Tree of life
COUNSELING CENTER & FOUNDATION
Main Office: 101 S. Central Ave. Oviedo, FL 32765
(407) 358- 7188

CLIENT INTAKE – Adult History Form

Name: _____ Date:_____

Age: _____Date of Birth: _____ Sex: Male ___ Female ___

Address:_____
Street City/State Zip code

Home Phone: _____Work Phone:_____

Cell Phone:_____ Email:_____

May we contact you at home? Yes____ No ____ Work? Yes ____ No ____

Cell? Yes _____ No _____ Email? Yes ____ No ____

Two Emergency Contacts:

_____
Name Phone Relationship

_____
Name Phone Relationship

In case of an emergency, please sign the line provided to authorize *Tree of Life Counseling Center* to contact the above emergency contacts: _____

Do you regularly attend a church, synagogue, or other religious institution? Yes__No__
If yes, where do you attend?_____

How did you hear about *Tree of Life Counseling Center & Foundation*?
□ Web □ Social Media □ Referral: Dr., Work, Other _____

□ Drive by □ Church □ Friend or Family: _____

□ Other Means:_____

What has led you to seek counseling at this time?

_____

_____

What specific goals do you hope to achieve during this counseling experience?

_____

_____

_____

Please place a mark **X** beside the following problem areas that pertain to you, **Circle** the following problem areas that pertain to your birth family, and **underline** the following problem areas that pertain to your immediate family if different from your birth family.

____ Stress	____ Depression	____ Anxiety
____ Fears	____ Panic	____ Hearing voices
____ Seeing things	____ Pregnancy	____ Temper
____ Chronic pain	____ Parenting	____ Recent death
____ Self-esteem	____ Confidence	____ Racing thoughts
____ Impulsive behavior	____ Career choices	____ Gender identity
____ Guilt	____ Grief	____ Marriage Problems
____ High risk behaviors	____ Trauma/Disaster	____ Unwanted thoughts
____ Communication	____ Abortion	____ Hopelessness
____ Self-injurious behavior	____ School problems	____ Work problems
____ Family problems	____ Relationship Problems	____ Health problems
____ Physical or sexual abuse	____ Verbal abuse	____ Cultural problems
____ Spiritual/Moral problems	____ Sexual addiction	____ Eating Problems
____ Gambling	____ Pornography	____ Compulsive shopping
____ Financial problems	____ Spiritual Apathy	____ Poor concentration
____ Loneliness	____ Indecisiveness	____ Drug use
____ Alcohol use	____ Bad dreams	____ Legal matters
____ Anger	____ Fatigue	____ Staying Focused

____ Other/Additional:_____

What is your relationship status?

____ Single ____ Engaged ____ Partner ____ Married ____ Divorced

____ Separated ____ Cohabitating and unmarried

If engaged, married, separated, divorced, or widowed, for how long? _____

If married or engaged their name: _____ Age: _____

Is your Spouse/Family supportive of you seeking counseling?

____ Yes ____ No ____ Unsure ____ Spouse/Family does not know'

Please provide a brief personal description of your spouse:

_____

_____

How would you describe your current relationship?

____ Excellent ____ Good ____ Fair ____ Poor ____ Not Applicable

How many times have you been married?

____ None ____ Once ____ Twice ____ Number of times

How many times have you lived with someone?

____ None ____ Once ____ Twice ____ Number of times

PLEASE TELL US ABOUT YOUR CHILDREN:

_____ I do not have children

Name: _____ Age: _____ Sex _____

____ Biological ____ Adopted ____ Step ____ Foster ____ Relative ____ Other: _____

Does this child live with you? _____ Yes _____ No

Does this child have a disability? _____ Yes _____ No

If yes, what kind of disability?

_____

How would you describe your relationship with this child?

____ Excellent ____ Good _____ Fair _____ Poor

Name: _____ Age: _____ Sex _____

____ Biological ____ Adopted ____ Step ____ Foster ____ Relative ____ Other: _____

Does this child live with you? _____ Yes _____ No

Does this child have a disability? _____ Yes _____ No

If yes, what kind of disability?

_____

How would you describe your relationship with this child?

____ Excellent ____ Good _____ Fair _____ Poor

Name: _____ Age: _____ Sex _____

____ Biological ____ Adopted ____ Step ____ Foster ____ Relative ____ Other: _____

Does this child live with you? _____ Yes _____ No

Does this child have a disability? _____ Yes _____ No

If yes, what kind of disability?

_____

How would you describe your relationship with this child?

____ Excellent ____ Good _____ Fair _____ Poor

Name: _____ Age: _____ Sex _____

____ Biological ____ Adopted ____ Step ____ Foster ____ Relative ____ Other: _____

Does this child live with you? _____ Yes _____ No

Does this child have a disability? _____ Yes _____ No

If yes, what kind of disability?

_____

How would you describe your relationship with this child?

____ Excellent ____ Good _____ Fair _____ Poor

***Please add additional children to the back of this form.**

Family History:

Parents Marital Status:

_____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Length of their relationship _____ year(s) _____ Month(s)

How would you describe their relationship? ____ Excellent ____ Good ____ Fair ____ Poor

Mother: _____ Age: _____ Father _____ Age: _____

Deceased ____ Yes ____ No Deceased ____ Yes ____ No

If Yes, cause _____ If Yes, cause _____

Your age at time of death: _____ Your age at time of death: _____

Her Occupation: _____ His Occupation: _____

Her Health ____ Good ____ Fair ____ Poor His Health ____ Good ____ Fair ____ Poor

How would you describe your relationship with your mother?

____ Excellent ____ Good ____ Fair _____Poor

How would you describe your relationship with your father?

____ Excellent ____ Good ____ Fair _____Poor

Do you have stepparents? ____ Yes ____ No

Step-Mother: _____ Age: _____ Step-Father: _____ Age: _____

How would you describe your relationship with your stepparent?

____ Excellent ____ Good ____ Fair ____ Poor

***Please add additional stepparents to the back of this form.**

Please tell us about your brothers and sisters:

Brother(s):

1. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

2. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

3. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

4. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

Sister(s):

1. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

2. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

3. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

4. Name: _____ Age: _____ Living ____ Deceased ____
   How would you describe your relationship when/if still living?

   Excellent ____ Good ____ Fair____ Poor____

What is the primary cultural background with which you most closely identify?

Caucasian ____ Black/ African -American ____ Hispanic/Latino ____ Asian ____

Biracial ____ Other: _____

Education:

What is the highest grade you have completed?

Grade Completed ___ GED ___ Special High School Diploma ___

High School Diploma ___ Some College ___ AA/AS Community College ___

Bachelor's degree ___ Master's degree ___ Specialist's degree ___

Doctorate degree ___

Were you ever in any special education / exceptional education program? Yes___ No__ If Yes, what kind of program?

Physically Impaired ___ Occupational Therapy ___ Speech Therapy ___

Language Impaired ___ Hearing Impaired / Deaf ___ Vision Impaired ___

Emotionally Handicapped ___ Learning Disability ___ Gifted ___

Hospital / Homebound ___ Deaf/Blind ___ Autistic ___

Severely Emotionally Disturbed ___ Educable Mentally Handicapped ___

Did you ever have any disciplinary problems in school? Yes ___ No ___

If Yes, check all the following that apply:

Suspension ___ Expulsion ___ Referrals ___ Alternative schools ___

Other _____

Please describe: _____

How would you rate your school experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive?

1 ___ 2 ___ 3 ___ 4 ___ 5 ___
Negative Average Very Positive

Occupation:

Are you currently employed? Yes, full-time ___ Yes, part-time ___ No ___

If Yes, how long have you been employed?

Less than 6 months ___ 6 months-l year ___ 1-2 years ___ More than 2 years ___

Employer: _____ How long have you been there? _____

Occupation: _____ Average hours worked per week: _____

Special Training:
_____

Are you currently receiving disability? Yes ____ No ____

Previous employment: _____ How long? _____

Reason for leaving: _____

Have you ever been terminated from employment? Yes _____ No ____

How many jobs have you held in the past ten years if applicable? _____

Legal History / Social Agency Involvement:

Have you ever been charged with a crime, other than minor traffic offenses?

Yes ____ No ____ If Yes, please describe: _____

Have you ever had involvement with the Department of Children & Families or a similar agency in another state? Yes ____ No ____

If Yes, please describe:
_____

Have you ever been involved in domestic violence? Yes ____ No ____

If Yes, please describe:
_____

Medical History:

Have you ever had?

Physical injury:

____ Yes, one physical injury ____ Yes, more than one ____ No

If Yes, please describe:
_____

Accident:

____ Yes, one Accident ____ Yes, more than one ____ No

If Yes, please describe:
_____

Major Illness:

____ Yes, one major Illness ____ Yes, more than one ____ No

If Yes, please describe:
_____

How would you describe your current health? Excellent____ Good____ Fair____ Poor____

Please describe any current medical problems: _____

_____

Do you take any prescription medications? Yes ____ No ____

Please list medications:
_____

_____

Who prescribed these medications?
_____

Do you take any over the counter or holistic medication? Yes ____ No ____

Please list:
_____

Have you received outpatient psychiatric/psychological /counseling in the past?

Yes ____ No ____

If Yes, please describe:
_____

Have you ever been in the hospital for psychiatric/psychological problems? Yes ____ No ____

If Yes, please describe:
_____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADD, ADHD, or anti-psychotic medication for you? Yes ____ No ____

If Yes, please describe:
_____

Has anyone in your family ever been treated or hospitalized for mental health issues, substance abuse, or psychiatric conditions? Yes ____ No ____

If Yes, please describe:
_____

Substance usage:

Do you use alcohol or drugs?

Alcohol ____ Drugs ____ Both ____ I do not use alcohol or drugs ____

If you use alcohol or drugs, how often do you use them?

Everyday ____ Several times per week ____ Several times per month ____

Once or twice a month Several times per year ____ Once a year ____

Other:

_____

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)? Yes ____ No ____

Has a friend or relative discussed concerns about your use? Yes ____ No ____

Have you ever felt guilty about your drinking or drug use? Yes ____ No ____

Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes ____ No ____

Are you a recovering alcoholic or recovering drug addict? Yes ____ No ____

Is there a history of problems with alcohol or drug use in your family? Yes ____ No ____

Abuse/Trauma History:

Have you ever been abused? Yes ____ No ____

If Yes, please describe_____

Have you ever been sexually abused? Yes ____ No ____

If Yes, please describe_____

Have you ever been emotionally or mentally abused? Yes ____ No ____

If Yes, please describe_____

Have you ever experienced any other severe trauma? Yes ____ No ____

If Yes, please describe_____

Have you ever experienced any other Spiritual Abuse? Yes ____ No ____

If Yes, please describe_____

Religious/Spiritual Issues
Are spiritual or religious issues important to you? Yes ___ No ___

How would you rate your overall involvement in spiritual or religious activities on a scale from 1-5, where 1 is not involved at all and 5 is very involved?

1 ___ 2 ___ 3 ___ 4 ___ 5 ___
Not Involved Average Very Involved

Growing up, how would you rate your spiritual or religious experiences on a scale from 1-5, where 1 is very harmful and 5 is very helpful?

1 ___ 2 ___ 3 ___ 4 ___ 5 ___
Very Harmful Average Very Helpful

Currently, how would you rate your spiritual or religious experiences on a scale from 1-5, where 1 is very harmful and 5 is very helpful?

1 ___ 2 ___ 3 ___ 4 ___ 5 ___
Very Harmful Average Very Helpful

Please describe your relationship with God?

_____

_____

Suicide Assessment:

Have you attempted suicide? Yes ___ No ___

If Yes, how long ago was the last attempt Year(s) _____ Month(s) _____

If Yes, how many times have you attempted suicide? 1 ___ 2 ___ 3 ___ 4 ___ If more than 4 times, how many times: _____

Do you have current thoughts of ending your life? Yes ___ No ___

If Yes, do you have a plan? Yes ___ No ___

If Yes, please describe_____

Do you feel that you have a support system? Yes ___ No ___

If Yes, who are they?
_____

_____
Client Signature Date

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Notice of Privacy Practices

SUMMARY OF NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
Federal law, commonly called HIPAA, requires that we describe for you our medical privacy practices and your rights as a patient under the law.
If you have any concerns about your medical privacy please notify us at 407-415-6557.

How we may use your personal medical information.

Tree of Life Counseling Center & Foundation creates and receives medical information about you as a part of your care. This information is called protected health information, or PHI. It is personal and private. We may use this information in many ways. We release only the information necessary to accomplish a task.

First, we use the information when we treat you or refer you for treatment. We may communicate with other professionals and referral agencies.

Second, we may use the information to submit bills for your medical care to insurers, Medicare, or third party payers.

Finally, we may use this information for our health care operations. This means the work we must do to provide quality services to you and all of our patients.

We will see your authorization when state or federal law requires it.

We may use PHI without your permission for the following reasons:

- As required by state or federal law
- For public health purposes, such as reporting child or elder abuse, or if you are a danger to yourself or to others.
- To treat you in an emergency
- To inform you of alternative treatments.
- When ordered by a regulatory agency, such as Health and Human Services.
- For law enforcement purposes or in response to a court order.
- For agencies involved in a disaster situation.
- For lawsuits and disputes.
- To communicate with coroners, medical examiners, and funeral homes when necessary.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with correctional officials if you are an inmate.
- To carry out treatment and billing operations through a billing or transcription service.

Your authorization is required for other disclosures.

The following PHI receives special protections under federal and/or state law.

Psychotherapy Notes are kept separate from the medical record and receive special protection.

Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Alcohol and drug abuse information has special privacy protections. Pathway will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse treatment unless: 1) the client consents in writing; 2) a court order requires disclosure of the information; 3) medical personnel need the information to meet a medical emergency; 4) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or 5) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

Your right to access and control your PHI

You have the following rights regarding your protected health information (PHI), provided that you make a written request.

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or when you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies.
- Right to request clarification of the record. If you believe that the PHI we have about you is inaccurate, you may ask to add clarifying information. WE are not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to entities other than for routine treatment, payment, or health care operations.
- Right to a copy of this Notice. You may request a paper copy of the full Notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services at 1-877-698-6775.

You will not be penalized or retaliated against in any way for making a complaint.
We are required to provide you with this notice that governs our privacy practices. We will provide any forms necessary to enforce your rights. State law may affect the enforcement of some rights.

INFORMED CONSENT & RELEASE OF LIABILITY

Tree of Life Counseling Center & Foundation provides professional counseling, life coaching & seminars to individuals and families throughout Central Florida & abroad. Fees are determined on an individual basis in line with our sliding scale based upon the normal licensed fee of $135.00. Our commitment is to make counseling an option for anyone who needs our help.

1. I, _____, understand that my counseling records are kept confidential except where disclosure is required by law (see Notice of Privacy Policy) or by the ethics of the counseling profession (ex: child abuse reporting serious threat of harm to others or self).
2. In consideration of the benefits derived from counseling, the receipt wherof is hereby acknowledged, I release, remise and forever discharge and covenant not to sue or hold legally liable *Tree of Life Foundation & Ministries* or employees from any and all claims, demands, actions or causes of action whatsoever kind and nature related to the counseling process.
3. The clinical records are the property of *Tree of Life Counseling Center & Foundation* and are deemed confidential. The records will be maintained by *Tree of Life Counseling Center & Foundation* according to the standards of HIPPA and the State of Florida. I waive any right I may otherwise have to seek to use the clinical records as evidence in any judicial proceeding or to compel the testimony of any clergy or counselor providing counseling to me through this ministry.
4. Confidentiality of cell phone, e-mails and fax's are very important to *Tree of Life Counseling Center & Foundation* and we will attempt to keep this confidentiality. But it is very important that you are aware that cell phones, e-mails, and faxes can be easily accessed by unauthorized people and hence, the privacy of such communication can be compromised. If you chose to contact any employee of *Tree of Life Foundation & Ministries* by any method mentioned above, you hereby remove *Tree of Life Foundation & Ministries* and their employees from any form of liability (see Notice of Privacy Policy).
5. There is a cancellation policy at *Tree of Life Counseling Center & Foundation* which requires a minimum of 24 hours advanced notice of cancellation. For the courtesy of other clients that could use that time, please call us in advance. Notice: You will be charged for your session if not cancelled in the above manner. Most insurance companies DO NOT reimburse for missed appointments.
6. ***Regarding confidentiality: It is the "legal and ethical" responsibility of the therapist to "break" confidentiality in the areas of: child abuse, elder abuse, suicidal/homicidal ideation. (See Notice of Privacy Policy).***

I have read the preceding information and agree to the polices of Tree of Life Counseling Center & Foundation. I understand that these comments are the prerequisite to my receiving and continuing counseling through this ministry.

Date: _____ ***Client/Guardian Signature:*** _____

Print Name: _____

Witness: _____

Tree of Life
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COUNSELING SERVICES FEE SCHEDULE 2022

Gross Income	Charge
Under $25,000	$85.00
$25,000 – 38,000	$95.00
$38,000 – $65,000	$115.00
$65,000 – $90,000	$135.00
$90,000 – $110,000	$150.00
Above $110,000	$165.00

Financial Life Coaching & Credit Consulting: 70.00

Certified Life Coaching: 65.00 – 85.00

Some In-Network and many Out of Network Insurances May Be Accepted*

Witness Fee / Court Appearance ..... $350.00 per hour (portal to portal)

Pre-Marital Program..... $130.00 per session/hr (per couple)

Testing and Evaluations..... Varied Based upon testing

- Based upon the financial situation, the therapist may lower the minimum "fee" for a specific number of sessions for a scholarship reduction rate case by case.
- All Insurance Forms will be provided at the end of each session upon request and we will assist you in Full submission of claims to your insurance carrier for maximum benefit reimbursement.

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INFORMED CONSENT

1. *Tree of Life Counseling Center & Foundation* has on staff many qualified Therapists and Life Coaches. All counselors have a minimum of a Master's Degree and are either a Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Social Worker, a Registered Intern in Mental Health or Marriage and Family Therapy, Pastoral Counselor, Certified Life Coach and/or an Ordained Minister.

2. During your counseling at *Tree of Life Counseling Center & Foundation*, you, the client, will be expected to be an active participant in your own therapy. It is impossible to come to counseling for 1 hour per week and expect change to occur without doing "homework." It is also expected for you to keep your regularly scheduled appointment and to be there on time.

3. Goals of Treatment: As your therapist, it is my intention to help you in the areas that you would like assistance without creating dependence…Specific goals will need to be negotiated in the therapy session and revisited on a regular basis to assess the effectiveness of the interventions being utilized.

4. During each session, the therapist will "work" to assist you in dealing with the issues you present. Your therapist will also respect the "scheduled appointment" and will attempt to start and end on time.

5. Guarantees: As much as we would like to be able to do so, there are NO GUARANTEES that the counseling sessions will produce the results you are seeking. We will work together to attempt to meet those results.

6. Risks associated with counseling: There are risks associated in beginning a therapeutic counseling relationship. During counseling, you will deal with difficult issues in your life that can produce "emotional, behavioral, and relational difficulties." At times, making your presenting issues even more difficult than when you first began counseling.

7. Contacting Clients**:** Unless otherwise noted by you to your therapist, each counselor will use the numbers you provide to them in order to reach you. We will work to be very discreet in our messages which are left for you.

8. Regarding E-mail, Cell Phones, and Messages: As stated in our "Notice of Privacy" policy (located at the counseling office) we will not provide "any type or form of therapy" through the use of E-mails,

nor can we guarantee "confidentiality" when you choose to contact us in this manner or in leaving messages on our cell phones. If you choose to contact us through E-mails, we will respond with appointment times and answers to questions that are not related to your therapy.

9. Client Emergencies: If you are experiencing an emergency, please contact 911 or the Central Florida Hotline. If you choose to call the answering service for *Tree of Life Counseling Center & Foundation*, there is NO GUARANTEE of when we will be able to return your call during this emergency.

10. Therapist vacations: During vacations, you can leave your message with the answering service, BUT there are times in which the messages you leave CANNOT be received by the therapist. Each therapist determines IF and WHEN they are able to return calls left to them while they are on vacation.

11. In cases of emergencies "while in the counseling session:" At times, during a counseling session, a client may become "very depressed or suicidal." At which point we (Tree of Life) may need to contact a family member to provide assistance. It is important for you to provide a "list of names: along with "authorization" for your counselor to contact these individuals.

12. Confidentiality and Privilege: The State of Florida, HIPPA, and our Notice of Privacy policy outline your rights to confidentiality and privilege during your counseling sessions. All information being dealt with during the therapy session is considered confidential and privileged UNLESS the information you provide meets the following EXCEPTIONS: (A) Client authorizes release of information in writing and waives privilege, (B) Client reports current abuse of a child, disabled person, elderly individual, or someone who is vulnerable and unable to leave a place of abuse due to institutionalization, (C) Client poses a danger to self or others, (D) Ordered by a "court of law" to make records available, (E) Bill collection/collection agency (as long as stated in the Informed Consent), (F) Parent-child relationship where parent has legal authority over the records.

13. Counseling Approach: *Tree of Life Counseling Center & Foundation* is a Faith Based counseling center where (depending on the individual client) we may use "prayer, Scripture, references to scripture or homework using books by Christian writers." Other approaches to counseling are based upon the personality of the therapist and the form of therapy which is most beneficial for the issues you are presenting. Your therapist will describe for you the various approaches they use in counseling. For example: Cognitive/Behavioral, Systematic, Family and Relational, Psychodynamic are just some of the types of therapy which are provided by *Tree of Life Counseling Center & Foundation*.

14. Counseling and Financial Records: All records are maintained as in accordance with HIPPA and the State of Florida guidelines for Mental Health counseling. You have the right to see and make amendments to your records by contacting your therapist. All records are kept for a minimum of 7 years (as described by law) but may be kept indefinitely. To insure your confidentiality, your records are kept behind a minimum of 2 locked doors.

15. Ethical Guidelines: Creating a safe therapeutic environment is essential for a healthy relationship to develop between the client and therapist. For this to occur, ethical guidelines are very important. Three of the most significant are: sexual contact, dual relationships and fees for service. (A) Sexual Contact: There is to be NO FORM of sexual contact between the client and therapist. This includes inappropriate and/or unwanted sexual conversations by phone, e-mail, or personal communication, touch, or any form of private meetings outside of the normal scheduled appointment. (B) Dual

relationships is best defined as a "relationship which exists both in the therapeutic environment and social or family settings. For example: employer/employee, family members, or close friendships. A "DUAL RELATIONSHIP" decreases the effectiveness of the counseling and puts undue pressure on the client. (C) Fees for service: There is a "fee for service" based upon the "household income" of the individual or family who is seeking therapy. There shall be NO FORM of "bartering" or exchanging of services for the counseling provided.

16. Dispute and complaints: If you have a dispute with one of the therapists at *Tree of Life Counseling Center & Foundation*, please contact the Clinical Director & Founder of *Tree of Life Counseling Center & Foundation* in an attempt to have the issue resolved. Also, since Tree of Life is a Faith-based counseling center, this is also the option of meeting with the Director of *Tree of Life Counseling Center/Foundation and Ministries* along with your Pastor (all releases must be signed). If there is a need to go beyond the *Director of the Tree of Life Foundation & Ministries*, you may contact the State of Florida Licensing Board for Mental Health Counselors.

17. Licensing Regulations: All therapists/counselors of *Tree of Life Counseling Center & Foundation* are either: Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Social Workers, Registered Interns, Life Coaches or Ordained Ministers. All Licensed therapists are required to complete 30 hours of continuing education (CEU) every two years. This is to ensure that you are receiving the best possible care by a qualified professional. For a minimum of 2 years, all Registered Interns meet regularly with a "Clinical Supervisor" to review their "case load" and they met regularly with the Director of *Tree of Life Counseling Center & Foundation* to ensure they are providing the best quality of care for their clients. Once the Registered Intern completes their STATE REQUIRED hours of supervision, they are allowed to take the State Exam to become a licensed therapist.

18. Fees, charges, and responsibility for payment: *Tree of Life Counseling Center & Foundation* charges fees for the counseling which is provided to the client. Those fees are based upon a "sliding scale" which is based upon the "household income" of the client. (A) A "fee schedule" is provided by the therapist and is placed in the client file. It is your responsibility to pay for services rendered at the end of each session. (B) Based upon the "fee schedule" your counseling fee shall be _____ per session. (C) Due to unforeseen issues in the life of the client, the therapist, at their discretion, may reduce the "fee amount" per session for up to 4 sessions. After that time, the fee amount will return to the original amount as determined by the "fee schedule." (D) Payment can be made by: check, cash or credit card. (E) There are additional charges for which you will be responsible if you choose the other services provided by Tree of Life:

    a. Witness fee/Court Appearance: a fee of $350 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the court appearance.

    b. Depositions: a fee of $300 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the date of the deposition and is to be PAID REGARDLESS of who's attorney is requesting the deposition.

    c. Preparation time for Deposition, Witness and Court Appearance: a fee of $150 per hour and is to be PAID IN FULL along with the payment fees for parts A and B listed above.

d. Pre-marital program: $130 per session normally lasting 3 to 5 sessions, based upon the couple and the issues being presented.

e. Testing and Evaluations for Learning Disabilities, Behavioral, Personality, Career, and ADD/ADHD: Prices vary based upon testing and materials. Cost shall be determined by your therapist.

19. Insurance Reimbursement: Due to the increased cost of "billing" for insurance reimbursement, delayed payment by the insurance company for the services rendered, and the expense of running the counseling center & foundation, *Tree of Life Counseling Center & Foundation* does not accept insurance as a means of "payment" for services being rendered at time of visit. For this reason, the "sliding scale" and "fee reduction" is being offered to assist clients as they come to *Tree of Life Counseling Center & Foundation* for counseling or testing. To assist you in submitting your insurance claims, we will provide the necessary claim forms which can be used to receive the benefits under your medical insurance and we will also walk with you in full submission of your insurance for maximum benefit reimbursement.

20. Cancellation Policy: In order to provide the best possible care to you and each of our other clients, *Tree of Life Counseling Center & Foundation* requires a minimum of 24 hours advanced notice of the cancellation of your scheduled appointment. Our answering service is open 24/7 and they will take all messages and inform your therapist of the cancellation. Based upon the reason for your missed appointment (if no notice is given) you will be charged for your missed session at the RATE OF YOUR STANDARD FEE. *** PLEASE NOTE*** By signing the INFORMED CONSENT you are AUTHORIZING *Tree of Life Counseling Center & Foundation* to charge your credit card for the amount of your standard fee. A credit card number shall be placed on file in our LOCKED file cabinet to be used for this purpose. When counseling is completed or terminated, the paperwork shall be destroyed.

21. Supervisory relationship and Colleague consultations: As stated in section 17, under "licensing regulations," each therapist of *Tree of Life Counseling Center & Foundation* who is a Registered Intern is required by law to meet regularly with their "Clinical Supervisor" to review their client case load. Guidelines are used to ensure your "confidentiality" when discussing your counseling sessions. Also during our regular staff meetings, or at times when assistance is needed in dealing with a "particular" situation, the staff of *Tree of Life* will discuss various client situations. This is done to ensure that each client received the best possible care.

***** Counseling Minor Clients *****

A minor can enter treatment in ONE of FOUR ways:

1) Parental Consent

2) Involuntary at a parent's insistence

3) By order of a Court of Law

4) The individual has become an "emancipated minor" as described by the American Bar Association as "living separately from parents and is managing his or her own financial affairs" (ABA, 1980, p. 66)

In order for *Tree of Life Counseling Center & Foundation* to provide the best possible care of Minor Clients, we require the "consent and involvement" of the parent or legal guardian.

In cases of DIVORCE, *Tree of Life Counseling Center & Foundation* must receive copies of guardianship orders, general and limited power of attorney, custody orders, or letters of authority, showing that you have the authority to provide "CONSENT" for the child to be seen by a therapist.

Also note that in cases of "joint legal custody," parents have equal legal responsibility of the child and are required to sign the "informed consent" of the minor child to be seen by a counselor at *Tree of Life Counseling Center & Foundation*. Both parents, in this case, shall be responsible for payment of counseling fees as is dictated in the "final divorce decree." Please note it is the responsibility of the Parent to obtain reimbursement from the EX-SPOUSE for the counseling fees which were paid.

***** Counseling Families and Couples *****

In order to provide counseling for either FAMILIES or COUPLES at *Tree of Life Counseling Center & Foundation*, the following issues are to be agreed upon:

1) Each individual is committed to preserving the "confidentiality" of all information disclosed during the therapy sessions.

2) Although CONFIDENTIALITY is strongly encouraged or even required, the therapist CANNOT GUARANTEE that other family members will not violate this trust.

3) The client recognizes the difficulty in maintaining confidentiality and will not hold the counselor "liable" for information which is shared between spouses, partners, or family.

I, the undersigned, agree to the terms of the INFORMED CONSENT and desire to seek counseling at *Tree of Life Counseling Center & Foundation*.

Client Name: _____ Date: _____

Signature: _____

Spouse Name: _____ Date: _____

Signature: _____

Parent Name: _____ Date: _____

Signature: _____

Therapist Name: _____

Payment Authorization Form

Here's How Payments Work:
In the event that your payment cannot be processed immediately after each session, you authorize us to charge your checking/ savings account or credit card. A receipt for each payment will be emailed to you and the charge will be appear in your bank statement as an "ACH Debit"

You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior the payment being collected.

Total Due: _____ Date: _____ # of Payments: _____ Payment Amount: _____ I, _____, authorize Tree Of life CCF, Inc to charge my account indicated (full name) below:

Account Type: _____ Visa ____ MC _____AMEX _____ DISCOVER _____ PAYFLEX _____ ETC Cardholder Name:_____
Account Number:_____
Expiration Date _____ Secure Code _____ ZIP CODE _____

*I also understand that according to the INFORMED CONSENT, which I signed, I must give 24-hour notice if I am unable to attend my scheduled appointment. If proper notice is not given I will be charged for my missed session at my standard fee rate.

Name (Printed): _____ Date: _____

SIGNATURE _____ DATE _____

I authorize the above business to charge the account indicated in the authorization form according to the terms outlined above. If the above noted payment date (s) falls on the weekend or holiday, I understand that the payment may be executed on the next business day. I understand that this authorization will remain in effect until the debt is fully discharged or I cancel in writing whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this account and that I will not dispute the payments with my credit card company or financial institution, so long as the transaction corresponds to the terms indicated in this form. Furthered questions please contact the main administrator Damelis J. Leslie (damelis@treeoflifecounselingcare.org).