ESPRIT COUNSELING & CONSULTING, LLC
40 Jewelers Park Drive, Suite 200
Neenah WI 54956
(920) 720-6000

CLIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Address: _____ City: _____ State: ____ ZIP: _____

Date of Birth: _____ Age: _____ Employer/Phone: _____

Primary Care Physician: _____

Referred By: _____

Contact Information	**Best way to contact you**
Home #:	○Home Leave Message N Y
Work #:	○Work Leave Message N Y
Cell #:	○Cell Leave Message N Y
Email address:	○Email

Parent/Guardian Information: *If client is a minor, this section must be completed by Parent/Guardian*

Name: _____Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Social Security #: _____ Date of Birth: _____ Relationship to Client: _____

Employer: _____ Phone: _____

Primary Insurance Information:

Name and DOB of person who carries insurance: _____

Name of Insurance: _____ Copy of card on file: Yes No

Policy #: _____ Group #: _____ Eff. Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Secondary Insurance Information:

Name of Insurance: _____ Copy of card on file: Yes No

Policy #: _____ Group #: _____ Eff. Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

I hereby attest that the information provided on the registration form is true, complete and accurate.

I hereby authorize Esprit Counseling & Consulting, LLC (ECC) to furnish my relevant personal health information to insurance carriers, payor sources, and accrediting agencies, concerning myself or my dependent's diagnosis and treatment. (See Notice of Privacy Practices Form) **I hereby assign to ECC all payments for services rendered to me, my dependents or the client named on the registration form. I agree to be jointly and severally responsible for all charges incurred to myself, my spouse, my dependents or the client named on the registration form.**

I hereby authorize and consent for ECC to provide behavioral health and/or substance abuse services for myself, or other identified client, for which I have legal authority to grant.
I have read and received a copy of the following from ECC:

- Clients Rights and Responsibilities
- Consent to Treatment and Agency Policy
- Grievance Policy
- Notice of Privacy Practices (HIPPA)

☐ Yes, I would like a copy of the signed documents.
☐ I do not wish to receive a copy of the documents.

Printed Name: _____ Date: _____
(Client)

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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CONSENT TO TREATMENT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health/substance abuse evaluation and/or treatment by staff from the Esprit Counseling & Consulting, LLC (ECC). I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment.
   b. Alternative treatment modes and services.
   c. The manner in which treatment will be administered.
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment.

   The evaluation or treatment will be conducted by a licensed therapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with verbal interviews, written assessment or testing, psychotherapy, medication management, and expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, education, and planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are as follows: (I have received the Financial Responsibility Agreement)
   Initials: _____

4. **Cancellation Policy:** You will be charged for appointments cancelled less than **48 hours** in advance. You can leave a message with our voicemail answering service if the office is closed.

5. **Emergencies:** In an emergency, you may call the office 24 hours, 7 days a week at 920-720-6000 to speak to your/a therapist. During non-working hours, you must call the emergency number or crisis number for the county you are in, or are residing in or call 911 for imminent matters.

6. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential record at ECC, and I consent to disclosure for use by ECC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: **1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.**

7. **Grievance Process:**
    1. If you have any questions or complaints concerning any aspect of treatment, you are encouraged to discuss them with your therapist or counselor.
    2. If you do not feel that your question or complaints have been resolved, you may contact the clinical director.
    3. If you wish to discuss the matter further, you may contact the clinic director.
    4. If you have been referred by your unified services agency, a copy of your complaint will be submitted to the appointed client's rights specialist.

    If you wish to file a formal grievance or complaint, you will need to follow the general procedure (also found in "Your Rights and the Grievance Procedure") and utilize the complaint/grievance form. We will assist you in processing your complaint/grievance as requested.

8. **Grievance Procedure:** Anyone who is receiving treatment at ECC may utilize a grievance procedure. The grievance procedure is a way for clients to arbitrate their grievances when they believe their rights are being violated.

    If a client has a grievance, they may file their complaints with the Client Rights Specialist for ECC. The complaint can be filed either in writing or by personally talking to the client's rights specialist. Another person can file a grievance on behalf of the client. If a court has not found the client to be incompetent to make his or her own decisions, this other person must obtain the client's permission before filing the complaint. The client rights specialist has further knowledge of the grievance procedure and will supply information on the procedure to clients and staff members upon request.

    If a grievance cannot be resolved in-house, the following steps may be taken to seek legal redress.
    1. The client may seek the advice of an attorney.
    2. The client may seek the advice of the Legal Aid Society.
    3. The client may seek the advice of the County Court Commissioner on how to proceed.

9. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

    A consumer may be involuntarily discharged from treatment for behavior that is reasonably a result of mental health symptoms only as provided in the following:

    Before the ECC can involuntarily discharge a consumer, the clinic shall notify the consumer in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and of the consumer's right to have the discharge reviewed prior to the effective date of the discharge.

10. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

11. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician Signature: _____ Date: _____

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NOTICE OF MENTAL HEALTH PROVIDER'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Esprit Counseling & Consulting, LLC (ECC) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations":
  - "Treatment" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another mental health provider.
  - "Payment" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - "Health Care Operations" are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within ECC, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of ECC, such as releasing, transferring, or providing access to information about you to other parties, or mental health providers outside ECC.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

ECC may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. In those instances when ECC is asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We also need to obtain an authorization before releasing your clinical notes. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If we have reasonable cause to believe a child known to us in a professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If we have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.
- Health Oversight Activities – We may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- Serious Threat to Health or Injury – If you communicate a specific threat of imminent harm against another individual or if it is believed that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we will make disclosures necessary to protect that individual from harm. If you present an imminent, serious risk of physical or mental injury to yourself, we will disclose information as necessary to protect you from harm.
- We may disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, criminal activity, military activity, national security, and Worker's Compensation. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

IV. Patient's Rights and Mental Health Provider's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. Under federal law, however, you many not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Your counselor is not required to agree to a restriction that you may request. If the clinician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and notes.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. If we deny your request you have the right to file a statement of disagreement.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice, however we reserve the right to change the terms of this notice. We will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Mental Health Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice.

V. Questions and Complaints

If you have questions about this notice you may contact us at (920) 720-6000. If you believe your privacy rights have been violated and wish to file a complaint, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

I have read and received a copy of the above Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of my Health Information.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

I have provided my client with a copy of the above Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of my Health Information.

Clinician Signature: _____ Date: _____

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CANCELLATION POLICY

Understanding our cancellation policy is extremely important to a healthy therapeutic relationship.

Clients are welcome to cancel or reschedule appointments up to 48 hours before an appointment. Cancelling your appointment within the 48 hours leading up to your appointment is considered a late cancellation. Late cancellations and no-shows will be charged.

We reserve a full hour of our time for our client's session and clinical notes. When cancelling with less than 48 hours' notice, it is unlikely we will be able to fill the slot and as a result will lose an hour from our work schedule.

Our cancellation policy is not a penalty or a punishment. Most people understand this and we want to make sure you understand this as well. We are not upset when our clients miss an appointment. That is life, we understand. However, in return, our clients understand that scheduling an appointment with one of our therapists is like buying tickets to an event. If you miss the event, it doesn't matter why you missed it, even if it was your first time, you can't turn in your tickets for a refund. Our late cancellation and no-show fee is $140. Insurance will not pay for missed appointments. Clients will be responsible for the full fee.

We would like your agreement and promise, that if or when the day comes that you miss an appointment, for any reason, you will gladly pay for the missed appointment, just like you pay for the session that you do attend.

We believe that sharing our expectations from the beginning will ultimately go a long way to build trust and a solid therapeutic relationship with our clients.

If you consent and promise to uphold this agreement, please sign below.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician Signature: _____ Date: _____

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ELECTRONIC COMMUNICATION AND TECHNOLOGY CONSENT

Esprit Counseling and Consulting, LLC (ECC) is dedicated to taking the precautions necessary to protect your confidential information. Email, text, or other forms of electronic messaging and document transferring can be helpful tools for communicating between sessions regarding non-clinical issues such as scheduling, billing, and other logistics. To make your experience at ECC as helpful and efficient as possible, we employ the newest technology.

While ECC attempts to maintain privacy and security in all areas, it is important to understand certain risks outlined below. You also have the option of opting out of this service. Please understand that if you opt out, you will receive your monthly invoice through the mail. However, by opting out, you will not receive appointment reminders or any of the below communication from ECC via email or text alert.

If you provide us with your email/phone number, it will only be used for the below reasons:

- Appointment reminders.
- Cancelling appointments.
- Monthly invoices and statements.
- Credit card receipts.
- Correspondence between you and ECC (and emails from Therapy Appointment).

Risks Associated with Using Email

ECC offers clients the opportunity to communicate with staff via email. However, transmitting client information by email has several risks that should be considered. These include, and are not limited to:

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Emails are not always encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept emails.
- Email senders could misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after sender or recipients have deleted their copy.
- Employers and online services may have a right to archive or inspect emails transmitted. Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails are part of the client's file and therefore can be used as evidence in court.

Conditions for the Use of Electronic Communication

ECC will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, ECC cannot guarantee this security and confidentiality, and will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Thus, individuals must consent to the use of email for communication with the following conditions:

- Please understand that clinical information sent via email is not secure.
- It is the client's or guardian's responsibility to notify ECC of any change in email address.
- Although ECC will do its best to respond promptly to an email, we cannot guarantee that any email will be read, received or responded to within any particular amount of time. No one shall use email for medical emergencies or other time-sensitive matters. Please call 911 for emergencies or go the nearest urgent care or immediate care center for urgent matters.
- All emails received by or sent from ECC may be made part of the client's record. Other individuals authorized to access the medical record, such as staff and billing personnel, will have access to email correspondence.
- ECC may forward emails internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other administrative handling.
- ECC will not forward emails to independent third parties without the client's prior written consent.

ECC also employs Facebook and other forms of social media as a means of marketing and connecting with the community. It is your choice as to whether to connect with our business on these or other sites; again, we cannot guarantee your confidentiality on these sites. To maintain the professional nature of our relationships, the providers at ECC do not accept requests from current or former clients on personal social networking sites.

By signing below, I hereby agree to this Electronic Communication and Technology Consent form. At any time, I understand that I have the right to revoke this consent in writing. I understand the risks associated with email communications with ECC, and consent to the conditions outlined above. I agree to the instructions for communicating by email outlined here, as well as any other instructions that ECC may impose to email or technology communications. I have taken all precautions to eliminate others from accessing my email, even during my absence. I will not hold ECC liable for others accessing my email sent by ECC.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician Signature: _____ Date: _____

Would you like session reminders? Yes No Method: Email Text Voice

Email: _____ Cell Phone #: _____

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FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Esprit Counseling and Consulting, LLC (ECC). We are committed to the success of your treatment and care. Please know that a mutual financial understanding is part of our relationship. We do not exclude, deny, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, gender, age, or financial status. We sincerely hope that by sharing our financial expectations we will strengthen the therapist-client relationship and keep the lines of communication open. If you have any questions, or need clarification of any of the policies below, please feel free to contact our billing department at (920) 720-6000.

Please initial on the following lines.

Length of Sessions

_____ Typical sessions are 45-50 minutes in length. Longer sessions will be billed to insurance as such, and may or may not be covered. Clients are responsible for any additional costs associated with longer sessions.

Proof of Insurance

_____ All copayments, deductibles, co-insurance and fees are due at the time of service unless you have made payment arrangements in advance of your appointment. ECC accepts cash, checks and credit cards (MC, Visa, HSA (please check with your therapist if you are not certain)).

_____ ECC charges an interest rate of 1.5% for balances that are older than 90 days. A $35.00 fee will be charged for returned checks.

_____ Balances that are older than 90 days will automatically be the responsibility of the client, regardless of whether insurance has returned an Explanation of Benefits. A refund will be provided once insurance pays.

_____ It is my responsibility to notify ECC of any changes in my health insurance.

Referrals

_____ Some insurances require a referral to our services to pay claims. It is my responsibility to obtain the referral authorization from the appropriate source, if needed.

Divorce and Child Custody Cases

_____ The parent who brings the child to the office for care is responsible for payment at the time of service.

Letter Writing

_____ Any letters requested for doctors, court, schools, etc. will be subject to a charge of $100 per hour with a minimum of $25, and must be requested at least 10 business days in advance.

Self-Pay Accounts

_____ We designate accounts self-pay under the following circumstances:

1. Client does not have health insurance coverage.
2. Client is covered by an insurance plan that our providers don't participate in.
3. Client does not have a current, valid insurance card on file.
4. Client does not have a valid insurance referral on file.

Billing, Payment and Refunds

_____ ECC sends out our statements electronically (through email). If you would prefer a paper statement, you must notify your therapist of this.

_____ When you receive a statement, the balance is due in full within 30 days of the statement date. If you cannot pay the balance in full within 30 days, please contact our billing department to discuss your options.

_____ It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

_____ We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, or take other collection action.

Please check one:

_____ I have called my insurance and have received information (as evidenced by filling out the box below) stating that **Mental Health** services are covered and the provider I am seeing is in network. I am also aware of my copay and deductible.

_____ I have not called my insurance and verified benefits and understand I will be responsible for all services not covered or denied by insurance.

_____ I am self-paying and understand that I am responsible for the balance at each session.

Do I have mental health benefits? Yes No
Is approval required from my physician? Yes No
Do I have a co-pay and how much is it? _____
What is the coverage amount per therapy session? _____

_____ If I am receiving services as part of a Driver's Safety Plan, my completion and compliance will not be released to the county until I have met all financial obligations and my account balance is $0. This will be my responsibility and ECC is not responsible for any consequences I may experience as a result of non-compliance.

I have read, understand and agree to the above Financial Policy.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician Signature: _____ Date: _____

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ACKNOWLEDGMENT OF PROGRAMS POLICIES AND PROCEDURES

This is acknowledgement that I understand and have been provided in writing, if requested, the following information:

1. The general nature and purpose of outpatient treatment services and the services available through the clinic.
2. Client responsibilities relating to treatment.
3. Clinic hours.
4. How to access emergency services.
5. Client rights and grievance procedure.
6. Follow up services after termination of treatment.
7. 48 hours' notice for cancellation of an appointment.
8. My right to request consultation with the consulting physician or psychologist.
9. Confidentiality of client information.
10. I understand that Esprit Counseling and Consulting, LLC is not responsible for the safety of a child left unattended.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician Signature: _____ Date: _____

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB: _____
(client name)

Authorize _____ (Esprit Counseling & Consulting, LLC) to
(therapist name)

DISCLOSE TO/OBTAIN FROM (circle one or both):

_____
(Name of person and/or organization)

_____
(Address/City/State/ZIP)

The following written and verbal information (please initial):

___ Evaluation
___ Summary of Services
___ Discharge Summary
___ Progress Notes
___ Academic Records
___ Psychological, Psychiatric Evaluation/Diagnosis
___ Substance Abuse Assessment
___ Other (specify): _____
___ Substance Abuse Treatment Plan
___ Substance Abuse Aftercare Plan
___ Substance Abuse Summary
___ Substance Abuse Discharge Summary
___ Drug Screen Results
___ Confirmation Letter to Referent
___ SAP/Counselor Involvement
___ Medical Records

For the purpose of:

___ Facilitate family/significant other involvement
___ Obtaining formal referral for treatment
___ Coordination of treatment
___ Establishing diagnosis and treatment plan
___ Determining and ensuring insurance coverage
___ Providing information for legal proceedings
___ Provision of primary treatment
___ Providing referral source with progress
___ Providing information to facilitate referral
___ Electronic transfer of information
___ Internet address _____
___ Other (specify): _____

I understand that my records are protected under the Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described below. I understand that if the person(s) or organization listed above are not health care providers, health plans, or health clearing houses, who must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be used or disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. I understand I have the right to inspect and receive a copy of the material to be disclosed as required under HSS 92.05 and 92.06 of the Wisconsin Administrative Code. **Right to receive copy of this authorization**- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. **Right to refuse authorization**- I understand that I am under no obligation to sign this form and that the person(s) and/or organizations listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to withdraw authorization**- I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already referred to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s)_____ or for one year from the date signed. I have had opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I further acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

Client Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Clinician Signature: _____ Date: _____

ESPRIT CLIENT EXPECTATIONS

1. Use of Email and Text Messages
    a. Emails and texts are to be utilized to share information that will be discussed in the next session.
    b. Therapy and/or advice will not be given via email or text message.
2. Length of Sessions
    a. Typical sessions are 45-50 minutes in length.
    b. Longer sessions will be billed to insurance as such, and may or may not be covered.
    c. Clients are responsible for any additional costs associated with longer sessions.
3. Billing Statements
    a. Unless other arrangements are previously made, bills will arrive electronically via email.
    b. Statements will come from Therapy Appointment, not ECC or your therapist's email address.
    c. The email will say, "You have a message from _____." You must login to Therapy Appointment to view and pay your bill.
4. Public Interactions
    a. Therapists will not acknowledge or approach you in public unless you do so first to respect your privacy.
5. Timeliness
    a. If you are late to your session, it will still end at the scheduled time.
    b. If you are more than 15 minutes late, your session will be rescheduled.
    c. If your session is rescheduled, it will count as a late cancellation and you will be responsible for the cost of the session as noted in the cancellation policy.

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    a. Therapists will not acknowledge or approach you in public unless you do so first to respect your privacy.
5. Timeliness
    a. If you are late to your session, it will still end at the scheduled time.
    b. If you are more than 15 minutes late, your session will be rescheduled.
    c. If your session is rescheduled, it will count as a late cancellation and you will be responsible for the cost of the session as noted in the cancellation policy.