Infinity Counseling and Therapeutic Services LLC

Patient Intake

Name: Olanrewaju Shotunde

Date of Birth: 03-11-1983

Marital Status: Married

Address: 108811 Gaylord, Reford. MI 48240

Contact Phone Number: 2484035466 Text Messages ok: ok

E-Mail Address: lan4more@gmail.om

Race/Ethnicity: Black

Emergency Contact:

Name Ayo Shotunde Relationship Spouse Phone: 2486796638

Employment status:

Name of Employer New Life Inc

Highest Level of Education Completed: Bachelors Degree

VETERAN STATUS: BRANCH: Non YEARS IN SERVICE: Non

Insurance Information

Name of Insure card holder: Non D.O.B Non

Name of Insured if not the same: _____ D.O.B _____

Insurance Company:_____

Subscriber ID: _____ Group Number: _____

Are you aware of any insurance coverages, co-payments or deductibles required?
(If NO it is your responsibility to know what your insurance coverages are prior to engaging in services)

How did you hear about us: (Psychology Today, Insurance company, Personal referral, Company Website

Friends

Are you a smoker? No Interested in Quitting?

Any current or history of Substance Abuse (drugs or alcohol)? No

Mental Health History

Any current or previous diagnosis? No

Previous history of Outpatient Mental Health Treatment: (Therapy/Counseling)

Agency: No _____

Ever been hospitalized for Mental Health concerns? No

Any history of suicide attempts? No

Any history of suicidal thoughts? No Currently? No

Any history of self-harm behaviors? (example: cutting) No

Any family history of Mental Health or Substance Abuse? No

Any current medical conditions? (asthma, cancer etc) No

If yes name of condition(s) No _____

Nathifa G Riley, LCSW
Informed Consent

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT
Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

I. My Responsibilities to You as Your Therapist

Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

Electronic Services such as e-mail and text will only be used as a means to discuss appointment times. All therapy sessions must take place in person. Infinity Counseling and Therapeutic Services, LLC does provide video counseling through a HIPAA complaint database and another Informed Consent will need to be signed for such service.

Infinity Counseling and Therapeutic Services LLC does offer telehealth modality for therapy session. To remain HIPAA complaint only approved telehealth services will be used therefore FaceTime, Google hangouts, Skype and any other non HIPAA complaint platforms will not be used.

In case I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague who is a licensed counselor as my professional executor. If I die or become incapacitated, my professional executor will be given access to all of my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services if needed; and/or to facilitate continued care with another qualified professional if needed. If you have any

questions or concerns about this professional executor arrangement, I will be glad to discuss them with you.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing, or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

Record-keeping.

I maintain your records in a secure location that cannot be accessed by anyone else. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your **written** request.

If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. In spite of that, I will not release information without your signed consent or a court order.

Infinity Counseling and Therapeutic Services LLC/ Nathifa G Riley, LMSW will **NOT** appear in court on your behalf in any matter without a court order signed by a Judge; a subpoena

is not sufficient. Also, no letters will be provided to any court or legal representative in a matter of custody/divorce.

Infinity Counseling and Therapeutic Services LLC is a place that assist upcoming professionals in getting hands on experience in their respective fields. All staff, interns or any other persons are held at the same level as a therapist with respect to confidentiality. Documents are signed ensuring that all parties understand HIPAA compliance and client confidentiality. Please sign below acknowledging that ICTS LLS can allow an intern or other professional to participate in your treatment. Understand that you can withdraw this portion of the consent at any time.

By signing below you are consenting to allowing interns/preceptors to participate.

Oluwaseyi Shofunde 07/26/2022

Signature **Date**

II. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. All of the diagnoses come from a book titled the ***DSM-5;*** I have an electronic copy to share and will be glad to let you see it and learn more about what it says about your diagnosis.

III. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

IV. Managed Mental Health Care (MC)

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the MC company as needed.

V. Your Responsibilities as a Therapy Client

Scheduled appointments

I will do my best to have a regularly scheduled appointment time for you. If I need to cancel for some unforeseen circumstance, I will do my best to get a hold of you as soon as possible and do my best to accommodate you. I will tell you well in advance of any planned absences and will provide referrals for any extended absences. You are responsible for coming to your session on time and at the time we have scheduled. There is a **10 minute** grace period for all confirmed sessions and each sessions will last for 55 minutes. All session will end 55 minutes after the scheduled appointment time. If you miss a session without canceling, or cancel less than twenty-four hour notice, you must pay a flat fee of **$35.00** not covered by your insurance at our next regularly scheduled meeting. No appointments to be scheduled until the fee is paid. The only exception to this rule about cancellation is in case of an Emergency situation that I approve which can be discussed. An appointment confirmation text/email will be sent 24 hours prior to your appointment. You **MUST** confirm your appointment otherwise your appointment will be automatically cancelled. If you have a no-show for two sessions in a row, you will not be able to reschedule any future appointments. It will be up to the discretion of the therapist to continue services. Failure to communicate an assumption will be made that you have dropped out of therapy and you may call to schedule another appointment.

Payment

You are responsible for paying for your sessions regards of insurance coverage. Please note that all insurance companies have differing deductibles and co-payments. Please contact your health insurance provider to determine specific behavioral/mental health benefits. If you have any difficulty, PLEASE CONTACT me I will be happy to help. Deductibles are due yearly and any co-payments and any other payments owed are due prior to seeing the therapist. If you need a preauthorization please contact your insurance companies behavioral health program for assistance or if assistance is needed please do not hesitate to ask me. You must provide me with your complete insurance identification card or information and update me if insurance changed or you are no longer covered. When using telehealth services please contact your insurance company to ensure that service is covered. You will be billed monthly for any outstanding balances. Payments can be made in the form of Cash and credit cards. No checks will be accepted. Any return payment of any kinds will result in a **$35** fee. A late fee will be added for all bills over 30 days late at 3% monthly. All credit cards must match the name of your identification. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

Other Fees

There is a fee for completing any necessary paperwork. (FMLA, STD, LTD etc). Fees are due at the time of request. $20 for up to 3 pages $5 a page after the 3rd page not to exceed $50.

Client Signature: Kaneeyah Shotwell **Date:** 07/26/2022

Complaints

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the LARA- Bureau of professional Licensing, 517-373-8068. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

VI. Risk Associated with Psychotherapy

Some risk to you include:

1. Disruptions to your daily life because of therapeutic changes
2. Emotional pain due to exploring personal issues
3. Tools will be given to help support change however without the required work on your part may risk no improvement
4. Therapy begins with hope that your life will improve but there are no guarantee this will occur

VII. Treating Minors (if applicable)

I understand when treating a minor parental consent is needed from both parents if they have legal rights. A court order will be needed to show custody and/or a document will need to be signed by the absent parent authorizing therapy.

Client Signature: _____ **Date:** _____

VIII. Communication

I will make every effort to return all calls/text within 24 hours Mon-Thurs otherwise calls will be returned the following business day. Due to confidentiality no communication will be made on any social media platforms. Text messages will only be used for scheduling purposes no HIPAA protected information can be provided via text or e-mail. I will try to make myself available during times of crisis however you must agree to calling 911 or go to your nearest Emergency Room for assistance.

Infinity Counseling and Therapeutic Services LLC

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee per session and any amount not covered by your insurance. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Nathifa G Riley, LMSW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Ms. Riley.

Olanrewaju Shotunde

Client Name

Olanrewaju Shotunde — 07/26/2022

Signature (Parent/Guardian Signature if applicable): Date

Nathifa Riley

Therapist Signature:

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

OS_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

OS_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

OS_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of at the time of this service.

OS_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

OS_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

• *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
• *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
• *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

OS_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

OS_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

OS_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform. Infinity Counseling and Therapeutic Services uses doxy.me or Therapy Notes telehealth platform. (HIPAA-complaint)

Infinity Counseling and Therapeutic Services LLC

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.
For electronic communication between and staff and Infinity Counseling and Therapeutic Services LLC/Nathifa Riley and staff and Olanrewaju Shotunde .
(Patient's name)

Olanrewaju Shotunde
Print Patient or Legal Representative

07/26/2022
Date

Olanrewaju Shotunde
Patient or Legal Representative Signature

Patient
Relationship to Patient

I certify that I have made myself available to explain the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative (circle one)* fully understands or have not made any further request to explain the nature of this informed consent.

Nathifa Riley
Therapist Signature

Copies available upon request

Optional National Emergency Crisis Language
I understand that due to the state of the current national emergency crisis, telehealth is offered by to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with Infinity Counseling and Therapeutic Services LLC and staff.

OS
Initials here

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?
May we leave a message on your answering machine at home or on your cell phone?
May we discuss your medical condition with any member of your family?
If YES, please name the members allowed:

Olanrewaju Shotunde

This consent was signed by: Olanrewaju Shotunde

(PRINT NAME PLEASE)

Signature: Olanrewaju Shotunde Date: 07/26/2022

Therapist Signature: Nathifa Riley

Infinity Counseling and Therapeutic Services LLC

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I Olanrewaju Shotunde **_____ authorize the Infinity Counseling and Therapeutic Services LLC to:**

X release to, obtain from and exchange with:

Olanrewaju Shotunde
_____(INSURANCE COMPANY HERE)

_____

_____

_____

the following information pertaining to myself:

X treatment summary

X history/intake

X diagnosis

X psychological test results

X dates of treatment attendance

_____other (specify) _____

for the purpose of:

X evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

Infinity Counseling and Therapeutic Services LLC

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event

_____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Olanrewaju Shotunde	03-11-1983
Print Name (Client)	**Client Date of Birth**
Olanrewaju Shotunde	07/26/2022
Signature of Client or Guardian	**Date**

Nathifa Riley

Signature of Therapist