ArborGate Associates, Inc.

CLIENT CONFIDENTIAL INFORMATION FORM

CLIENT LAST NAME	FIRST NAME		MIDDLE INITIAL	DATE
STREET ADDRESS				BIRTHDATE
CITY	STATE	ZIP		SOCIAL SECURITY NUMBER
EMPLOYER				HOME PHONE
OCCUPATION				WORK PHONE
MARITAL STATUS	EDUCATION ❑ HIGH SCHOOL ❑ COLLEGE			CELL PHONE
SPOUSE LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTHDATE
ADDRESS, IF DIFFERENT				SOCIAL SECURITY NUMBER
EMPLOYER				HOME PHONE
OCCUPATION				WORK PHONE
EMERGENCY CONTACT: NAME			RELATIONSHIP	
ADDRESS, IF DIFFERENT				PHONE
RESPONSIBLE PARTY ❑ SELF ❑ PARENT/GUARDIAN ❑ SPOUSE ❑ OTHER (SPECIFY)				
INSURANCE COMPANY				SOCIAL SECURITY NUMBER
NAME OF SUBSCRIBER				I.D. NUMBER
ADDRESS OF INSURANCE COMPANY				PHONE INSURED'S DATE OF BIRTH
CO-INSURANCE COMPANY				GROUP NUMBER
NAME OF SUBSCRIBER				I.D. NUMBER
ADDRESS OF CO-INSURANCE COMPANY				PHONE INSURED'S DATE OF BIRTH
WHO REFERRED YOU TO ARBORGATE ASSOCIATES, INC. ?				
NAME				PHONE
ORGANIZATION				

ArborGate Associates, Inc.

CLIENT COUNSELING HISTORY

NAME OF PREVIOUS COUNSELOR	PHONE
ADDRESS	
HAVE ANY OF YOUR FAMILY MEMBERS HAD COUNSELING BEFORE? IF SO, FOR WHAT?	
BRIEFLY DESCRIBE WHY YOU ARE SEEKING COUNSELING AT THIS TIME	
PLEASE STATE WHAT YOU HOPE TO ACHIEVE THROUGH COUNSELING	
OTHER INFORMATION YOU MIGHT WANT TO ADD	

ArborGate Associates, Inc.

CLIENT FAMILY HISTORY FORM

FATHER'S NAME			AGE
MOTHER'S NAME			AGE
NUMBER OF BROTHERS	NUMBER OF SISTERS	WHERE ARE YOU IN THE BIRTH ORDER?	
SPOUSE'S NAME			AGE
CHILDREN'S NAMES			AGE
			AGE
			AGE
			AGE

CLIENT MARITAL STATUS

❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED (HOW LONG)_____ ❑ MARRIED

IS THERE ANY HISTORY OF DRUG OR ALCOHOL ABUSE (AGE 11 AND OVER)?

❑ FATHER'S FAMILY ❑ MOTHER'S FAMILY ❑ SELF/SPOUSE

PLEASE DESCRIBE:

IS THERE ANY CURRENT DRUG, ALCOHOL OR TOBACCO SUBSTANCE ABUSE (AGE 11 AND OVER)?

❑ FATHER'S FAMILY ❑ MOTHER'S FAMILY ❑ SELF/SPOUSE

PLEASE DESCRIBE:

IS THERE ANY HISTORY OF PHYSICAL OR SEXUAL ABUSE TO YOU, BROTHERS, OR SISTERS?

❑ YES ❑ NO

PLEASE DESCRIBE

ARE THERE ANY LEGAL JUDGEMENTS PENDING OR PREVIOUS CRIMINAL CONVICTIONS?

❑ YES ❑ NO

PLEASE INDICATE PERSON(S) INVOLVED AND BRIEFLY DESCRIBE

PLEASE NOTE ANY OTHER COMMENTS THAT YOU FEEL MIGHT BE IMPORTANT TO THIS COUNSELING PROCESS

ArborGate Associates, Inc.

CLIENT MEDICAL INFORMATION

FAMILY PHYSICIAN	PHONE
ADDRESS	DATE OF LAST COMPLETE PHYSICAL EXAM
PSYCHIATRIST	PHONE
ADDRESS	DATES SEEN

ARE YOU TAKING ANY PRESCRIPTION DRUGS AT THIS TIME?

❑ YES ❑ NO

IF YES, THEN WHAT TYPE, FOR WHAT PURPOSE, AND PRESCRIBED BY WHOM?

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS?

❑ YES ❑ NO

IF YES, LIST MEDICATION AND DESCRIBE REACTION

HAVE YOU HAD ANY RECENT SURGERY OR TREATMENT FOR ANY ILLNESS WITHIN THE LAST YEAR?

❑ YES ❑ NO

IF YES, EXPLAIN

PREVIOUS HOSPITALIZATIONS?

❑ YES ❑ NO

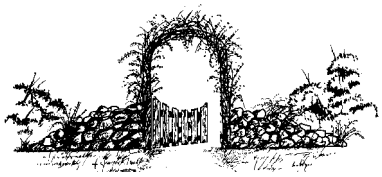
REASON

PLEASE INDICATE ANY ACCIDENTS / CIRCUMSTANCES AND DATES:

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

❑ Eating disorder/ bulimia and anorexia	❑ Attention deficit disorder	❑ Kidney problems
❑ Irritable bowel syndrome	❑ Panic attacks	❑ Lupus
❑ PMS / menopause	❑ Hyperthyroidism / hypothyroidism	❑ High blood pressure
❑ Alzheimer's / dementia	❑ Hypoglycemia / diabetes	❑ Multiple sclerosis
❑ Learning disabilities	❑ Allergies / candida	❑ Arthritis
❑ Depression	❑ Infectious mononucleosis	❑ Heart disease
❑ Severe anxiety	❑ Anemia	❑ Ulcers
❑ Sleep difficulty	❑ Cancer	❑ Epilepsy / seizures
❑ Headaches	❑ Asthma	❑ AIDS or HIV+

HOW HAVE THESE PROBLEMS AFFECTED YOUR LIFE?



ArborGate Associates, Inc.

Counseling and Psychological Services

COUNSELING AGREEMENT

Professional time involved in the Initial Consultation/Intake Session is billed at $125.00 per hour.

Professional time involved in the following direct and indirect services is computed at the rate of $100.00 per hour. These professional services include but are not limited to:

Psychotherapy, Preparation of reports and letters,

Consultation, Telephone calls of significant length.

Services computed at the rate of $125.00 per hour include but are not limited to:

Legal Proceedings, Special Reports

Psychological and Career Testing

Payment is expected at the time of service unless other arrangements are made. Although most services are fully or partially covered by insurance, payment for services is ultimately the responsibility of the client. The regular session charge will be made for a missed appointment or an appointment not canceled 24 hours in advance. In case of inclement weather, payment is required for appointments scheduled. Should the client or counselor be unable to meet at the office a telephone session will be offered.

A $30.00 fee will be charged for returned checks. For any account balance remaining after 90 days, a $5.00 service charge will be incurred. If necessary, unpaid bills will be submitted for collection by an agency of our choice.

Your right to confidentiality is guaranteed. Please be advised that the Law does require that we report incidences of physical and/or sexual abuse as well as threatened and /or realistic suicidal or homicidal risks.

A psychologist, psychiatrist, or clinical counselor provides supervision. You may have access to the supervising professional upon request.

CLINICAL PSYCHOLOGIST	James E. Kaplar, PhD.
CONSULTING PSYCHIATRIST	Said Haidar, MD
CLINICAL COUNSELOR	Sally P. Rapp, Ph.D., P.C.C.-S
COUNSELOR	Jill S. Oatey, L.S.W., L.P.C.
CLINICAL COUNSELOR	Susan A. Dieterich, P.C.C.
CLINICAL COUNSELOR	Koren H. Bierfeldt, P.C.C.
CLINICAL COUNSELOR	Carrie A. Singer, P.C.C.

_____ _____

(Client signature/parent(guardian) if under 18) Relationship to Client

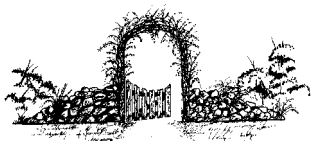
_____

(Counselor signature)

Date: _____

24551 Detroit Road, Suite 5 Westlake, OH 44145 440.892.0452

Revised 05.01.2016



ArborGate Associates, Inc.
CANCELLATION POLICY

ArborGate Associates Inc. will adhere to the following policy and procedures as pertains to cancellation and rescheduling of appointments. Committing to and following through with scheduled appointment times is considered to be a significant element to the counseling process. Appointment times are considered valuable to both client and therapist and are considered reserved time as the therapist plans and prepares according to the treatment plans. We do realize that unforeseen circumstances may warrant a client's need to reschedule an appointment. We do require a 24-hour notice so that that appointment time may be offered to another. In the event a 24-hour notice of cancellation is not offered the client will be charged the full session fee for the missed appointment as insurance companies do not honor these charges. In the event of inclement weather cancellation of the session will be according to the discretion of the counselor. A telephone session may be offered in lieu of the face-to-face session. **Appointments cannot be cancelled on-line.**

FOLLOW-UP ON NO-SHOWS FOR THE FIRST APPOINTMENT

In the event a client does not show for a first appointment, there is not yet a formal treatment contract between the potential client and the therapist. An attempt will be made to contact the potential client within 24-hours (working day) to reschedule the appointment. If the potential client fails to show for an appointment a second time no further contact will be initiated.

FOLLOWING UP NO-SHOWS BEYOND THE FIRST APPOINTMENT

In the event a client does not show for a scheduled appointment (or failed to keep or cancel an appointment) that client will be called within the session hour. If the problem was not a simple mix-up, the client will be asked why he or she did not come in. ArborGate Associates, Inc. recognizes that many reasons may lead to a client not keeping an appointment and every effort is made to respect those possibilities. At the same time we expect that clients be responsible and be held accountable for their therapist's reserved time.

TERMINATION OF THE COUNSELING RELATIONSHIP

In the event a client drops out of counseling (either canceling and reporting such or simply not scheduling appointments) the therapist will send the client a letter noting the unplanned termination and urging the client to schedule an appointment for further treatment or to attempt to put temporary closure on the current problem or situation, summarize issues, discuss progress, and or provide for future treatment implications. Additionally, the risks that can stem from premature termination of treatment are noted. ArborGate Associates, Inc. believes the termination of services is significant to the therapeutic process and should be negotiated appropriately.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature (parent/guardian if under 18)	Date	Therapist Signature	Date
Relationship to Client		Psychologist Signature	Date

ArborGate Associates, Inc.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Personal Health Information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the home.

I wish to be contacted in the following manner (check all that apply).

❑ Home Phone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

❑ Written Communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax to this number _____

❑ Work Phone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

❑ Cell Phone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Other _____

Patient /Parent(Guardian) Signature	Print Name	Relationship to Client	Date

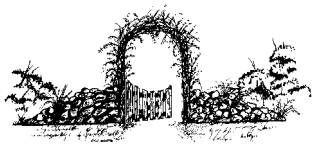
This policy will remain in effect until revoked in writing by authorized party.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosure made pursuant to an authorization requested by the individual. Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will be considered adequate record

NOTE: Uses and disclosure of PHI may be permitted without authorization in special situations, i.e. required by law, emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom: Address or Fax Number	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	Position/ Title



ArborGate Associates, Inc.
Counseling and Psychological Services

OUTPATIENT SERVICES CONTRACT

Welcome to ArborGate Associates, Inc. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that they can be discussed at your next meeting. Once you sign this, it will constitute a binding agreement between us.

PSYCHOLOGICAL SERVICES

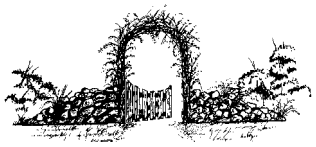
Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches that can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things talked about both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. It you have questions about our procedures they should be discussed whenever they arise. If your doubts persist, we will be happy to help you to secure an appropriate consultation with another mental health professional.

MEETINGS

Our normal practice is to conduct an evaluation that will last from 2 to 4 sessions. During this time, we can decide whether Arborgate is the best practice to provide the services that you need in order to meet your treatment objectives. If psychotherapy is initiated, we will usually schedule one fifty-minute session (one appointment hour of fifty minutes duration) per week at a mutually agreed time, although sometimes sessions will be longer or more frequent. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances which were beyond your control).



ArborGate Associates, Inc.
Counseling and Psychological Services

PROFESSIONAL FEES

Initial consultation/intake appointments and Special Reports, Psychological and Career testing are billed at the rate of $125.00. Our regular session hourly fee is $100.00. In addition to weekly appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than ten (10) minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service which you may request of us. If you become involved in litigation that requires our participation, you will be expected to pay for the professional time required even if we are compelled to testify by another party. [Because of the complexity and difficulty of legal involvement, we charge $125.00 per hour for preparation and attendance at any legal proceeding.]

BILLING AND PAYMENTS

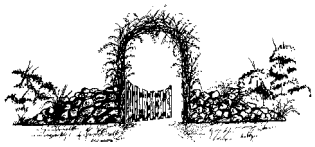
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to at the time these services are requested. [In circumstances of unusual financial hardship, we may be willing to negotiate an installment payment plan.]

If your account is more than 60 days in arrears and suitable arrangement for payment has not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information that we will release about a client's treatment would be the client's name, the nature of the services provided, and the amount due. (See Notice of Privacy Practices)

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with whatever assistance we can in facilitating your receipt of the benefits to which you are entitled, including filling out forms as appropriate. However, YOU, and not your insurance company, are responsible for full payment of the fee that we have agreed to. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in you insurance coverage booklet that describes mental health services. If you have questions, you should call your plan administrator and inquire. Of course, we will provide you with whatever information we can based on our experience and will be happy to try to assist you in deciphering the information you receive from your carrier. If necessary to resolve confusion, we are willing to call the carrier on your behalf.



ArborGate Associates, Inc.
Counseling and Psychological Services

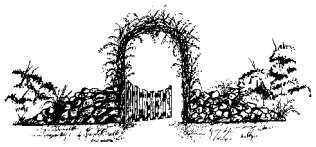
The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits which sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short term treatment approach designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In our experience, while quite a lot can be accomplished in short term therapy, many clients feel that more services are necessary after insurance benefits expire. In the event your managed care plan will not allow us to provide services to you once your benefits are no longer available, we will do our best to find you another provider who will help you continue your psychotherapy.

You should also be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases they may share the information with a national medical information data bank. If you request it, we will provide you with a copy of any report we submit. (See Notice of Privacy Practices; Patient Record of Disclosures)

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself and avoid the complexities, which are described above.

CONTACTING US

Our office phone number is 440-892-0452. While we are usually in our offices between 9 AM and 8 PM, we are often not immediately available by telephone. We rarely take phone calls when we are with a client. When we are unavailable, our telephone is answered by our secretary or confidential voice mail, which we monitor frequently. If you are difficult to reach, please leave some times when you will be available. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you cannot reach us, and you feel that you cannot wait for us to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. Emergency care is also available for Cuyahoga County residents by contacting Lakewood Hospitals Mental Health Center or The Nord Center for Lorain County residents. Those numbers are printed on the last page of this contract. If we are unavailable for an extended time, we will provide you with the name of a trusted colleague whom you can contact if necessary.



ArborGate Associates, Inc.
Counseling and Psychological Services

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records, but if you wish, we can prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/or can be upsetting to lay readers. If you wish to see your records, we recommend that you review them in our presence so that we can discuss the contents. Clients will be charged an appropriate fee for any preparation time required to comply with an information request. (See Notice of Privacy Practices)

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they consent to give up access to your records. If they agree, we will provide them only with general information about our work together unless we feel that there is a high risk that you will seriously harm yourself or another, in which case we will notify them of our concern. We will also provide them with a summary of your treatment when it is complete. Before giving them any information we will discuss the matter with you, if possible, and will do the best we can to resolve any objections you may have about what we are prepared to discuss.

CONFIDENTIALITY

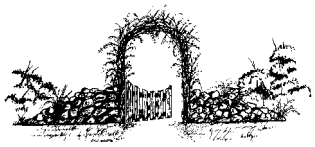
In general, the confidentiality of all communications between a client and a psychologist is protected by law, and we can only release information about our work to others with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require our testimony if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which we are legally required to take action to protect others from harm, even though that requires some information about a client's treatment. For example, if we believe that a child, an elderly person, or a disabled person is being physically or sexually abused, we may be required to file a report with the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, we may be required to seek hospitalization for the clients, or to contact family members or others who can help provide protection.

These situations have rarely arisen in our practice. Should such a situation occur, we would make every effort to fully discuss it with you before taking any action. (See Notice of Privacy Practices)



ArborGate Associates, Inc.
Counseling and Psychological Services

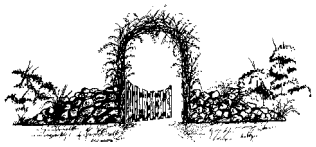
We may occasionally find it helpful to consult about a case with other professionals. In these consultations, we make every effort to avoid revealing the identity of our client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. The laws governing these issues are quite complex and we are not attorneys. While we are happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable state laws governing these issues.

After Hours Emergency Phone Numbers	
In Cuyahoga County	**In Lorain County**
Lakewood Hospital	The Nord Center
Mental Health Services	Emergency Line
216.363.2122	800.888.6161 or 440.233.7232

Your signature below indicates that you have received and read the information in this Outpatient Services Contract and the Notice of Privacy Practices document and agree to abide by their terms during our professional relationship.

Client Signature (Parent/Guardian if under 18)	Date
Relationship to Patient	
Therapist Signature	Date
Psychologist Signature	Date



ArborGate Associates, Inc.

Counseling and Psychological Services

THIRD PARTY PAYMENT: SUBMISSION AND REIMBURSEMENT

Clients are responsible for verifying their own insurance coverage. We will assist you in this process. Our office routinely contacts insurance companies to verify benefits.

Upon payment of the full fee, clients may submit their own insurance. Their insurance company then usually sends reimbursement checks directly to the client.

Payment for sessions is expected at the time of the service. Payment is subject to the benefits for which the patient is eligible under the terms of his or her insurance contract at the time services are rendered. The co-pay amount will be accepted as payment once we have received verification from your insurance company that the annual deductible has been met and ArborGate Associates, Inc. begins receiving insurance payments.

Insurance claim forms are submitted on a timely basis. Payment usually is then made directly to ArborGate Associates, Inc. These checks are applied to the client's account against the session they were submitted for. Payment in excess of the balance is either reimbursed to the client by ArborGate Associates, Inc. or applied to future sessions. This is the client's decision. Reimbursement checks are written on the 1st and 16th of each month. Should the insurance company reimburse a check to a client who has an outstanding account balance, it is their responsibility to immediately forward this check to ArborGate Associates, Inc.

I request that payment of authorized Medicare or insurance benefits be made to ArborGate Associates, Inc. for any services furnished me or my dependent by that provider. I authorize said assignee to release all necessary information to the insurance carrier and its agents required to determine benefits payable for related services and to secure payment.

I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the services are not covered by my insurance policy, I will be responsible (to the provider) for payment of the entire bill.

I understand that as of this date my insurance carries a $ _____ deductible with a $ _____ co-pay. Insurance then covers _____ % of the remaining charges.

This information was provided "as is" without warranty of any kind, either expressed or implied. I further understand that eligibility and benefit information does not guarantee payment of a related claim. Eligibility and benefit plan limitations are subject to change and will be determined at the time that the applicable claim is processed.

_____	_____	_____
Patient / Parent (Guardian) Signature	Relationship to Client	Date