Section 1: Registration & Contact Information

Section 1: Registration & Contact Information

Welcome to Garrett Counseling. We are honored that you have chosen us to be part of your journey. We understand that beginning counseling can feel overwhelming, and we appreciate the trust you are placing in our team. This packet helps us gather the information needed to provide safe, ethical, and effective care while making the process as simple as possible.

The entire intake process should take approximately 15 minutes to complete and consists of four sections:

- Section 1: Registration & Contact Information
- Section 2: Clinical Questionnaire
- Section 3: Privacy Practices & Informed Consent
- Section 4: Acknowledgement & Signature

If you have questions or need assistance completing any part of this paperwork, please contact our office. We are happy to help.

Important: Garrett Counseling is not a crisis or emergency service. If you are experiencing thoughts of harming yourself or someone else, or you are experiencing a medical or psychiatric emergency, call 911, go to your nearest emergency department, or contact the 988 Suicide & Crisis Lifeline immediately.

CLIENT INFORMATION
Legal Name: _____
Preferred Name (if different): _____
Date of Birth: _____
Street Address: _____
City, State, ZIP: _____
Primary Phone Number: _____
Email Address: _____

COMMUNICATION PREFERENCES: Garrett Counseling/Brave Play may communicate with you regarding scheduling, billing, appointment reminders, additional services and mental health information and other administrative matters by phone, text message, email, or through our secure client portal.
Preferred Method of Communication
☐ Phone Call
☐ Text Message
☐ Email
☐ Secure Client Portal
May we leave a voicemail if we are unable to reach you?
☐ Yes
☐ No

EMERGENCY CONTACT: Please provide the name of someone we may contact if we are unable to reach you during a medical or psychiatric emergency, or if your counselor believes there is an immediate concern for your safety or the safety of others. This contact may also be used if an emergency occurs during a telehealth session and we are unable to reach you directly. Providing an emergency contact does not authorize Garrett Counseling to routinely share your protected health information or discuss your treatment with that individual. Any disclosure will be limited to what is reasonably necessary to protect your health or safety or as otherwise permitted or required by law. If we are unable to reach your emergency contact during a medical or psychiatric emergency, Garrett Counseling may contact emergency services. Any costs associated with emergency services are the responsibility of the client.

Emergency Contact Name: _____
Relationship to Client: _____
Primary Phone Number: _____
Alternate Phone Number (Optional): _____

TELEHEALTH SERVICES: Telehealth services are provided using HIPAA-compliant technology when clinically appropriate and permitted by applicable law. While telehealth offers increased convenience and access to care, it also has limitations, including technology failures and the inability to respond in person during an emergency. By participating in telehealth services, you acknowledge that these benefits and limitations have been explained to you and that you may withdraw your consent for telehealth services at any time. At the beginning of each telehealth session, you will be asked to verify your current physical location. Clients scheduled for telehealth appointments who are located outside of Alabama (or outside another state in which their counselor is authorized to practice) at the time of the appointment will be considered unavailable for services and will be charged the applicable late cancellation/no-show fee. You may not be driving during your appointment.

If a telehealth session is interrupted, your counselor will first attempt to reconnect through the telehealth platform. If unsuccessful, we will contact you at the phone number in your file. If you need to provide an alternative/backup phone number please do so below.

Alternative/Backup Phone Number: _____
Verification Word or Phrase: _____
Preferred Hospital: _____
City of Preferred Hospital: _____

Client Responsibilities During Telehealth: For each telehealth session, I agree to participate from a private location; Provide my current physical location at the beginning of each session; Notify my counselor if my location changes during the session; and Cooperate with emergency procedures if a safety concern arises. My counselor may ask me to briefly show my surroundings at the beginning of a telehealth session to help ensure privacy and safety. You may not be driving during your appointment.

Telehealth Consent: By signing the acknowledgment in Section 4, you acknowledge that you have read and understand this Telehealth Services section and consent to receive telehealth services when clinically appropriate.

FINANCIAL RESPONSIBILITY
(Complete only if someone other than the client is financially responsible for counseling services.)

If someone other than you (such as a parent, guardian, spouse, or another individual) is responsible for paying for your counseling services, please complete the information below. A release of information may be required for financial aspects to be resolved.

Responsible Person's Name _____
Relationship to Client _____
Social Security Number _____
Date of Birth _____
Mailing Address _____
City, State, ZIP _____
Primary Phone Number _____
Email Address _____
Employer (Optional) _____

HOW WILL YOU BE PAYING FOR COUNSELING SERVICES?
☐ I plan to use my health insurance benefits.
☐ I will be paying privately (self-pay) and will not be using health insurance.

INSURANCE INFORMATION
(Complete this section only if you selected "I plan to use my health insurance benefits" above.)
If you are paying privately (self-pay), you may skip this section. It is your responsibility to notify Garrett Counseling of any changes to your insurance coverage prior to your appointment. Failure to do so will result in you being financially responsible for services that cannot be billed to your insurance.
Primary Insurance Company: _____
Member ID: _____
Group Number: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Employer: _____

REGISTRATION AGREEMENT: By signing below, I acknowledge that:

- The information I have provided is complete and accurate to the best of my knowledge.
- I will promptly notify Garrett Counseling of any changes to my contact information, insurance information, or financial responsibility.

- I understand that providing inaccurate or incomplete information may delay services or affect insurance billing.
- I understand that additional practice policies, financial policies, privacy practices, and informed consent are outlined in Section 3: Privacy Practices & Informed Consent, which I will review and acknowledge before beginning services.

Client Signature: _____
Date: _____
If completed by a parent, legal guardian, or personal representative:
Printed Name: _____
Relationship to Client: _____

Section 2: Your Health & Counseling History

Section 2: Your Health & Counseling History

Thank you for taking the time to complete this questionnaire. The information you provide helps your counselor better understand your concerns, health history, and goals before your first appointment. While some questions may not seem directly related to why you are seeking counseling today, they help us provide safe, individualized, and effective care. Please answer each question as honestly and completely as possible. There are no right or wrong answers.

WHAT BRINGS YOU TO COUNSELING?
What prompted you to seek counseling at this time?

What would you like to accomplish through counseling?

STRENGTHS & SUPPORTS
Everyone has strengths they bring into counseling, even during difficult seasons of life.
What personal strengths, coping skills, or qualities have helped you through difficult times in the past?

Who are the people you consider to be your biggest sources of support? (Family, friends, faith community, coworkers, etc.)

PREVIOUS COUNSELING & MENTAL HEALTH TREATMENT
Have you previously received counseling, psychotherapy, or other mental health treatment?
☐ Yes
☐ No
If yes: Where did you receive services? Approximately when did you receive services?
_____

Have you ever been hospitalized for a mental health concern?
☐ Yes
☐ No
If yes, please explain. _____

MEDICAL INFORMATION
Do you currently have a Primary Care Provider?
☐ Yes
☐ No
If yes:
Provider Name

Practice Name

Current Medications & Supplements
Please list all prescription medications, over-the-counter medications, vitamins, and supplements you currently take on a regular basis.

Medication / Supplement	Dose	Reason for Taking	Prescribing Provider (if applicable)

Current Medical Conditions
Please check any current medical conditions that apply.
☐ Headaches
☐ High Blood Pressure
☐ Thyroid Disorder
☐ Diabetes
☐ Heart Disease
☐ Chest Pain
☐ Seizures
☐ Head Injury
☐ Chronic Pain
☐ Bone or Joint Problems
☐ Gastrointestinal Problems
☐ Kidney Disease
☐ Cancer
☐ Hormonal Concerns
☐ Other: _____

ALCOHOL & SUBSTANCE USE
Do you currently drink alcohol?
☐ No
☐ Occasionally
☐ Weekly
☐ Daily

Do you currently use recreational drugs or misuse prescription medications?
☐ No
☐ Occasionally
☐ Weekly
☐ Daily
If yes, please describe.

CURRENT LIVING SITUATION

Who do you currently live with?
☐ Alone
☐ Spouse/Partner
☐ Parents
☐ Children
☐ Roommates
☐ Other
If you selected "Other" or would like to provide additional information, please explain.

RELATIONSHIPS
Current Relationship Status
☐ Single
☐ Dating
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Complicated
If you are currently in a relationship:
Approximately how long have you been together?

Is there anything you would like your counselor to know about this relationship?

EDUCATION & EMPLOYMENT
Highest Level of Education Completed

Current Occupation

Employer (Optional)

FAMILY MENTAL HEALTH HISTORY
Has anyone in your immediate family experienced mental health concerns?
☐ Yes
☐ No
☐ Unsure
If yes, please explain.

CURRENT SYMPTOMS
During the past six months (6), have you experienced any of the following symptoms?

☐ Anxiety
☐ Excessive Worry
☐ Panic Attacks
☐ Fear
☐ Depression
☐ Hopelessness
☐ Low Motivation
☐ Low Self-Esteem
☐ Isolation
☐ Tearfulness
☐ Trouble Concentrating
☐ Difficulty Sleeping
☐ Sleeping Too Much
☐ Fatigue
☐ Increased Appetite
☐ Decreased Appetite
☐ Irritability
☐ Mood Swings
☐ Anger
☐ Chronic Stress
☐ Grief
☐ Other: _____

DEPRESSION SCREENING (PHQ-9)
Over the last 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things.
    ☐ Always
    ☐ Very Often
    ☐ Sometimes
    ☐ Rarely
    ☐ Never
2. Feeling down, depressed, or hopeless
    ☐ Always
    ☐ Very Often
    ☐ Sometimes
    ☐ Rarely
    ☐ Never
3. Trouble falling or staying asleep, or sleeping too much
    ☐ Always
    ☐ Very Often
    ☐ Sometimes
    ☐ Rarely
    ☐ Never

4. Feeling tired or having little energy
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
5. Poor appetite or overeating
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
7. Trouble concentrating on things, such as reading the newspaper or watching television
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
9. Thoughts that you would be better off dead or of hurting yourself in some way
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all

- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

ANXIETY SCREENING (GAD-7)
Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
2. Not being able to stop or control worrying
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
3. Worrying too much about different things
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
4. Trouble relaxing
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
5. Being so restless that it's hard to sit still
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
6. Becoming easily annoyed or irritable
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes

- ☐ Rarely
- ☐ Never

7. Feeling afraid as if something awful might happen
   - ☐ Always
   - ☐ Very Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

SUICIDE RISK SCREENING (C-SSRS)
Assessment: CSSRS Self-Report

Please place a check mark in the box for the appropriate answers.
In the past month….

1) Have you wished you were dead or wished you could go to sleep and not wake up?
   - ☐ Yes
   - ☐ No

2) Have you actually had any thoughts of killing yourself?
   - ☐ Yes
   - ☐ No

3) Have you thought about how you might do this?
   - ☐ Yes
   - ☐ No
   - ☐ N/A - No Thoughts

4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you having the thoughts, but you definitely would not act on them? (For example, “I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.”)
   - ☐ Yes
   - ☐ No
   - ☐ N/A - No Thoughts

5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? For example, “I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.”)

- ☐ Yes
- ☐ No
- ☐ N/A - No Thoughts

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? (For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn’t swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn’t, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)

- ☐ Yes
- ☐ No
- ☐ N/A - No Thoughts

If YES, did this occur in the past 3 months?

- ☐ Yes
- ☐ No
- ☐ N/A - No Thoughts

ADVERSE CHILDHOOD EXPERIENCES (ADULT ACES)

This questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during the first 18 years of your life:

1. Did you feel that you didn’t have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
   - ☐ Yes - 1
   - ☐ No - 0
2. Did you lose a parent through divorce, abandonment, death, or other reason?
   - ☐ Yes - 1
   - ☐ No - 0
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?
   - ☐ Yes - 1
   - ☐ No - 0
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?

- ☐ Yes - 1
- ☐ No - 0

5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?
   - ☐ Yes - 1
   - ☐ No - 0
6. Did you live with anyone who went to jail or prison?
   - ☐ Yes - 1
   - ☐ No - 0
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?
   - ☐ Yes - 1
   - ☐ No - 0
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
   - ☐ Yes - 1
   - ☐ No - 0
9. Did you feel that no one in your family loved you or thought you were special?
   - ☐ Yes - 1
   - ☐ No - 0
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?
    - ☐ Yes - 1
    - ☐ No - 0

IS THERE ANYTHING ELSE YOU WOULD LIKE YOUR COUNSELOR TO KNOW?
Before your first appointment, is there anything else you would like your counselor to know about you, your concerns, your history, or what you hope to gain from counseling?

_____

_____

Section 3: Privacy Practices & Informed Consent

Section 3: Privacy Practices & Informed Consent

Thank you for taking the time to review these policies. This section explains your rights as a client, how we protect your privacy, how counseling services are provided, and what you can expect while receiving services at Garrett Counseling. We encourage you to read this information carefully. If you have any questions about these policies or your rights as a client, please ask before signing the acknowledgment at the end of your paperwork. We want you to feel informed and comfortable before beginning counseling. By signing this packet, you acknowledge that you have received and reviewed this information and agree to the policies outlined below.

BEFORE YOUR FIRST APPOINTMENT: To help us prepare for your first appointment and ensure a smooth check-in process, please complete the following before we schedule your first appointment.
Required for All Clients
☐ Upload a clear photo or scanned copy of your valid government-issued photo identification (driver's license or other government-issued photo ID) through the secure client portal or email it to records@garrettcounseling.com

If You Plan to Use Health Insurance
☐ Upload a clear photo or scanned copy of the front and back of your current insurance card through the secure client portal or email it to records@garrettcounseling.com. If You Are Paying Privately (Self-Pay) you do not need to upload an insurance card.

OUR COMMITMENT TO YOU: At Garrett Counseling, we are committed to providing compassionate, ethical, evidence-based care tailored to your unique needs. We strive to create a safe, welcoming environment where every client is treated with dignity, respect, and professionalism. Our commitment includes protecting your privacy, collaborating with you to develop meaningful treatment goals, communicating openly about your care, and providing services that meet the highest professional and ethical standards. If you have questions, concerns, or feel your needs are not being met, we encourage you to discuss them with your counselor or our administrative team so we can work together toward a positive resolution.

INFORMED CONSENT FOR COUNSELING: Counseling is a collaborative relationship between you and your counselor designed to help you better understand yourself, address concerns, improve relationships, develop healthy coping skills, and work toward your personal goals. Because every individual is unique, counseling experiences and outcomes vary. While many clients experience meaningful improvement, Garrett Counseling cannot guarantee specific results or outcomes. During counseling you may experience a wide range of emotions, including relief, hope, sadness, anxiety, frustration, or discomfort as difficult experiences, thoughts, or feelings are explored. These reactions are often a normal part of the therapeutic process. Your counselor may recommend different therapeutic approaches, interventions, or resources based on your individual needs and professional judgment. You are encouraged to

ask questions about any recommendation and to actively participate in decisions regarding your treatment.

As a client, you have the right to: Ask questions about your treatment at any time; Participate in developing your treatment goals; Decline or discuss treatment recommendations; Request a referral if you believe another provider may better meet your needs; Withdraw from counseling at any time, and subject to any financial obligations for services already provided.

You also have responsibilities that contribute to effective counseling, including: Providing accurate and complete information about your health and circumstances; Attending appointments as scheduled; Communicating openly with your counselor; Informing your counselor of significant changes in your health, medications, or personal circumstances; and Following through with agreed-upon treatment recommendations to the best of your ability. Counseling is most effective when there is mutual trust, open communication, and active participation by both the client and counselor. We are committed to partnering with you throughout your counseling journey while respecting your autonomy and personal goals.

CLIENT RIGHTS: At Garrett Counseling, we are committed to providing counseling services in a safe, respectful, and professional environment. As our client, you have the right to participate in your treatment, ask questions, discuss recommendations, and make informed decisions about your care. You may request information about your counselor's qualifications, access your health records as permitted by law, request corrections when appropriate, or discontinue counseling at any time. If you have concerns about your care, we encourage you to discuss them with your counselor or a member of our administrative team.

PRIVACY PRACTICES (HIPAA): Garrett Counseling protects your Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws. Your health information may be used or disclosed for treatment, payment, and healthcare operations. We may also disclose information without your written authorization when required or permitted by law, such as to report suspected abuse or neglect, comply with court orders, respond to public health requirements, or help prevent a serious threat to your health or safety or the safety of another person. Except as permitted or required by law, your information will not be released without your written authorization. When information is disclosed, we make reasonable efforts to limit the disclosure to the minimum information necessary.

YOUR PRIVACY RIGHTS: You have the right to request access to your health records, request amendments when appropriate, request confidential methods of communication, request certain restrictions on disclosures, receive an accounting of disclosures as permitted by law, and revoke most written authorizations you have previously signed. Some requests may be denied when permitted or required by law. If this occurs, we will explain the reason for the denial and any rights you may have to request a review.

HEALTH INFORMATION & RECORDS: Garrett Counseling maintains your clinical records in accordance with professional standards and applicable federal and Alabama law. Your record may include intake paperwork, assessments, treatment plans, progress notes, billing information, and other documentation related to your care. You may request a copy of your records by submitting a written request. Requests are processed in accordance with applicable law, and reasonable fees may apply where permitted. Current fees are available upon request and are based on Garrett Counseling's fee schedule in effect at the time your request is received. Except as permitted or required by law, we will not release your records without your written authorization. If you would like us to communicate with another healthcare provider, family member, school, attorney, or another individual regarding your care, a separate Authorization for Release of Information must be completed. Garrett Counseling maintains your records electronically and uses reasonable administrative, technical, and physical safeguards to protect the confidentiality and security of your information.

FINANCIAL POLICIES: Payment is due at the time services are provided unless other arrangements have been made. You are ultimately responsible for payment of all services received, regardless of insurance coverage. Garrett Counseling files claims with participating primary insurance plans as a courtesy. Verification of insurance benefits is not a guarantee of payment. You remain responsible for deductibles, copayments, coinsurance, non-covered services, and any balances not paid by your insurance company. Garrett Counseling does not file secondary insurance claims.

Insurance Responsibilities: Clients are responsible for understanding the requirements of their insurance plan, including referrals, prior authorizations, benefit limitations, session limits, and other coverage requirements. Garrett Counseling submits claims to participating insurance companies as a courtesy but cannot guarantee payment or coverage. Verification of benefits is not a guarantee of payment.

Claim Processing: Garrett Counseling will make reasonable efforts to submit and, when appropriate, resubmit insurance claims. If a claim continues to be denied after reasonable resubmission efforts, any remaining balance becomes the client's responsibility.

Credit Card on File: A valid credit card is required to remain securely on file throughout treatment. By signing this agreement, you authorize Garrett Counseling to charge your card for amounts that are your financial responsibility, including copayments, deductibles, coinsurance, self-pay services, balances remaining after insurance processing, late cancellation or no-show fees, and other authorized charges outlined in these policies. Payment information is securely maintained through a PCI-compliant payment processor. Garrett Counseling does not store your complete credit card information.

Good Faith Estimate: Clients who are uninsured or choose not to use their insurance have the right to receive a Good Faith Estimate under the No Surprises Act. Additional information is available at: https://garrettcounseling.com/good-faith-estimate/

Current Fee Schedule: Garrett Counseling periodically reviews and updates its fee schedule. Current fees for counseling services, records requests, legal services, court appearances, administrative services, and other non-covered services are available upon request by emailing hello@garrettcounseling.com. The fee schedule in effect at the time services are provided or requested will apply.

Collection of Unpaid Balances: If your account becomes past due, Garrett Counseling will make reasonable efforts to collect the outstanding balance, including contacting you using the contact information you have provided. Garrett Counseling will generally attempt to collect the balance internally for 30 to 60 days before referring the account to a third-party collection agency or pursuing other lawful means of collection. By signing this agreement, you accept financial responsibility for any outstanding balance, including collection agency fees equal to 33.33% of the unpaid balance, reasonable attorney's fees, court costs, and other costs of collection to the extent permitted by law. For clients who are considered to be at higher clinical risk, Garrett Counseling will make reasonable efforts to avoid an interruption in care. When clinically appropriate, clients will receive at least 30 days' written notice and an opportunity to establish a payment plan before services are terminated due to nonpayment. If continued treatment is not possible, appropriate referrals to alternative providers or community resources will be offered.

APPOINTMENTS & CANCELLATIONS: Your appointment time is reserved specifically for you. If you need to cancel or reschedule, we require at least 48 hours' notice. Appointments cancelled with less than 48 hours' notice or missed without notice will result in a $150 late cancellation/no-show fee, except where prohibited by law or payer policy. Payment for the late cancellation/no-show fee will be processed on the day of the missed appointment.

MEDICAID SPECIFIC: After two no-shows your counselor will contact the doctor about excessive no-shows. Garrett Counseling strictly enforces the current policy of referring you to other mental health providers when you excessively no-show for appointments or cancel sessions less than 48 hours in advance. Your counselor will be required to notify the referring pediatrician of the no-shows. Please plan ahead and cancel at least 48 hours in advance to avoid termination of services. Medicaid recipients will not be charged a show fee.

If you show up 30 minutes late for your session, you will not be seen and will not be charged. The session will count as a no show. After two no-shows you will be referred out for excessive no-shows.

COURT, LEGAL PROCEEDINGS & RECORD REQUESTS: Garrett Counseling provides treatment services and does not provide forensic evaluations. Services related to legal matters including records preparation, letters, attorney consultations, subpoenas, depositions, court appearances, testimony, or other legal or administrative requests, are not covered by insurance and are billed separately according to the current fee schedule. Payment is required before these services are provided. Garrett Counseling cannot guarantee counselor availability for legal proceedings. If required to participate in legal proceedings, counselors are ethically and legally obligated to provide truthful, objective information.

ELECTRONIC COMMUNICATION: Garrett Counseling may communicate with you by phone, text message, email, and through the secure client portal regarding scheduling, billing, and other administrative matters. Electronic communication carries inherent privacy risks. Please do not use email or text messaging for emergencies or urgent clinical concerns. Whenever possible, confidential information should be communicated through the secure client portal.

TELEHEALTH SERVICES: Telehealth services are provided using HIPAA-compliant technology and are available when clinically appropriate and permitted by applicable licensing laws.
At the beginning of each telehealth appointment, your counselor may verify your identity, physical location, emergency contact information, and a phone number in case the session is interrupted. Clients are responsible for participating from a private location where confidentiality can be maintained. If a technical issue occurs, Garrett Counseling will make reasonable efforts to reconnect using an approved alternative method. If you experience a medical or psychiatric emergency during or outside of a telehealth session, call 911, go to the nearest emergency department, or contact the 988 Suicide & Crisis Lifeline.

EMERGENCY & SAFETY PROCEDURES: Garrett Counseling is not an emergency or crisis service and does not provide 24-hour care.If you are experiencing a medical or psychiatric emergency, call 911, go to the nearest emergency department, or contact the 988 Suicide & Crisis Lifeline. If your counselor believes there is an immediate risk to your safety or the safety of another person, Garrett Counseling may contact emergency services, your designated emergency contact, or others as permitted or required by law to help protect your safety (including call 911 for welfare check).

VIDEO SURVEILLANCE: To promote the safety and security of our clients, staff, and counselors, Garrett Counseling utilizes video surveillance throughout our facilities.
Counseling rooms are monitored by video only and do not record audio. Common areas may include both video and audio recording where permitted by law. Video recordings are used solely for safety, security, quality assurance, and administrative purposes. They are not part of your clinical record and are retained according to Garrett Counseling's record retention practices unless needed for legal or safety purposes.

MEDITATION & WILDLIFE GARDEN: Your counselor may recommend meeting in Garrett Counseling's outdoor Meditation & Wildlife Garden when clinically appropriate.
Participation is completely voluntary. Because the garden is an outdoor environment, Garrett Counseling cannot guarantee the same level of privacy available inside the office. The garden may contain naturally occurring hazards such as uneven terrain, insects, wildlife, weather conditions, and other environmental risks. By choosing to participate in outdoor sessions, you acknowledge these inherent risks and agree to exercise reasonable care.

AI-ASSISTED DOCUMENTATION: To improve efficiency and allow counselors to spend more time focusing on clients, Garrett Counseling may use HIPAA-compliant AI-assisted documentation technology. These tools assist with creating clinical documentation but do not

replace your counselor's professional judgment. All documentation is reviewed, edited, and approved by your counselor before becoming part of your clinical record. Garrett Counseling only utilizes AI technologies that meet applicable privacy and security standards.

QUESTIONS: We understand that counseling, privacy laws, and healthcare policies can sometimes be confusing. If you have questions about any information in this packet or would like additional clarification, please ask your counselor or a member of our administrative team before signing the acknowledgment. We want you to feel informed and comfortable before beginning services.

ACKNOWLEDGMENT OF RECEIPT & CONSENT: By signing below, I acknowledge that I have received, reviewed, and understand the information contained in this New Client Welcome Packet, including Garrett Counseling's Privacy Practices & Informed Consent.
I understand that: I have had the opportunity to ask questions about these policies; I understand my rights and responsibilities as a client; I consent to participate in counseling services at Garrett Counseling; I understand Garrett Counseling's financial, cancellation, telehealth, communication, and privacy policies; I understand that I may request copies of these policies at any time; I understand that my signature acknowledges receipt and understanding of these policies and serves as my informed consent to begin treatment.

Client Signature

Date

If completed by a legal guardian or personal representative:
Printed Name

Relationship to Client

Section 4: Acknowledgement & Signature

Section 4: Acknowledgement & Signature

ACKNOWLEDGEMENT OF RECEIPT & INFORMED CONSENT: By signing below, I acknowledge that:

- ☐ I have received Garrett Counseling's Client Registration & Welcome Guide, including the Privacy Practices & Informed Consent and Good Faith Estimate.
- ☐ I have had the opportunity to review this information and ask questions before beginning counseling services.
- ☐ My questions, if any, have been answered to my satisfaction.
- ☐ I understand my rights and responsibilities as a client.
- ☐ I understand Garrett Counseling's policies regarding privacy, payment, appointments, cancellations, telehealth, electronic communication, and records.
- ☐ I understand that Garrett Counseling may update its policies and fee schedule from time to time. The most current versions are available upon request.
- ☐ I understand that I may withdraw my consent for counseling at any time by notifying my counselor, although I remain financially responsible for services already provided.
- ☐ I voluntarily consent to participate in counseling services at Garrett Counseling.

CLIENT CERTIFICATION: I certify that the information I have provided throughout this intake packet is complete and accurate to the best of my knowledge.I understand that it is my responsibility to notify Garrett Counseling if my contact information, insurance information, medications, emergency contact, or other significant information changes during treatment.

NOTICE OF PRIVACY PRACTICES: I acknowledge that Garrett Counseling has made its Notice of Privacy Practices available to me and that I have been provided the opportunity to receive or review a copy. I understand I can download these at any time on the Garrett Counseling website.

TELEHEALTH: I acknowledge Garrett Counseling's Telehealth Services Policy, including the benefits and limitations of telehealth, emergency procedures, technology-related risks, and my responsibilities during telehealth appointments. I understand that telehealth services may only be provided while I am physically located in the State of Alabama, and I consent to receive telehealth services when clinically appropriate.

CONSENT TO TREATMENT: By signing below, I voluntarily consent to receive counseling services from Garrett Counseling under the terms described in this packet. I understand that counseling is voluntary and that I may discontinue treatment at any time, subject to any financial obligations for services already provided.

Client Information
Client Name: _____
Client Signature: _____
Date: _____

Parent, Legal Guardian, or Personal Representative (Complete only if applicable.)
Printed Name: _____
Relationship to Client: _____
Signature: _____
Date: _____