COUNSELING Solutions OF ALASKA, LLC

701 East Tudor Road Suite 215
Anchorage, Alaska 99503
Office: (907)644-8044 Fax: (907) 644-8004

11470 Business Blvd. Ste. 100
Eagle River, Alaska 99577
Office: (907)689-3450

Patient Information

Name: (Last, First, M.I.)		Preferred Name (if different than legal name)	DOB	Soc. Sec. Number
Mailing Address		City	State	Zip Code
Home Phone #	Work Phone #	Message Phone #	OK to leave message? Yes No	Cell Phone #
Marital Status (Circle one): Single / Married / Divorced / Widowed		Sex Male / Female	Occupation/ Place of work	
Name of Spouse		Name of Parent / Guardian		
Emergency Contact Information (other than home)		Phone Number:		
Name:		Relationship:		

Primary Insurance Information

Insurance Company Name:	Billing Address:			Phone Number:
Policy Holder's Name (Last, First, M.I.)		Male/Female		Policy Holder's DOB
Policy Holder's Address	City	State		Zip Code
Policy ID #	Policy Group #	Relationship to Policy Holder Self / Spouse / Dependant		
Policy Holder's Employer	Address			Phone Number

Secondary Ins. Information

Insurance Company Name:	Billing Address:			Phone Number:
Policy Holder's Name (Last, First, M.I.)		Male/Female		Sponsor's DOB
Policy Holder's Address	City	State		Zip Code
Policy ID #	Policy Group #	Relationship to Policy Holder Self / Spouse / Dependant		
Policy Holder's Employer	Address			Phone Number

Welcome to CSA! Please take a few moments to read the following information. Your decision to visit us is a serious one and it is our desire that our work will be beneficial to you. We comply with strict confidentiality measures. For assurance to quality care, all providers in this office may share charts when treating you and will review cases with a supervisor and/or peers on a regular basis. It is also mandatory by law to report sexual and physical abuse of a minor or senior citizen, or threats of harm to self or others. Your medical records may be subpoenaed by a court of law.

I consent to be treated and/or have my child treated by Counseling Solutions of Alaska. I authorize the release of any medical or other information to process my insurance claims. I also acknowledge responsibility for payment of my account(s) regardless of my insurance coverage (i.e. all deductibles, co-pays, and unpaid balances). All payments are due at the time of appointment. I Authorize Assignment of benefits to this provider for services rendered. I agree to pay any collection costs, including interest or attorney fees in attempting to collect on any delinquent balances.

Signature _____ Date _____

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Name: _____ DOB: _____

2024 Clinic Policies and Procedures

Treatment: Thank you for choosing Counseling Solutions of Alaska for your care. We will make every attempt to schedule your initial visit with the clinician who best meets your needs. However, please be aware that the initial visit is an evaluation. The evaluation will involve obtaining your history, concerns, needs and preferences, so that symptoms can be evaluated, a diagnosis determined and treatment goals established. At the end of the evaluation, the clinician will provide his/her recommendations and an agreement will be established about beginning a treatment relationship.

Confidentiality: In general, the confidentiality of communications between a patient and their clinician is protected by law and written consent must be obtained before any information about your care is released. However, the law has established some exceptions to written consent that require the clinician to disclose, including:

1. We must notify others if there is a clear threat of violence to an identifiable victim.
2. We must notify the proper authorities or others if a patient is determined to be suicidal/homicidal or unable to take care of himself/herself.
3. We must report suspected abuse and neglect of children, the elderly or the handicapped.
4. We must respond to subpoenas and court orders from a legitimate court of law requesting records or testimony.
5. We must release information to your insurance company or companies if they request information to help in the processing of your insurance claims.

Attendance: You are responsible for attending your scheduled appointments. Reminder calls are provided as a courtesy only. Because your appointments are reserved for you, it is important that you provide a 24-hour notice when cancelling appointments so that they can be offered to someone else that needs the time. If you do not show up for an appointment, or you cancel your scheduled session with less than a 24-hour notice, your clinician will determine whether it is feasible to continue the therapeutic relationship. In the case of sudden illness or genuine emergency, 24-hour notice may not be feasible; in this case, please call as soon as you know that you cannot make the appointment. There is a $50.00 fee for late cancellations or “no-show” appointments, applied at the provider’s discretion. The second, and repeat occurrences of Late Cancellations and No Shows may incur a $100 fee for each instance.

Services for Minors: Patients under the age of 18 must have a parent or legal guardian present at the intake appointment and minors under 16 must have a parent at every appointment. Minors whose parents share custody must have both parents authorize care in writing. If there are legal changes to the custody, you must inform our office in writing. And payment is due at the time of the appointment, regardless of how the parents split the costs between themselves. Counseling Solutions of Alaska will provide Statements and Payment Receipts upon request, but it is the Parent/Guardian(s)' responsibility to track which party paid or owes for services.

Children and Appointments: Children may not be left unattended in the clinic. Our office staff cannot provide supervision of your children under any circumstances. In addition, children should not participate in the appointments of their parents or siblings, except for planned family therapy sessions, as it can be distracting to therapy and potentially detrimental to the treatment process.

Name: _____ __ DOB: _____

Use of Mood-Altering Substances: Please do not use mood-altering substances, including alcohol and other drugs such as marijuana, on the day of your session. If you have driven to our facility and a clinician determines that you are impaired, you will be asked to arrange for safe transportation home. Our staff can also assist with calling a cab. If you choose to leave the premises under the influence, we have the obligation to contact the authorities to assure your safety, as well as the safety of others.

Weapons on Premises: For the safety of everyone, Counseling Solutions of Alaska is a weapons-free facility. Please leave any firearms or other weapons in your car.

Service Animals: Only registered service animals are permitted in the clinic. Given that our clinicians are providing therapy services, we respectfully request that you leave therapy animals at home.

Medication Refills: If a refill is needed before your next scheduled appointment, please allow at least three business days for a medication refill, or five business days for certain controlled medications. If you run out of medication on the weekend, you will need to wait or go to the emergency room.

Payment for services: It is important for you to evaluate the financial resources that you have available to pay for your treatment before beginning care. We will bill your insurance as a courtesy, but ultimately you are responsible for any amount that is not covered by insurance. Please note, some health insurance plans only reimburse for 45-minute sessions and some require prior authorizations. Co-pays and/or deductibles are expected to be paid at the time of each session. Please inform us when you have any changes to your health insurance. Health insurance does not cover the cost of court appearances or report generation—those services are your financial responsibility. Please inform us of all of your insurance coverage, including if you have Medicaid or Medicare. We cannot bill Medicaid/Denali Kid Care for therapy, but it can be used for psychiatric evaluations and medication management.

Saving Payment Method on File: You have the option to save your credit card information on file and request that our Billing Department charge you for payment as claims process and return from your insurance. If you wish to do this, please speak to the Front Desk to provide Consent.

Coordination of Benefits (COB): COB is the process insurance companies use to determine how to cover your medical expenses. Your insurance carrier will request you update your information with them routinely. It is your responsibility to communicate with your insurance carrier in a timely manner to insure that they continue processing your claims. In the event your claims are denied due to this reason, Counseling Solutions of Alaska will contact you as a courtesy to notify you of this need. However, you will be unable to keep scheduled appointments or schedule future appointments, at Counseling Solutions of Alaska, until your insurance carrier confirms their request has been satisfied. If the request from your insurance carrier(s) is not satisfied by you in a timely manner, the total balance may become your responsibility. The COB ultimately impacts all medical providers and your claims. This issue has to be resolved by the policy Sponsor or Client.

Fee Schedule:

Therapy Intake Assessment	$275
Therapy Session, 53+ minutes	$220
Therapy Session, 38-52 minutes	$190
Therapy Session, 16-37 minutes	$130
Family Therapy Session	$250
Psychiatric Assessment	$450
**Medication Management	$240 - $370
Court Appearances (door to door including preparation)	$450 per hour
Late Cancellation / No Show Fee	$50
Late Cancellation / No Show Fee - 2nd and subsequent times	$100

*These are our most commonly billed appointment types, please note length of appointments may vary and other billing codes with different fees may apply. Please ask your provider if you have any questions about your services.

Records: The law and standards of the mental health profession necessitate that we keep written records of your treatment. You are entitled to view your records, have a copy or provide written permission to have your records sent to another treatment or medical professional. Please allow 7-10 business days for our staff to copy and send records. If you are requesting a copy of your records for yourself, there is a $50.00 fee for records over 25 pages and a $75.00 fee for records over 100 pages. There is no fee if we are sending your records to another provider's office. **For minors in coparenting situations, please refer to the ***required*** coparenting agreement for record-related consents.**

Communication: Your clinician is scheduled hourly; therefore, they are not readily available by phone. You are welcome to leave your clinician a voice-mail message. Please include your name, phone number and a time when you can be reached. Your clinician will make every effort to return your phone call within one business day. Please be aware that clinicians are not available to return calls on weekends, holidays and vacations. Due to the lack of security of cell phones and e-mail, we cannot send you a text message, nor can we respond to issues involving your care in an e-mail. Also, as a privacy protection measure, most of our phone numbers show up as private or unknown on caller IDs.

Emergencies/Crisis: Our clinicians are often scheduled up to two or more weeks in advance; therefore, they are not typically available to respond to crises or emergencies. If you are experiencing a psychiatric emergency such as thoughts of harm to yourself or others, or you are in a crisis involving the need for immediate help, please call the community-wide 24-hour Crisis Hotline at (907) 563-3200, go to the nearest hospital emergency room or call 911.

My signature below indicates that I have read, understand and agree to abide by these policies.

Name: _____ Relationship to Patient: _____
(as applicable)

Signature: _____Date: _____

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Client Name: _____ DOB:_____

2024 Privacy Practices

Counseling Solutions of Alaska is a private physician's office.

Your health record contains personal information about you and your past, present, or future physical or mental health, and related health care. It is referred to as Protected Health Information (PHI). We are required by law to maintain privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of the notice of Privacy Practices at any time. Any new notice of Privacy Practices will be effective for all PHI that we maintain currently at that time. We will provide you with a copy of the revised notice of Privacy Practices by providing it to you at your next appointment, or by sending a copy to you upon request.

We may use or disclose your Protected Health Information (PHI) for treatment, payment and health care operation purposes without your consent. To help clarify these terms, here are some definitions:

PHI refers to information in your health record that could identify you.

Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your physician or another mental health care provider.

Payment is when we obtain reimbursement for your health care. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits and processing claims with your insurance company.

Health Care Operations are activities that relate to the performance and operation of our practices. We may use or disclose, as needed your PHI in order to support our business activities. For example, we may share your PHI with third parties that perform various business activities for our practice billing, typing and answering services provided with whom we have a written contract with.

Use applies to activities we perform within our offices. Disclosure applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

We may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An authorization is written permission about and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment or health care operation, we will obtain an authorization from you before releasing your Psychotherapy Notes. Psychotherapy Notes are notes that your therapist or medical provider has made about your conversation during individual, group, couple or family counseling sessions. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The insurer has the right to contest the claim under the policy.

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

Child Abuse or Neglect

If we, in the performance of our occupational duties, have reasonable cause to suspect that a child has suffered, or might suffer, harm as result of child abuse or neglect, we must immediately report the harm to the appropriate authority.

Child abuse or neglect means the physical injury or neglect, mental injury, sexual abuse, sexual exploitation, or maltreatment of a child under the age of 18 by a person under circumstances that indicates that the child's health or welfare is harmed or threatened thereby.

Adult and Domestic Abuse

If we, in the performance of our occupational duties, have reasonable cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect, then we must report the belief to the appropriate authority. We must also report incidents of abuse of any disabled persons disclosed to our therapist/medical provider by you.

Abandonment means desertion of a vulnerable adult by a caregiver.

Disabled person means a person who has a physical or mental disability or a physical or mental impairment.

Exploitation means unjust or improper use of another person or another person's resources for one's own profit or advantage.

Neglect means the intentional failure by a caregiver to provide essential care or services necessary to maintain the physical and mental health of the vulnerable adult.

Self-neglect means an act of omission by a vulnerable adult that results or could result in the deprivation of essential services necessary to maintain minima mental, emotional or physical health and safety.

Vulnerable Adult means a person 18 years of age or older who, because of physical or mental impairment, is unable to meet the person's own needs or to seek help without assistance.

Health Oversight Activities

We may disclose PHI to the Alaska Board of Occupational Licensing or to the Department of Community and Economic Development in proceedings conducted by the board or the department where the disclosure of confidential communications is necessary to defend against charges before the board or department.

Judicial and Administrative Proceedings

If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the record thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We will inform you in advance if this is the case.

Serious Threat to Health or Safety

We may disclose PHI where you communicate an immediate threat of serious physical harm to an identifiable victim. If you present an imminent risk of serious harm to yourself, we may disclose information necessary to protect you.

Although we are not required by law, whenever possible, we will inform you of our intent to disclose your PHI in situations described above even though your consent and/or authorization is not required.

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

You have the following rights regarding your PHI that we maintain about you. To exercise any of these rights, please submit your request in writing to the clinic at the address we have listed at the top of this notice.

Right to request restrictions: You have the right to request restrictions on use and disclosure of PHI for treatment, payment or health care operations. Although we will try to honor your request, we are not required to agree to a restriction you request.

Right to receive confidential communication by alternative means and at alternative locations: For example, you may not want a family member to know you are being seen at our clinic. Upon request, we will send your bills to another address.

Right to inspect and copy. You have the right to inspect and/or obtain a copy of your mental health and billing records. The law allows for your access to be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. There is a minimum $25 document processing fee. It takes 7-10 business days in the event that you request a copy of your PHI.

Right to amend: If you feel that your PHI is incorrect or incomplete, you may ask your provider to amend the information. We will give your request careful consideration; however, the provider is not required to agree to the amendment.

Right to an accounting of disclosures: You have the right to request an accounting of disclosures that are made of your PHI. You may be charged a reasonable fee if you request more than one accounting in a 12 month period.

Right to a paper copy: You have a right to a copy of this notice.

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Counseling Solutions of Alaska, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact the clinic.

Printed Name: _____ Date: _____

Signature of Client or Parent/Guardian: _____

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Medication Refills (907) 770-0357
Email: counselingsolutionsofalaska@gmail.com
Website: www.counselingsolutionsak.com

Telemental Health Informed Consent

Telemental Health or Distance Therapy is the provision of mental health services between a practitioner and client who are not in the same location over electronic communications (audio, video or other electronic communications). It can provide an efficient and effective way to engage in therapy, which has traditionally occurred face-to- face in office settings. The following summarizes the information you need to know in order to determine whether you wish to supplement your experience of therapy through telemental health:

Risks:
Telemental heath is a new delivery method for mental health services and is not fully validated by research. There may be potential risks, including some that are not currently recognized. The known risks include the possibility the technology can fail during the session, the transmitted information could be unclear or inadequate due to technical issues, and the information could potentially be intercepted by unauthorized person(s). It is also possible that the security protocols could fail, resulting in a breach of privacy of personal health information (PHI). To the extent that Counseling Solutions of Alaska, LLC is able, telemental health sessions will be considered and treated with the same degree of privacy and confidentiality as in-office sessions. However, telemental health has some limits to confidentiality as a result of the electronic means required to provide the service. There are risks in electronic transmission of information including but not limited to breaches of confidentiality, theft of PHI and disruption of sessions due to technical difficulties.

Location:
Counseling Solutions of Alaska provides mental health services from the above indicated locations. All of our practitioners are licensed to practice in Alaska and the practice is limited to clients in the state of Alaska at this time.

Records:
In accordance with state law, client records are maintained and archived for a period of seven (7) years following the termination of counseling as identified by the last therapeutic session of record.

Limits of Confidentiality:
Confidentiality is defined in the clinic policies and procedures.

Potential Limits Impacting Service Delivery:
When providing distance therapy services, a variety of issues may impact service delivery. These include, but are not limited to: time zone differences (we are located in the Alaska Time Zone, GMT-9), differences in local customs, cultural and language differences.

Insurance for Telemental Health or Distance Therapy:
In 2016, Alaska enacted a law expanding the use of telemedicine in the state. This law authorizes the use of telemedicine (also known as telemental health and distance therapy) in certain clinical practices, including counselors. In addition, a law was enacted requiring insurance plans in Alaska to cover telemental health services the same as in-person mental health services and without the need for a prior in person visit between the health care provider and the patient. **However, it is your responsibility to determine if outpatient mental health and telemental health services are covered by your insurance plan. Ultimately you are responsible for any balance not covered by your insurance.**

Emergency or Crisis Procedures:
I understand my practitioner and I will regularly reassess the appropriateness of continuing to deliver services through the use of the technologies in the provision of my care and we will modify our plan as needed. I understand that as a result of the distance involved, some therapeutic interventions that my provider might provide in-person may not be available. I also recognize my provider will not be able to render any emergency assistance if I experience a crisis.

In emergencies, in case of service disruption or for other routine administrative purposes, it might be necessary to communicate by other (non-video) means:

Client alternative contact in emergency situations: _____

Client alternative contact in non-emergency situations (if different):_____

I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or another person, I agree to seek care immediately though my own health care practitioner, at the nearest hospital emergency department or by calling 911.

There are the names and telephone numbers of my local emergency contacts (including local physician, crisis line, trusted family, friend and/or advisor):

_____ _____
Name and relationship Telephone Number

_____ _____
Name and relationship Telephone Number

_____ _____
Name and relationship Telephone Number

If a need for direct, in-person services arises, it is my responsibility to contact my mental health providers office for an in-person appointment or my primary care physician if my mental health provider is unavailable I understand that an opening may not be immediately available in either office, or that due to distance involved, it might be more appropriate for me to seek emergency care. Emergency care providers in my area that I could contact include:

_____ _____
Name of emergency care provider Telephone Number

I have discussed local support services that may be available in case of emergency. I am aware my practitioner may contact the proper authorities and/or my designated local contact persons in case of an emergency. I acknowledge that I have read and understood the above description of risks and responsibilities involved with telemental health participation. With this knowledge, I voluntarily consent to participate in telemental health treatment.

Authorized Email Address (Please Print):_____

Printed Client Name: _____

Client Signature:_____ **Date:**_____

Parent/Guardian Signature if Client is a Minor:_____ **Date:**_____

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Authorization for Release of Information

Name: _____ Date of Birth: _____ SSN (last 4): _____

I, the [ ] client / [ ] parent / [ ] legal guardian, hereby authorize Counseling Solutions of Alaska, LLC, to:

[ ] Release Counseling Solutions' information to: [ ] Obtain information from:

Person / Organization: _____

Phone / Fax: _____

Address: _____

Please send records by: [ ] fax [ ] mail or [ ] I will pick them up in person.

Your contact information (phone # with voice-mail, or e-mail): _____

Fees: $50.00 for records of 25 – 100 pages or $100.00 for over 100 pages; fee is waived when records sent directly to another provider.

Purpose of This Request: [ ] Treatment [ ] Personal [ ] Legal [ ] Other: _____

For Treatment Dates: _____

Information to be Released: ____ Verbal Exchange of Information
initials

Medication Management	Counseling	Other
____ Psychiatric Assessment *initials*	____ Therapist Intake Assessment *initials*	____ Gastric Bypass Mental Health Evaluation *initials*
____ Pharmacologic Progress Notes *initials*	____ Therapy Progress Notes *initials*	____ Psychological Testing *initials*
____ Medication Tracking Sheet *initials*	.	____ _____ *initials*
____ Laboratory Reports *initials*		____ _____ *initials*

I authorize the release of records relating to:

_____ Mental Health (**required**) *initials* _____ Alcohol/Substance Abuse *(if applicable)* *initials* _____ HIV/AIDS status *(if applicable)* *initials*

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment, payment, enrollment or eligibility of benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164,524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Counseling Solutions of Alaska, LLC. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Without a written revocation, this authorization will remain in effect for one (1) year, unless an earlier date or condition / event is specified here:

_____

_____ _____ _____
Signature of Client or Parent / Guardian / Legal Representative | Relationship *(if applicable)* | Date

_____ _____
Signature of Witness (**required**) | Date

A photocopy or faxed copy shall be considered as valid as the original.

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Medication Refills

Medication Refill phone number: 907-771-7105

Medication Refills Fax: (907) 770-0357

You can also send refill requests through the patient portal

Please be advised that the administrative staff for our ANPs will be in office Monday-Friday from 8 am-4 pm. Any refill request or other message for our ANPs made past 4 pm will be received the following business day. If you call for a refill on Thursday, it may not be sent until the following Monday.

Please request refills at least 3 business days before you run out of medication, or 5 business days for controlled substances. If you're not able to provide enough lead time, you may be without your medication for a day or two, as we need time to be able to reach your provider if they are out of the office.

For most medications, the first step is to contact your pharmacy and have them send a refill request to us. They can request it electronically through our e-prescription software or fax the request. The best fax number is (907) 770-0357. Please ask the pharmacy to fax it by hand, as faxes sent by computer do not always reach our office. (If you use the JBER pharmacy, they do not fax refill requests, so skip this part.)

After requesting that your pharmacy send us a refill request, please ALSO contact our office and let us know you need a refill. This provides a back-up in the event the pharmacy's request does not reach us.

- You can call the medication refill line directly at 07-771-7105, or call the main number, 907-644-8044, and press option 3. You can also send us a message through the patient portal. (We do not recommend regular email, as our email is not HIPAA- compliant).
- Speak with or leave a message for the medication assistant. When you leave a message, be sure to include your first and last name, date of birth, pharmacy, pharmacy branch, and how many days you have left of your medication(s).

If your medication is a Schedule II controlled substance (medications like Adderall, Vyvanse, Concerta), pharmacies will not fax a refill request, so just call our office to ask for a new prescription. In addition, if you use the JBER pharmacy, they will not accept faxed prescriptions or verbal prescriptions called in over the phone for controlled substance medications.

If you are travelling out of state and will need a medication refill, please let us know at least 5 business days ahead of time. Some states do not accept controlled substance prescriptions from any outside states. Please plan accordingly.

Due to a high volume of refill requests, we do not automatically call you back unless there is a problem, or we need more information. If you would like a call back, please ask for one. You can also check with your pharmacy 24 hours after making your request.

If you run out of medications because of insufficient lead-time to your request, you should contact your primary care provider or go to an urgent care clinic to request a prescription. For certain medications, you can also ask your pharmacy if they can give you a bridge loan.

The office closes for all major holidays (New Year's, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas). Sometimes during the holidays, we may also be closed for extra days, so please plan ahead.

Regular follow-up appointments are required to continue to get refill prescriptions, usually every 3 to 6 months once you are stable on the medication. Controlled, class II substances like Adderall require face-to-face appointments every 3 months.

I acknowledge that I have received and will follow the procedures of Counseling Solutions of Alaska's Medication Refill Policy.

Printed Client Name: _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature if Client is a Minor: _____ **Date:** _____

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COUNSELING Solutions OF ALASKA, LLC

Second office:
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Ph: (907) 644-8044

Contract and Expectations for Adults Co-Parenting Minors

At Counseling Solutions of Alaska, LLC we believe that every child has the potential to thrive and deserves a safe place in which they can learn about their emotions and process their feelings. One of the key indicators helping a child develop into a healthy adult is being raised within a loving and supportive family. Parents have the challenging responsibility to make sure this happens.

Children thrive in a supportive and loving environment, but there are times when for the parents to remain married is no longer healthy and it becomes in the best interest of all parties for the parents to separate. In these instances, it remains in the best interest of your child for you and your child's co-parent to learn to peacefully co-parent so that the supportive and loving environment remains intact. Working with children whose parents are separated, separating, or divorced brings a unique set of challenges.

First, please understand that while working with your child does require a certain understanding of what your child has experienced, we do not need to know all the details surrounding your separation/divorce. During the assessment process, we will collect the information needed to begin working with your child. As therapy progresses, we may request additional information regarding the separation/divorce or your current situation as it relates to the child. Please do not take offense if we do not inquire about the details of your relationship. Situations that would be important to bring to our attention include but are not limited to: new relationships, moves, upcoming court dates, changes in visitation or custody agreements, and OCS involvement.

Individual sessions range from 30-55 minutes depending on the child's needs and abilities. This time includes an occasional 5 to 10-minute check-in with a parent to provide updates and progress reports. These check-ins are limited to allow the appointment time to focus on the child's issues and not those of the parent. One-on-one time with the therapist allows your child to freely communicate their thoughts and feelings without worrying about their parent's reactions and should be a safe space in which to process events that are significant to them at their own rate. Please do not excessively question your child or instruct them to tell us about certain issues. However, you are always welcome to request updates or provide information regarding your child's progress towards their treatment goals.

If you are aware that you are going to court for custody of your child, or anticipate that you will soon be going to court, we request that therapy with your child be postponed and only started after the court date is finished. If therapy has already started with your child and your case is going back to court to decide custody, therapy may be temporarily halted until the court date is over and the custody determination has been made.

In order to help maintain your child's best interests and to allow the therapeutic environment to be maximized, we have outlined our expectations below.

1. We recommend that each parent seek their own therapist in order to help process their thoughts and feelings related to the separation and transition to co-parents. In addition, it is very helpful for the parents to agree to find a co-parenting therapist to help them manage agreements and conflicts.

2. We **DO NOT** make custody recommendations. No exceptions. Both parents agree not to request that the child's therapist testify in court.

3. As long as both parents have medical custody, both parents must sign a consent that Counseling Solutions of Alaska can treat your child. If both parents do not consent, we will **not** start treatment with your child. If treatment is already started and one of the parents no longer agrees or consents to treatment, that parent must notify Counseling Solutions of Alaska of this in writing and therapy with your child will be terminated immediately.

4. We will not keep track of which parent pays and you will need to decide to what single address we send the bill. This address could be that of the lawyer of your choice. We require each parent to cooperate with insurance information and they must update us if there are any changes.

5. We will not play "middle-man" or pass messages on to the child's other parent. We will not keep things from the other parent, especially if we feel it affects the child's treatment.

6. We have expectations regarding records that include:
   a) The parents agree not to use the child's records in any way for any type of court or custody matter.
   b) The parents agree that the child's clinical records can only be used for clinical purposes, such as, but not limited to, giving records to another provider to improve the child's quality of care and continuity of care.
   c) The parents agree not to have the child's records released directly to themselves, unless the therapist deems that releasing those records to the requesting parent is clinically necessary for the child's clinical care or is in the child's best interest.
   d) If one parent requests records for any reason, the therapist will inform the other parent that this request has been made.
   e) The parent agrees that they may request a written summary regarding the child's individual therapy only for the purposes of clinical care or continuity of care, and understands it is at the provider's discretion to provide only if deemed clinically appropriate.
   f) ****IMPORTANT: This agreement is between both parents, to avoid therapy causing harm to the child. However, please keep in mind that HIPAA states that a parent has full rights to all their child's records and information regarding the treatment of their child, regardless of this contract.**

By signing below, you acknowledge you have read this document and agree to the terms of individual therapy with your child. Both parents must sign this form.

Signature: _____ **Date**: _____

Printed name: _____ **Contact Number**: _____

Signature: _____ **Date**: _____

Printed name: _____ **Contact Number**: _____