plus banking account Non-Sufficient Fund (NSF) fees assessed to my business and is payable immediately with a major credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

Some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by you before the insurance company is willing to begin paying any amount for therapy services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met. The deductible amount begins at the start of each calendar year or with some insurance companies may have different eligibility dates. It is important to know that you always have the right to pay for therapy services yourself to avoid the problems described above unless prohibited by my provider contract with your insurance company. If I am not a participating provider for your insurance company, I will supply you with a receipt of payment for services for you to submit to your insurance company, and you will need to be informed if your insurance company accepts out-of-network providers. Please note: The Center for Life Changes does not provide end of year statements. If you use your insurance, The Center for Life Changes will submit your claims electronically due to required insurance company processes.

In addition to weekly sessions, there are additional fees for other requested professional services. These services include but are not limited to: report writing, release of medical records, a diagnosis and treatment summary and along with recommendations, phone calls that last longer than 15 minutes. This can also include FMLA paperwork. If you are seeing a therapist under an EAP session, FMLA or any other disability paperwork cannot be completed as it may be considered a conflict of interest on the part of the therapist. Additionally, these may fees vary and will be discussed with you prior to any additional fees that may be assessed. If you anticipate being involved in a court case, I recommend a discussion before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. These fees will be provided in advance, in writing, and upon agreement prior to services rendered.

Credit Card Payment Advisory: If a third-party credit card is used for payment, use of the card acts as a release of information to the card holder. It is your duty to inform the card holder of payment details listed as The Center for Life Changes as well as the payment amount.

I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

Telephone & TELEHEALTH Services

The Center for Life Changes uses the HIPPA compliant platform TherapyNotes and Google Meet Business Suite. There are potential risks to this technology, including interruptions and technical difficulties. You have the right to switch to phone should these difficulties arise. You will need to agree to provide a private location in which to attend the session. It is not the responsibility, or the liability of The Center for Life Changes should you not secure privacy.

I have read and understand this statement:

Signature: _____ **Date:** _____

Electronic Communication

If you need to contact me between sessions, please leave a message via confidential voice mail and I will attempt to return your call within 24 hours with, the exceptions of weekends. If you have a brief question about appointment times or other **non-sensitive** information, you can text the number I have given you. If a true life or health threatening emergency arises, please call 911 or go to any nearest emergency room.

I have confidential voicemail and I cannot ensure the confidentiality of any other form of communication through electronic media, including text messages and email. While email on my end is HIPPA complaint, it may not be on your end when sending an email. If you prefer to communicate via email and/or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages within the 24-hour notice, as has been noted before, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Videotaping and Audio Taping of Therapy Sessions

Videotaping or audio taping is **not** allowed during sessions. Sessions are conducted online by the HIPPA compliant platform Google Meet or by phone. Some phone services are not HIPAA compliant and if you choose to use one, as such you will be waiving your right to HIPAA compliancy for the phone service.

I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests *in writing* to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a way that there is a risk of great bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. Indications as stated above in the case of a dependent or elderly adult or a minor who may be subjected to these abuses.
4. If a court of law issues a legitimate subpoena for information stated on the subpoena.
5. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
6. If client attends session under the influence of drugs or alcohol, it may be necessary to request medical or a family member's assistance in furthering safety.
7. If insurance requests records, privilege is consider waived under your insurance policy. However, records will not be released before informing you of the request.
8. If a third party source is needed to collect or return payment.

On occasion I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your protected health information.

I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

Parents and Minors—Confidentiality *(Please read and sign only if this applies)*

Privacy in therapy is crucial to successful progress, parental involvement can also be just as essential. It is the policy of The Center for Life Changes not to provide treatment to a child under the age of 13 years old to include parental participation. For children 14 and older, I will request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, and a treatment summary upon completion of therapy. All other

communication will require the child's specifically written agreement, unless I feel there is a safety concern in which case, I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

The parent will review and sign this Informed Consent and provide a brief overview of concerns. When parents are divorced and share joint legal custody or have custody litigation in process, both parents must sign below and submit this parental consent form prior to scheduling the child's first appointment along with the court order of parental custody.

In the instance of a minor being treated for mental health concerns and where the parents have custodial issues facing difficulties or in litigation it is outside the scope of my practice to recommend or suggest custody at any time.

I have read and understand this statement:

Signature: _____ **Date:** _____

Confidentiality between Therapist and Client in the community

If you and I might see each other outside of the therapy office I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance, and I do not wish to jeopardize your privacy. However, if you acknowledge me, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office. If there are other individuals present, these individuals will not be introduced out of respect for privacy.

I have read and understand this statement:

Signature: _____ **Date:** _____

The Center for Life Changes

RELEASE OF CONFIDENTIAL INFORMATION to/from ALEX BABANI, PSY.D., LPCC

Please Answer the Following:

I hereby authorize_____, _____
(Individual) (Agency)

_____, _____, _____
(Address) (City, State, Zip) (Phone Number)

AND:
The Center for Life Changes 3321B Candelaria Road Suite 305, Albuquerque, NM 87107
(505) 492-7252 Cell. (505) 393-5148 Fax

To release information regarding the following individual:

Name:_____ D.O.B.: ____/____/_____ _____ - _____ - _____
(Social Security)

The following Information:
_____ Medical Records _____Psychiatric Records
_____Mental Health Records _____Out-Patient Records
_____HIV/AIDS _____Alcohol/Drug Abuse
_____Prescription Drug Information
I understand that all such information released is to be treated as confidential.
This Release of Information will expire on _____.
Date

_____ _____
Signature Date

_____ _____ _____
Witness Signature Title Date

If you do not want to release information please fill out bottom box

At this time, I _____ do not want any information released to anyone.

_____ _____
Signature **Date**

_____ _____
Witness **Date**

The Center for Life Changes

Professional Records

The Center for Life Changes is required to keep secured electronic records through a HIPPA compliant system with corresponding security measures called Therapy Notes along with any communications through Google Suite Gmail. The Center for Life Changes is required to keep appropriate records of therapy services. Records may include, reasons for seeking therapy, goals and progress set for treatment, your diagnosis, topics of discussion, medical, social and treatment history, records received from other sources, and your billing receipts. The Center for Life Changes is not responsible for how this information is shared once it has left my office.

I have read and understand this statement:

Signature: _____ **Date:** _____

In-Person Services During or After COVID-19 Health Crisis

The Center for Life Changes follows the State of New Mexico Health Ordinances. To decrease potential exposure. As of this writing, it is best to wait in your car or outside of the building as it is a shared space with various businesses. We are required to wear masks in the common areas within the building, though mandate may be subject to change. Within the office we will discuss pertinent protocols. You have the right at any time to opt for telehealth sessions should there be any question of possible exposure or change in comfort levels to insure an optimal focused session.

I have read and understand this statement:

Signature: _____ **Date:** _____

Termination/Continuation of Counseling Services

Ending relationships can be complex as well as difficult and are a part of the therapy process. More importantly they are a part of the landscape of life changes. Therefore, it is important to have a termination process in order to achieve healthy closure. The appropriate length of the termination depends on the length and intensity of the treatment. The Center for Life Changes may terminate treatment after a discussion with you. If it is determined that you have met all treatment plan goals and clinically there is no additional need for treatment therapy may be completed. Additionally, if therapy is not being effectively used, and if you are in default of payment therapy may be terminated. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

The Center for Life Changes

Should I be incapacitated or in the event of my death your health records will be made available to the next provider of your choosing. It is important to know that you have recommendation resources provided through your insurance company for continuation of care.

I have read and understand this statement:

Signature: _____ **Date:** _____

Complaints:

You have the right to ask questions about any aspects of therapy and about my specific training and experience. If you are unhappy with what is happening in therapy, I encourage and hope that you will speak with me directly so that I can respond to your concerns. Such comments will be taken seriously and handled with care and the respect they deserve. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual identity and orientation, age, religion, national origin, or source of payment. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

I have read and understand this statement:

Signature: _____ **Date:** _____

Most importantly, ***WELCOME*** to The Center for Life Changes, as you embark on this journey seeking clarity, change, and a different direction for your life. I am honored that you have chosen us, and me as your counselor.

BY SIGNING this AGREEMENT BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT ALONG WITH MY CONSENT TO RECEIVE THERAPY.

The Center for Life Changes is the authenticator of this Informed Consent. Any unauthorized modifications or alterations made to this Informed Consent will render this agreement null and void.

_____ _____

Client Signature Date

_____ _____

RENDERING PROVIDER Date