Section 1: Registration & Contact Information

Section 1: Registration & Contact Information (Who Your Child Is)
Welcome to Garrett Counseling. We are honored that you have chosen us to be part of your child's journey. We understand that beginning counseling can feel overwhelming, and we appreciate the trust you are placing in our team. Before beginning, please know this packet must be completed solely by the child's legal guardian or custodial parent. Individuals who do not have legal guardianship or custodial rights are not authorized to complete or submit this packet on the child's behalf. The entire intake process should take approximately 20 minutes to complete.

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

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

PARENT / LEGAL GUARDIAN INFORMATION
Parent / Legal Guardian #1
Name: _____
Relationship to Child: _____
Date of Birth: _____
Primary Phone Number: _____
Email Address: _____
Address (if different from child): _____

Parent / Legal Guardian #2
Name: _____
Relationship to Child: _____
Date of Birth: _____
Primary Phone Number: _____
Email Address: _____
Address (if different from child): _____

Parent Communication:Garrett Counseling requests contact information for both legal parents or guardians, regardless of which parent is completing this paperwork. Unless Garrett Counseling receives current legal documentation stating otherwise, both parents or legal guardians who have legal rights are expected to be informed that the child is receiving counseling services and will be given the opportunity to participate in treatment. Participation is voluntary, and either parent may choose not to be involved. Routine communication regarding scheduling,

administrative matters, treatment recommendations, and other non-emergency matters will generally be communicated by email with both parents included, unless current legal documentation restricts communication.

If legal documentation limits a parent's rights or restricts communication, copies of the most current court orders, custody agreements, guardianship documents, DHR paperwork, or other applicable legal documents must be emailed to records@garrettcounseling.com before services begin. Until documentation is received and reviewed, Garrett Counseling will presume both parents retain the rights afforded to them under applicable law.

Parents are responsible for notifying Garrett Counseling of any changes to custody, legal decision-making authority, court orders, or contact information throughout treatment.

COMMUNICATION PREFERENCES
Garrett Counseling may communicate with you regarding scheduling, billing, appointment reminders, 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 a parent or legal guardian during a medical or psychiatric emergency, or if your child's counselor believes there is an immediate concern for your child's 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 child's protected health information or discuss treatment with that individual. Any disclosure will be limited to what is reasonably necessary to protect your child's health or safety or as otherwise permitted or required by law. If we are unable to reach a parent, legal guardian, or 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 or parent/legal guardian.
Emergency Contact Name: _____
Relationship to Child: _____
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 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 child's current physical location. Clients scheduled for telehealth appointments who are located outside of Alabama (or another state in which their counselor is authorized to practice) at the time of the appointment will be considered unavailable for services and may be charged the applicable late cancellation or no-show fee. The parent/legal guardian and child may not be driving during a telehealth appointment.

Telehealth Safety Information: To help us respond appropriately during a telehealth appointment, please complete the following information.
☐ I authorize Garrett Counseling to contact my emergency contact if a medical or psychiatric emergency occurs during a telehealth session.

If We Become Disconnected: 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 below.
Best Phone Number: _____
Verification Word or Phrase: _____

Emergency Information
Preferred Hospital: _____
Hospital Address: _____
Hospital Phone Number: _____

Parent/Guardian Responsibilities During Telehealth: For each telehealth session, I agree to:

- Participate from a private location whenever possible.
- Provide my child's current physical location at the beginning of each session.
- Notify my counselor if my child's location changes during the session.
- 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.
- Provide my child with a private space for counseling sessions (driving in car with others is not considered private)

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

FINANCIAL RESPONSIBILITY
(Complete only if someone other than a parent or legal guardian is financially responsible for counseling services.)

If someone other than the parent or legal guardian is responsible for paying for counseling services, please complete the information below. A Release of Information may be required to discuss financial matters with the responsible party.

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

HOW WILL YOU BE PAYING FOR COUNSELING SERVICES?

☐ We plan to use health insurance benefits.
☐ We will be paying privately (self-pay) and will not be using health insurance.

INSURANCE INFORMATION

(If you are not using insurance (but you are self-pay, please put N/A in each of these sections)
It is your responsibility to notify Garrett Counseling of any changes to your insurance coverage prior to your child's appointment. Failure to do so may 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 (Optional): _____

Primary Care Provider (PCP) Care Coordination (Required for Alabama Medicaid)

To comply with Alabama Medicaid requirements and coordinate your healthcare, Garrett Counseling communicates with your Primary Care Provider (PCP) as needed regarding your behavioral health treatment. This coordination may include referral information, attendance, diagnoses, treatment recommendations, medication-related information, treatment summaries, progress updates, discharge summaries, and other protected health information (PHI) necessary to coordinate your care and maintain your Medicaid referral or authorization for services.

Primary Care Provider (PCP): _____
Practice Name: _____

Acknowledgement

☐ I understand that if I am using Alabama Medicaid, I authorize Garrett Counseling to communicate with my Primary Care Provider as necessary to coordinate my care and maintain Medicaid referral requirements. I understand that failure to provide this authorization may

prevent Garrett Counseling from billing Alabama Medicaid or providing services through my Alabama Medicaid benefits.
☐ I am not using Alabama Medicaid. (This authorization is not required.)

REGISTRATION AGREEMENT
By signing below, I acknowledge that:

- The information I have provided is complete and accurate to the best of my knowledge.
- I have the legal authority to complete this registration or will provide documentation establishing that authority.
- I will promptly notify Garrett Counseling of any changes to contact information, insurance information, financial responsibility, custody, guardianship, or court orders affecting my child's care.
- I understand that providing inaccurate or incomplete information may delay services, affect insurance billing, or delay Garrett Counseling's ability to verify legal authority to consent to treatment.
- I understand that additional practice policies, including Privacy Practices, Custody, Parent Communication, Zone of Privacy, Financial Policies, Telehealth, and Informed Consent, are outlined in Section 3, which I will review and acknowledge before my child begins services.

Client Name: _____
Parent/Legal Guardian Signature: _____
Date: _____
Printed Name: _____
Relationship to Child: _____

Section 2: Your Child's Health & Counseling Histo…

Section 2: Your Child's Health & Counseling History

Thank you for taking the time to complete this questionnaire. The information you provide helps your child's counselor better understand your child's concerns, strengths, health history, development, and goals before the 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 YOUR CHILD TO COUNSELING?
What prompted you to seek counseling for your child at this time?

What would you like to accomplish through counseling?

If appropriate for your child's age, what do you think your child hopes to accomplish through counseling?

YOUR CHILD'S STRENGTHS & SUPPORTS
Every child has strengths they bring into counseling, even during difficult seasons of life.
What personal strengths, talents, coping skills, or positive qualities best describe your child?

Who are your child's biggest sources of support?
☐ Parent(s)
☐ Siblings
☐ Extended Family
☐ Friends
☐ Teacher/School Staff
☐ Faith Community
☐ Coach/Mentor
☐ Other _____
Favorite hobbies, interests, or activities

PREVIOUS COUNSELING & MENTAL HEALTH TREATMENT
Has your child previously received counseling, psychotherapy, or other mental health treatment?
☐ Yes
☐ No
If yes:
Provider/Agency: _____
Approximate Dates: _____
Reason for Treatment: _____
Has your child ever:
☐ Seen a psychiatrist

☐ Received medication management
☐ Had psychological testing
☐ Been hospitalized for a mental health concern
If yes, please explain.

MEDICAL INFORMATION
Does your child currently have a Primary Care Provider?
☐ Yes
☐ No
If yes:
Provider Name: _____
Practice Name: _____
Phone Number: _____
Current Medications & Supplements
Please list all prescription medications, over-the-counter medications, vitamins, and supplements your child currently takes.

Medication	Dose	Reason	Prescribing Provider

Current Medical Conditions
Please check any current medical conditions that apply.
☐ Asthma
☐ Allergies
☐ Recurrent Ear Infections
☐ Vision Problems
☐ Hearing Problems
☐ Seizures
☐ Head Injury/Concussion
☐ Thyroid Disorder
☐ Diabetes
☐ Gastrointestinal Problems
☐ Hormonal Concerns
☐ Developmental Delay
☐ Chronic Medical Condition
☐ Other _____
Please list any allergies

Previous surgeries or hospitalizations

Other medical concerns

DEVELOPMENTAL HISTORY
Were there any concerns with your child's:
☐ Pregnancy
☐ Birth
☐ Speech/Language
☐ Motor Development
☐ Learning
☐ Toilet Training
☐ Social Development
☐ Other _____
If yes, please explain.

If your child was adopted, at what age?

SCHOOL INFORMATION
Current School

Current Grade

Current academic performance
☐ Above Average
☐ Average
☐ Below Average

Has your child ever received any of the following?
☐ Repeated a grade
☐ Skipped a grade
☐ IEP
☐ 504 Plan
☐ Special Education Services
☐ Speech Therapy
☐ Occupational Therapy
☐ School Counseling
☐ Tutoring

Is your child currently experiencing concerns with:
☐ Reading
☐ Writing

☐ Math
☐ Attention
☐ Behavior
☐ Peer Relationships
☐ School Attendance
☐ Other _____

CURRENT SYMPTOMS (Past 30 Days)
Please check any symptoms your child has experienced during the past 30 days.

Attention & Learning
☐ Trouble paying attention
☐ Easily distracted
☐ Hyperactivity
☐ Impulsivity
☐ Difficulty following directions
☐ Difficulty completing tasks

Mood & Emotions
☐ Sadness
☐ Tearfulness
☐ Irritability
☐ Mood swings
☐ Low self-esteem
☐ Low motivation
☐ Loss of interest

Anxiety
☐ Excessive worry
☐ Fearfulness
☐ Panic attacks
☐ Separation anxiety
☐ Obsessive thoughts
☐ Compulsive behaviors

Behavior
☐ Defiance
☐ Temper tantrums
☐ Aggression
☐ Lying
☐ Stealing
☐ Running away
☐ Fire setting
☐ Cruelty to animals

Social
☐ Difficulty making or keeping friends
☐ Social withdrawal
☐ Bullied by others
☐ Bullies others

Sleep
☐ Trouble falling asleep
☐ Trouble staying asleep
☐ Nightmares
☐ Sleeping too much

Development & Communication
☐ Speech or language concerns
☐ Sensory concerns
☐ Autism concerns
☐ Repetitive behaviors

Safety & Trauma
☐ Self-harm
☐ Suicidal thoughts
☐ Suicide attempt
☐ Physical abuse
☐ Sexual abuse
☐ Witnessed domestic violence
☐ Grief or loss
☐ Substance use
☐ Other _____

FAMILY & HOME
Who currently lives with your child?

Does your child regularly stay in another home?
☐ Yes
☐ No
If yes, please describe.

Please list your child's siblings (name and age).

DAILY ROUTINE

Average bedtime _____
Average wake time _____
Average hours of sleep _____
Average recreational screen time per day _____

RECENT LIFE CHANGES (Past 6 Months)
Please check any significant changes your child has experienced.
☐ Separation/Divorce
☐ Marriage/Remarriage
☐ New Baby
☐ Change in Living Situation
☐ Death of Family Member
☐ Death of Friend
☐ Serious Illness/Injury
☐ Parent Job Change/Loss
☐ Legal Issues
☐ Military Changes
☐ Trauma
☐ Other _____

OTHER SERVICES
Is your child currently receiving services from any of the following?
☐ School Counselor
☐ School Psychologist
☐ DHR/CPS
☐ Juvenile Court
☐ Probation
☐ Speech Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Other _____

FAMILY MENTAL HEALTH HISTORY
Has anyone in your child's immediate family experienced mental health concerns, substance use concerns, or developmental disorders?
☐ Yes
☐ No
☐ Unsure
If yes, please explain.

ADDITIONAL INFORMATION
Is there anything else you would like your child's counselor to know before the first appointment?

REQUIRED SCREENING QUESTIONNAIRES
The following standardized questionnaires are required as part of your child's intake. These screening tools help your counselor better understand your child's current symptoms, monitor progress over time, and develop an individualized treatment plan.

ANXIETY SCREENER - Guardian Report (6-17YO)

In the past SEVEN (7) DAYS, my child said that he/she…

1. Felt like something awful might happen.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
2. Felt nervous.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
3. Felt scared.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
4. Felt worried.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
5. Worried about what could happen to him/her.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes

- ☐ Often
- ☐ Almost Always

6. Worried when he/she went to bed at night.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
7. Got scared really easily.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
8. Was afraid of going to school.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
9. Worried when he/she was at home.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
10. Worried when he/she was away from home.
    - ☐ Never
    - ☐ Almost Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Almost Always

The counselor will score this screening and discuss the results with you.

DEPRESSION SCREENER - Guardian Report (6-17YO)

Adapted from APA emerging measures, PROMIS Emotional Distress - Depression - Parent Item Bank

In the past SEVEN (7) DAYS, my child said that he/she…

1. Could not stop feeling sad.
   - ☐ Never

- ☐ Almost Never
- ☐ Sometimes
- ☐ Often
- ☐ Almost Always

2. Felt alone.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
3. Felt like heshe couldn’t do anything right.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
4. Felt lonely.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
5. Felt sad.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
6. Felt unhappy.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always
7. Thought that his/her life was bad.
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Often
   - ☐ Almost Always

8. Didn’t care about anything.
    - ☐ Never
    - ☐ Almost Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Almost Always
9. Felt stressed.
    - ☐ Never
    - ☐ Almost Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Almost Always
10. Felt too sad to eat.
    - ☐ Never
    - ☐ Almost Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Almost Always
11. Wanted to be by himself/herself.
    - ☐ Never
    - ☐ Almost Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Almost Always

The counselor will score this screening and discuss the results with you.

HISTORY OF DHR INVOLVEMENT FORM

- ☐ My child has NEVER been involved with DHR in any way and to my knowledge, no reports of abuse or neglect have ever been made.

If your child (the client) has never been involved with DHR (Department of Human Resources) for suspected abuse or neglect , please check the box that says: "My child has never been involved in any way with DHR, and to my knowledge, no reports of abuse or neglect have ever been made." Then, scroll to the end of this form, answer the last question, and sign the form.

If your child has been involved with DHR in any way, please complete the rest of the questions before signing.

If your child (the client) has ever (even for suspected) been involved with DHR for suspected abuse or neglect, please complete this form. If you do not know an answer, write “I do not know.”

Client Legal Name (First/Last): _____
Legal Sex of Client: _____
Date of Birth: _____
Client Address: _____
Other Persons Living with the Client (everyone): _____
_____
Person(s) Allegedly Responsible for Abuse/Neglect: _____
_____
Legal Sex of Alleged Abuser: _____
Person(s) Allegedly Abuser Date of Birth: _____
Person(s) Allegedly Abuser Address: _____
Person(s) Allegedly Abuser Phone Number: _____
Person(s) Allegedly Abuser Relationship to Client: _____
Describe what happened, how it affected the client: _____
_____
_____
_____
Dates Allegations Occurred (when): _____
Did you see the abuse/neglect when it occurred? _____
If you did not see it, how did you hear about it? _____
_____
List any one who witnessed the abuse/neglect: _____
Contact information of who witnessed abuse/neglect: _____
_____
Contact information of the witness? _____
Was a case opened? What did DHR do? _____
Is there current DHR involvement? _____
Anything else you can tell us about this? _____
Person Completing Form (YOUR Full Name): _____
Person Completing Form Relationship to Client: _____
Phone Number of Person Completing Form: _____

- ☐ My child has NEVER been involved with DHR in any way.
- ☐ My child has been involved with DHR and I completed all the questions above.

Signature of Person Completing this form: _____

MINOR ACES - Adverse Childhood Experiences (Minors)
Client Legal Name(First/Last): _____
Clients Date of Birth: _____
Today's Date: _____

This questionnaire will be asking you some questions about events that happened during your childhood so far; specifically the first 18 years of your life (if applicable). 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.

DISCLAIMER: We value your confidentiality and privacy. Please note that any information selected below will be subject to mandated reporting.

While you were growing up, during the first 18 years of your life (or the years thus far):

1. Were your parents separated, divorced, or not living together?
   - ☐ Yes - 1
   - ☐ No - 0
2. Has your parents or anyone you ever lived with gone to prison, jail or other correctional facility?
   - ☐ Yes - 1
   - ☐ No - 0
3. Did you ever live with anyone who was depressed, mentally ill or suicidal?
   - ☐ Yes - 1
   - ☐ No - 0
4. Did a parent or other adult ever hit you so hard that you had marks or were injured?
   - ☐ Yes - 1
   - ☐ No - 0
5. Did you ever live with anyone who acted in a way that made you feel afraid?
   - ☐ Yes - 1
   - ☐ No - 0
6. Have you ever been touched, or asked to touch, an adult or someone at least 5 years older sexually?
   - ☐ Yes - 1
   - ☐ No - 0
7. Did you ever not have enough to eat, had to wear dirty clothes, and had no one to protect you, take care of you, or take you to the doctor if you needed?
   - ☐ Yes - 1
   - ☐ No - 0
8. Have you ever witnessed adults in the home hitting, slapping, kicking or physical threatening each other?

- ☐ Yes - 1
- ☐ No - 0

9. Do you spend time with anyone who uses drugs or drinks too much alcohol?
   - ☐ Yes - 1
   - ☐ No - 0
10. Do you feel that no one in your family loves you or thinks that you are important or special?
   - ☐ Yes - 1
   - ☐ No - 0

SEVERITY MEASURE FOR DEPRESSION
Adolescent (11-17YO). PHQ

How often have you been bothered by each of the following symptoms during the past 7 days?

Feeling down, depressed, irritable, or hopeless?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Little interest or pleasure in doing things?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Trouble falling asleep, staying asleep, or sleeping too much?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Poor appetite, weight loss, or overeating?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Feeling tired, or having little energy?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Trouble concentrating on things like school work, reading, or watching TV?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Moving or speaking so slowly that other people could have noticed?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

Thoughts that you would be better off dead, or of hurting yourself in some way?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday

SEVERITY MEASURE FOR GENERALIZED ANXIETY DISORDER - ADOLESCENT
Adolescent Screening. 11-17 Years Old

The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work.

During the PAST 7 DAYS, I have…
Felt moments of sudden terror, fear, or fright

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time

- ☐ All of the time

Felt anxious, worried, or nervous.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Felt a racing heart, sweaty, trouble breathing, faint, or shaky.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Avoided, or did not approach or enter, situations about which I worry.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Left situations early or participated only minimally due to worries.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries.

- ☐ Never

- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Sought reassurance from others due to worries.

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

Needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people).

- ☐ Never
- ☐ Occasionally
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

SUICIDE SCREENER 13 AND OLDER

Have you recently wished you were dead or wished you could go to sleep and not wake up?

- ☐ Yes
- ☐ No

Have you had thoughts about killing yourself?

- ☐ Yes
- ☐ No

Have you ever tried to kill yourself? (if only this question is yes, then further explore)

- ☐ Yes
- ☐ No

Are you having thoughts about killing yourself right now?

- ☐ Yes
- ☐ No
- ☐

If all answers above are no, you may stop here.
If you answered yes to any questions, move to the next four questions.

Do you have a plan?

- ☐ Yes
- ☐ No

Do you intend to act on these thoughts?

- ☐ Yes
- ☐ No
- ☐ I do not have a plan

Do you have access to the means you would use?

- ☐ Yes
- ☐ No
- ☐ I do not have a plan

** If you're experiencing suicidal thoughts, call 911 or go to the nearest emergency room immediately. For non-urgent support before your next appointment, contact your scheduler to find the next available counselor. New patients who haven't seen a counselor yet should also seek urgent help at the ER.**

SUICIDE SCREENER UNDER 13

Parents and/or guardians should use their discretion in deciding whether to read these questions to their child.

Have you wished you could disappear or not be alive?

- ☐ Yes
- ☐ No

Have you thought about hurting yourself or making yourself die?

- ☐ Yes
- ☐ No

Have you ever tried to hurt yourself or make yourself die?

- ☐ Yes
- ☐ No

Are you thinking about hurting yourself right now?

- ☐ Yes
- ☐ No

Have you thought about how you would do it?

- ☐ Yes
- ☐ No

The counselor will review these answers and discuss next steps during the client's next session.

**If you're experiencing suicidal thoughts, call 911 or go to the nearest emergency room immediately. For non-urgent support before your next appointment, contact your scheduler to

find the next available counselor. New patients who haven't seen a counselor yet should also seek urgent help at the ER.**

Section 3: Privacy Practices & Informed Consent

Section 3: Privacy Practices & Informed Consent

Welcome: 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.

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. If You Are Paying Privately (Self-Pay) you do not need to upload an insurance card.

Under the federal No Surprises Act, clients who are uninsured or choose not to use their insurance have the right to receive a Good Faith Estimate explaining the expected cost of their care. Additional information is available on our website: https://garrettcounseling.com/good-faith-estimate/ You may also request a Good Faith Estimate from our office at any time.

OUR COMMITMENT TO YOU: At Garrett Counseling, we believe that healing begins with trust. Our commitment is to provide counseling services that are compassionate, ethical, evidence-based, and individualized to your unique needs. We strive to create an environment where every client feels respected, heard, and supported regardless of age, race, ethnicity, religion, national origin, disability, gender identity, sexual orientation, socioeconomic status, or life circumstances. We are committed to: Providing services that meet professional and ethical standards; Treating every client with dignity, compassion, and respect; Protecting your privacy and confidential information; Working collaboratively with you to develop meaningful treatment goals; Communicating openly and honestly about your care, recommendations, and progress; and Providing a safe, welcoming, and professional environment for counseling. We recognize that counseling is a partnership. Your active participation, honesty, and willingness to engage in the therapeutic process are important factors in helping you achieve your goals. If at any time you have questions, concerns, or feel your needs are not being met, we encourage you to discuss them with your counselor or a member of 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.
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. Medicaid clients are subject to separate cancellation policies consistent with applicable regulations.

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 parent, legal guardian, or personal representative:
Printed Name

Relationship to Client

Section 4: Custody, Parental Rights & Consent to …

Section 4: Custody, Parental Rights & Consent to Treatment

To authorize mental health treatment for a minor, the individual providing consent must have the legal authority to do so. Garrett Counseling relies on the most current custody, guardianship, DHR, or other court documents provided by the parent or legal guardian to determine who may consent to treatment and receive information regarding the child's care. If your family is separated, divorced, involved with DHR, or subject to any court orders affecting custody or decision-making, you are responsible for providing Garrett Counseling with complete and current legal documentation before services begin. You also agree to notify Garrett Counseling and provide updated documentation if legal custody or decision-making authority changes at any time during treatment.

If parents share joint legal custody, Garrett Counseling may require the consent of both parents or documentation demonstrating that the consenting parent has the legal authority to authorize treatment. Parents are responsible for ensuring that Garrett Counseling is informed of any legal restrictions regarding communication, access to records, or decision-making authority.

Garrett Counseling provides counseling services only. We do not perform custody evaluations, parental fitness evaluations, visitation evaluations, or forensic interviews, nor do we make recommendations regarding custody or visitation arrangements. Counselors do not serve as expert witnesses in custody disputes unless legally compelled by a court. If a counselor is required to participate in legal proceedings, applicable court and legal fees will apply according to Garrett Counseling's current fee schedule.

Parents acknowledge that custody disputes can interfere with effective treatment. Garrett Counseling's role is to promote the child's mental health and well-being, not to advocate for either parent or provide opinions regarding custody or parental rights.

Custody Acknowledgment

By signing Section 5, I acknowledge that:

- ☐ I have the legal authority to consent to mental health treatment for this child or have provided documentation establishing that authority.
- ☐ I have provided Garrett Counseling with all current custody, guardianship, DHR, or other court orders affecting this child's care.
- ☐ I agree to notify Garrett Counseling immediately if there are any changes to custody, guardianship, or legal decision-making authority.
- ☐ I understand Garrett Counseling's role is limited to providing treatment and does not include custody evaluations, parental fitness evaluations, visitation recommendations, or forensic services.
- ☐ I understand that counselors may be required to comply with valid court orders and applicable laws, and that legal services are subject to Garrett Counseling's current fee schedule at the time of request.

Parent & Guardian Contact Information: Garrett Counseling requests contact information for both legal parents or guardians, regardless of which parent is completing this paperwork.

If you are unable or unwilling to provide the other parent's contact information, you must provide current legal documentation demonstrating that:

- the other parent does not have legal rights regarding the child,
- the other parent's parental rights have been terminated,
- a court has restricted or prohibited contact or disclosure, or
- another legal order exists that prevents Garrett Counseling from communicating with that parent.

If no such legal documentation is provided, Garrett Counseling will presume that both legal parents or guardians have the rights afforded to them under applicable law and may require contact information for both parents before services begin.

Other Parent/Guardian Information
Name: _____
Relationship to Child: _____
Phone Number: _____
Email Address: _____

☐ I am unable to provide this information because I have uploaded court documentation supporting the exception described above.

Parent Communication Expectations: Garrett Counseling believes children generally benefit when both parents or legal guardians who have legal rights have the opportunity to participate in treatment. Unless Garrett Counseling receives current legal documentation stating otherwise, contact information for both legal parents or guardians is required, including each parent's phone number and email address. This information is required regardless of which parent is completing the intake paperwork or whether one parent chooses to participate in treatment. When both parents have legal rights, Garrett Counseling expects that both parents be informed that the child is receiving counseling services and be given the opportunity to participate, consistent with any applicable court orders. Participation is voluntary, and either parent may choose not to be involved.

Routine communication from Garrett Counseling, including scheduling, administrative matters, treatment recommendations, and other non-emergency communications, will generally be conducted by email with both parents included, unless Garrett Counseling has received current legal documentation restricting communication or access to information. If a parent states that the other parent should not receive communication or information, current court documentation supporting that restriction must be provided before services begin. Court orders, custody agreements, DHR documentation, or other legal documents should be emailed to records@garrettcounseling.com for review. Until such documentation is received and reviewed, Garrett Counseling will presume that both parents with legal rights are entitled to receive information as permitted by law.

Parents are responsible for notifying Garrett Counseling of any changes to custody, legal decision-making authority, contact information, or court orders during the course of treatment.

Garrett Counseling will not serve as an intermediary between parents or become involved in parental disputes. Our role is to provide treatment that supports the best interests of the child.

If you are unable to provide the other parent's contact information, please explain:

☐ I have emailed current legal documentation supporting this exception to records@garrettcounseling.com.

ZONE OF PRIVACY & PARENT COMMUNICATION
Why We Have a "Zone of Privacy": At Garrett Counseling, we believe counseling is most effective when children and adolescents have a safe place to talk openly with their counselor. To build trust and encourage honest communication, we provide an age-appropriate "Zone of Privacy." Our client is your child. While parents and guardians play an essential role in treatment, some conversations between the child and counselor may remain confidential to support the therapeutic relationship.

Parent Involvement: Parents and guardians are important members of the treatment team. Throughout treatment, your counselor will provide information about your child's overall progress, treatment goals, recommendations, and ways you can support your child outside of counseling. To protect the therapeutic relationship, counselors generally will not share the specific details of individual therapy sessions without the child's permission.

When Confidentiality Cannot Be Maintained: There are situations in which your child's counselor is legally or ethically required to share information, regardless of the child's wishes. These situations include, but are not limited to: moderate or high risk of suicide or serious self-harm; A threat of serious harm to another person; Suspected abuse or neglect; Court orders or other legal requirements; and Any situation where the counselor believes disclosure is necessary to protect the safety of the child or another person. When possible and appropriate, the counselor will discuss the need to share information with the child before speaking with a parent or guardian.

Professional Judgment: Not every concern requires a breach of confidentiality. Counselors use their professional judgment to determine when information should remain private to support treatment and when a parent or guardian should be informed for the child's safety or well-being. You are always welcome to ask your counselor questions about the types of situations that would require information to be shared.

Meetings With Parents: Your counselor may occasionally meet with parents or guardians separately or together to discuss your child's treatment. Because your child is the client, documentation from those meetings becomes part of your child's clinical record.

Parent Access to Treatment Records: Although parents or legal guardians may have legal rights regarding a minor's treatment records, Garrett Counseling encourages parents to respect their child's Zone of Privacy by allowing counseling sessions to remain confidential whenever

appropriate. Parents will receive information necessary to participate in treatment and to protect their child's safety but are encouraged not to request detailed therapy notes or records solely to learn the content of counseling sessions.

Custody & Legal Proceedings: Garrett Counseling provides treatment services, not forensic services. Our counselors do not conduct custody evaluations, visitation evaluations, parental fitness evaluations, or forensic interviews. We do not make recommendations regarding custody, visitation, or parental rights. Parents agree not to request their child's counselor's testimony or treatment records for custody litigation unless legally compelled by a court. If a counselor is legally required to participate in legal proceedings, applicable court and legal fees will apply in accordance with Garrett Counseling's current fee schedule.

Parent Agreement: By signing this agreement in Section 5, I acknowledge that I understand the purpose of Garrett Counseling's Zone of Privacy; I understand that my child may have confidential conversations with the counselor that will not routinely be shared with me; I understand that I will receive information regarding my child's progress, treatment recommendations, and any significant safety concerns; I understand that confidentiality may be limited when required by law or when necessary to protect my child or another person; I understand Garrett Counseling's role is to provide treatment, not custody evaluations, forensic services, or recommendations regarding parental fitness or visitation and I agree to respect my child's therapeutic relationship and understand that counseling is most effective when trust exists between the child and counselor.

Section 5: Acknowledgement & Signature

Section 5: Acknowledgement & Signature

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

- ☐ I have received and reviewed Garrett Counseling's Client Registration & Welcome Guide, including the Privacy Practices & Informed Consent and Good Faith Estimate.
- ☐ I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.
- ☐ I understand my rights and responsibilities and agree to follow Garrett Counseling's policies, including those related to privacy, payment, appointments, no shows and cancellations, telehealth, electronic communication, records, and, when applicable, minor client services.
- ☐ I understand that Garrett Counseling may update its policies and fee schedule from time to time and that the most current versions are available upon request.
- ☐ I understand that counseling is voluntary and that I may withdraw consent for treatment at any time, although I remain financially responsible for services already provided.

CLIENT/PARENT CERTIFICATION
I certify that:

- ☐ The information provided throughout this intake packet is complete and accurate to the best of my knowledge.
- ☐ I will promptly notify Garrett Counseling of any changes to contact information, insurance, medications, emergency contacts, custody or guardianship status, court orders affecting treatment or communication, or other significant information relevant to care.
- ☐ If signing on behalf of a minor, I certify that I have the legal authority to consent to treatment according to any legal custody agreements.

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

TELEHEALTH CONSENT
I acknowledge Garrett Counseling's Telehealth Services Policy, including its benefits, limitations, emergency procedures, technology-related risks, and my responsibilities during telehealth appointments. I understand that telehealth services may only be provided while the client is physically located in a state where the assigned counselor is authorized to practice, and I consent to telehealth services when clinically appropriate.

CONSENT TO TREATMENT
I voluntarily consent to receive (or authorize my child to receive) counseling services from Garrett Counseling under the terms described in this packet.

Client Information
Child's Name: _____
Child's Date of Birth: _____
Date:_____