Please take these sheets out of the binder. For your privacy, DO NOT leave them behind.

Date	**Cell Number**
Email Address (for appointment reminders**)**	**Emergency Contact Name & Phone Number**

CLIENT INFORMATION			
Name		**Social Security Number**	
Address			
City		**State**	**Zip**
Relationship Status			
MARRIED DOMESTIC PARTNER SINGLE DIVORCED SEPARATED WIDOWED			
Age	**Birth Date**	**Sex**	
Employer		**Occupation**	
Business Address		**Business Phone**	
Primary Physician (name and city/state)		**Who referred you?**	
Are you taking any medications? Do you have medical problems? If so, please list.			

Please Continue to Next Page →

BUCK BLACK THERAPY, LLC

Consent for Mental Health Services

I, the undersigned, agree and consent to participate in the mental health services offered and provided by **Buck Black LCSW, LCAC**, a mental health provider, as defined in Indiana Law. Services may be provided in office or via Telemental Health (on the phone, secure email and/or via videoconference). I understand that I am consenting and agreeing only to those mental health services the above named provider is qualified to provide within: (a) the scope of the provider's license, certification, and training; or (b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.

I understand the treatment offered will be best suited to the problem presented by me or my family. This treatment will consist of an interview to assess the nature of the problem and counseling or psychotherapy to help solve the personal aspects of the problem. In some instances, you will be referred to a doctor to be assessed for medication to help control the potential medical aspects of the problem.

I understand that I have the right to an explanation of any treatment provided to me and the associated charges, and may upon request review my treatment with my therapist. A $50 cancellation fee will be charged for missed appointments not canceled at least two business days in advance.

I understand that my records are confidential and will not be released to other individuals or agencies without my written consent. However, I realize that certain information may be released without my authorization under the following circumstances:

1. Upon receipt of a court order
2. In the event of a medical emergency
3. If there is reason to believe that a child, an elderly person, or a disabled person is being abused or that abuse has occurred
4. When a danger to self or others (such as threat of serious bodily harm)
5. To the noncustodial parent, upon request (for minors)
6. Or as otherwise required by state law
7. Buck may sometimes consult with other mental health professionals about your treatment. This other person is also required by law to follow professional ethics and to keep your information confidential. Likewise, when Buck is out of town or unavailable, another therapist will be available to help clients.

I understand and agree to the above conditions for treatment to be received.

_____
Client Name (Please Print)

Sign Here

_____ _____
Client Signature Date

The consent must be signed by the client, or by the nearest relative or guardian if the client is a minor or is physically or mentally incompetent. *If the client's signature is not present above, please complete the following:*

_____ _____
Reason Client is Unable to Sign Date

_____ _____
Parent/Guardian Signature Relationship

_____
Witness

Please Continue to Next Page →

BUCK BLACK THERAPY, LLC

BuckBlack.com | TruckerTherapy.com | 765-807-6778

Policies

Please take next set of paperwork out of binder for your records

APPOINTMENTS

Please give at least two business days notice if you cannot keep your appointment. Failure to do so will result in a $50 broken appointment fee that you are responsible for paying. Insurance will not pay for broken appointments. Late cancellations make it impossible for clients on the waiting list to be helped.

Please use www.BuckBlack.com to schedule your appointments online. If we lose contact for some reason, please call me at 765-807-6778, send me a message through www.BuckBlack.com, mail a letter to my office, or come to my office during business hours 100 Saw Mill Rd. Ste 3102 Lafayette IN 47905. In the event of a crisis/emergency, call me (do not text). If I am not available or return your call within two minutes, go to the nearest emergency room, medical facility, or call 911. The Lafayette Crisis Center can also help 24 hours per day at 765-742-0244. Text messages and emails will not be answered during vacation and is not for emergencies. If I do not respond to a text or email, please call me.

I check all messages at the end of most business days, unless I am out of the office.

I will be out of the office and completely unavailable each February. Please refer to my voicemail greeting for the therapist on call and follow the emergency procedures outlined above. I leave the country and travel to parts of the world without cell phone coverage several times per year. I will alert you when I will be traveling and my autoreply/voicemail will also indicate when I will be able to communicate with you.

CHILDCARE

No childcare is provided.

AUDIO OR VIDEO RECORDING

Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by me.

PAYMENTS

Credit/Debit cards are the preferred method of payment. Please write checks as a last resort. I expect you to pay for services in full at the time of each appointment. Failure to do so will result in me being unable to provide you with future services. Please inform me if you do not wish to have your credit card stored in the secure system for future charges. There is a $20 fee plus any additional bank charges for all returned checks.

PRIVACY POLICY

The full privacy policy is available upon request in paper format or at www.BuckBlack.com

Notice of Privacy Practices (Brief Version)
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.

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer, Buck Black, about any questions or problems.

How we use and disclose your protected health information with your consent
We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent
There are some times when the laws require us to use or share your information. For example:
1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.

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2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.
There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information
1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care
we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Buck Black and can be reached by phone at 765-807-6778.

The effective date of this notice is 7/1/2007.

COLLECTIONS

If you have an outstanding balance that is not paid within 60 days of invoice, your account will be turned over to a collection agency. In addition, the balance owed will be doubled in order to pay the collection agency fees.

REMINDER CALLS, EMAILS, AND TEXTS

If you do not wish to have reminders for your appointments, please let me know. Appointment reminders via email are the default. If you wish to have phone or text reminders, please let me know. Please alert me if you do not wish me to leave voicemails, text messages or emails regarding details of your treatment. These are not secure methods of communication. You can send me secure emails by creating a www.HushMail.com account or using the contact form on www.BuckBlack.com

THERAPY FEES

Assessment-45 minutes (90791): $200, Individual and couples-45 minutes (90834, 90846, 90847) $125, group-60 minutes (90853) $65. The same prices apply to telehealth (phone and video conferencing). Emails are billed at $30 per 15-minute increment.

Extended sessions: I will alert you if the session is running over time. Sessions are billed at $30 per 15-minute increment.
Reports: $30 per 15-minute increment of time I spend on your report.

Payment is due in full at the time of service.

Crisis services, whether face-to-face, phone, email, video conferencing or anything else will be billed at $50 per 15-minute increment.

Court is $250 per hour with a minimum of 4 hours. Payment is due 5 business days in advance of court date and time billed will include preparation, driving, and waiting time.

THE BENEFITS AND RISKS OF THERAPY

There is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in the community may mistakenly view anyone in therapy as weak, or perhaps as seriously disturbed or even dangerous. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therampy may not work out well for you.

While you consider these risks, you should know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved.

Please Continue to Next Page →

Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives.
The current version of these policies is always at www.BuckBlack.com/client

SOCIAL MEDIA POLICY

Please do not interact with me on any social media platforms or on the web because this may expose to others that you are in therapy, thus violating your confidentially. Feel free to read my tweets. ☺ Likewise, I will not acknowledge you in public or online in order to protect your confidentially…I am not being rude.

INFORMED CONSENT FOR A VISITOR TO ATTEND A SESSION

I understand that if I choose to invite a person or persons to be present during a session, my confidentiality may be compromised. I do so with the understanding that my therapist will use his clinical discretion when he chooses to share or reveal confidential and/or sensitive information. I understand that my therapist will use his clinical discretion and reasoning in sharing any information. I also understand that this may be upsetting or uncomfortable for me. Unless specified in writing, this consent does not give permission to the therapist to discuss any confidential information with the visitor any time after the visit.

Your signature indicates that you have read and understand Buck Black Therapy, LLC policies, including the privacy policy.

_____ _____

*Signature of Client or Legal Guardian Date Witness

Sign Here

INSURANCE CLAIMS

If you (or your child) have in-network medical insurance that may cover services provided at Buck Black Therapy, LLC, we will file insurance claims as a courtesy to you. If you have out-of-network insurance, upon request, you will be given paper insurance claim forms to send to your insurance company. Your insurance company will reimburse you in accordance to the benefits of your policy.

Assignment of Benefits and Release (*complete only if using insurance*)

I, the undersigned, certify that I (or my dependents) have insurance coverage with (insurance company name)_____ and assign directly to Buck Black Therapy, LLC, all insurance benefits, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I further hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand the insurance company may require all notes and all documentation from therapy sessions to be submitted to them at any time.

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Buck Black Therapy, LLC has no control over, or knowledge of, what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

I understand insurance companies may or may not cover telemental health services. Please call your insurance company for details.

I understand that I am responsible for any late cancellation and no-show fees and that insurance companies do not pay for this.

_____

Client signature (or legal guardian if patient is a minor)

Please Continue to Next Page →

Sign Here

Telemental Health Informed Consent

I hereby consent to engage in Telemental Health (e.g., internet, email or telephone based therapy) with Buck Black LCSW as part or all of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to Telemental Health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to Telemental Health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from Telemental Health. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that Telemental Health-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from Telemental Health, but results cannot be guaranteed or assured. The benefits of Telemental Health may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Indiana law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

If you are considering hurting yourself or someone else, Telemental health is not for you! Please go to an emergency room of a hospital, call 911, or contact the National Suicide Hotline (United States) at 1-800-SUICIDE or 1-800-273-TALK.

I certify that I will not operate a motor vehicle or do any other dangerous or multitasking types of behavior during my sessions. This is a significant safety concern and any distraction may lessen the benefit of the session.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

Name _____ Date _____

Client Signature: _____

Parent/Guardian Signature if applicable_____

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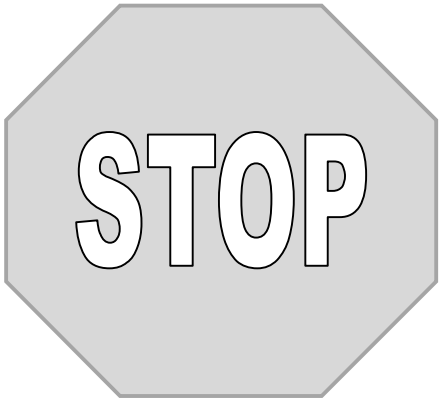

This is the end of your paperwork.

Please ***remove these pages*** from this binder, take the next set of pages as your copy, and press the buzzer (you will NOT hear a tone) on the wall next to "Buck Black Therapy" and hold for two seconds. You will be greeted at your appointment time. Please enjoy the guest Wi-Fi (PW: smile123) or a magazine. I'll be looking forward to meeting you shortly.

Thank you!

Please be sure to use the buzzer when you arrive for each appointment.

Schedule appointments online at BuckBlack.com

Credit card payments preferred; please write checks as a last resort.

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Anger Management

Buck Black Therapy, LLC

100 Saw Mill Rd. Suite 3102 Lafayette IN 47905

What is Anger Management?

Anger Management is an evidenced based therapy program. It focuses on both education and therapy. Unlike many other anger management programs, there is an effort to get to the root of the problem, instead of simply teaching anger management techniques. Workbooks are included at no extra cost.

Learn:

Reasons for having anger, Anger reduction strategies, How to have better relationships Ways to reduce stress, How to make anger work for you

Client Population

Anyone who is tired of being angry, wants to get along with their loved ones, friends, and people at the workplace. This is therapy that is aimed at helping the client understand why he or she is having angry feelings and has an education component.

What Anger Management is Not

This program is not simply education. Its emphasis on therapy provides an evidenced based model that often provides much more benefit compared to education alone.

If the primary problem is domestic violence and/or substance abuse, the client will be referred to appropriate programs.