Lotus
Therapy Solutions, LLC

New client paperwork

Date:	☐ In person sessions ☐ Telehealth sessions
Program/service enrollment: ☐ Individual therapy ☐ Group therapy (identify group): ☐ DUI program (telehealth not available) ☐ Other:	
Patient's name: Date of birth (DOB):	Gender Identification:
Patient/parent/guardian phone number:	
Patient/parent/guardian email:	
Patient primary address:	
Specific needs for treatment/primary presenting problem to address (e.g., problems to be addressed, court involvement, etc.):	

Please send to: administrator@lotustherapysolutions.net

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

The standard appointment time for psychotherapy is 53 minutes. Requests to change the 53-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

Please remember to cancel or reschedule 24 hours in advance. Cancellations and re-scheduled sessions may be subject to a $50 charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If late for a scheduled appointment, your clinician will either have to shorten the time frame of the appointment or you may not be seen for that visit.

TELEPHONE ACCESSIBILITY

If you need to contact your clinician between sessions, please leave a message on his or her voice mail. Often your clinician will not be immediately available; however, they will attempt to return your call within 48 hours. Please note that face- to-face sessions are highly preferable to phone sessions. However, in the event that you are sick or need additional support, phone sessions are available.

If a crisis occurs and you are unable to reach your therapist or it's outside of business hours, please contact 859-331-3292, text or call 988, call 911 or proceed to any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, staff will NOT accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Snapchat, Instagram, X, Discord). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

Staff cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, staff may do so. While staff will make effort to respond in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to

understand that:
(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. Your therapist will discuss with you and your parents what information is appropriate for them to receive, and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Staff may terminate treatment after appropriate discussion with you and a termination process if your therapist determines that the psychotherapy is not being effectively used or if you are in default on payment. Staff will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, your therapist will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, staff will consider the professional relationship discontinued and your case will be closed.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS

DOCUMENT.

Signature Date

Lotus
Therapy Solutions, LLC

Lotus Therapy Solutions, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Lotus Therapy Solutions, LLC. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Psychotherapy Notes.** We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For our use in treating you.
   b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For our use in defending ourselves in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes.** As a psychotherapist, we will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI.** As a psychotherapist, we will not sell your PHI in the regular course of our business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on date signed by client.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By agreeing to this form, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Signature Date

Lotus
Therapy Solutions, LLC

Client Rights and Responsibilities

Client Rights

1. You have a right to services free from discrimination. As a client, you have the right to therapy services offered within this LLC regardless of your age, race, ethnicity, gender, sexual orientation, or disability.
2. You have the right to receive quality care from trained staff.
3. You have the right to be treated with respect and dignity for who you are and your beliefs. As a client, you have the right to expect your cultural, psychosocial, spiritual and personal beliefs, values, and preferences to be respected.
4. You have a right to confidentiality regarding your health record. As a client, you have the right to confidentiality of treatment, in accordance with agency policies, legal guidelines, and the ethical principles associated with mental health disciplines. You also have the right to request and receive a copy of the HIPAA privacy practices.
5. You have a right to a clean, safe treatment center.
6. You have the right to give informed consent to treatment, to receive individualized treatment, be informed of your treatment process, and be involved in the treatment planning process.
7. You have the right to be informed of rules of client conduct, including consequences for using alcohol and/or other drugs.
8. You have the right to review your file at any time. You have the right to a free copy of your records upon written request in accordance with the policy of Lotus. You will receive a copy of your records within 30 days of the written request.
9. You have the right to refuse or terminate services and to be informed of potential consequences of your actions.
10. You have the right to be involved in discharge and aftercare planning.
11. You have the right to give informed written consent regarding participation in a research study.
12. You have the right to be informed of any charges and/or payments related to your treatment. As a client, you have the right to obtain an itemized statement regarding services paid for as well as an explanation of charges and fees for services.
13. You have the right to submit grievances, opinions, and recommendations about the program or the services received through the internal grievance procedure of the LLC or the Cabinet for Health Services Ombudsman – Jonathan R. Grate, 209 St. Clair St., Frankfort, KY 40601, 866-596-6283.

Client Responsibilities

1. It is your responsibility to arrive on time, attend, and participate in all scheduled sessions.
2. It is your responsibility to cancel any sessions you are unable to attend, giving 24-hour notice when possible.
3. It is your responsibility to participate in all services in a state of full sobriety.
4. It is your responsibility to provide an accurate and complete description of current complaints, current medications, past treatment and hospitalizations as well as any

changes to your health during treatment.
5. It is your responsibility to work on your treatment goals both in session and outside of session. It is necessary for you to understand your role in your treatment and to accept responsibility for the outcome of your care if you do not work toward your treatment goals.
6. It is your responsibility to provide your insurance information and pay for services at the time of service. It is your responsibility to provide financial information and make payment arrangements (if needed). It is also your responsibility to be aware that nonpayment of services will result in completion paperwork of court ordered programs not be forwarded to the appropriate agencies and nonpayment may result in a report of noncompliance to the court.
7. It is your responsibility to show respect for other clients and their privacy. It is your responsibility if participating in a group to protect the confidentiality of all group members.
8. It is your responsibility to be respectful of staff and the environment/property in which services are provided.
9. It is your responsibility to follow any rules and regulations set forth by the LLC.
10. It is your responsibility to ask questions anytime you need further information regarding your treatment, or the services provided by the LLC.

Signature Date

Lotus
Therapy Solutions, LLC

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INFORMED CONSENT FOR THERAPY SERVICES

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with your assigned therapist. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items (3) and (4).
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally, we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize

your privacy. However, if you acknowledge us first, we will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Date

Lotus
Therapy Solutions, LLC

Lotus Therapy Solutions, LLC

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Lotus Therapy Solutions, LLC providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

I hereby authorize Lotus Therapy Solutions, LLC to use any HIPAA-compliant platform as a means for providing psychotherapy remotely.

I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Lotus Therapy Solutions, LLC has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Date

Lotus
Therapy Solutions, LLC

Lotus Therapy Solutions, LLC

Consent to Bill Insurance

Insurance

- [ ] Name
- [ ] Date of Birth
- [ ] Insurance Provider
- [ ] Member ID Number
- [ ] Group ID number
- [ ] Subscriber's Name
- [ ] Subscriber's Date of Birth
- [ ] Subscriber's Employer
- [ ] Insurance Provider's Phone Number

By completing and signing this form, I give consent for staff at Lotus Therapy Solutions, LLC to bill my insurance for services provided to myself or my child.

Signature

- [ ] Client's Name
- [ ] Parent/Legal Guardian's Name
- [ ] Date

Lotus
Therapy Solutions, LLC

Lotus Therapy Solutions, LLC

Credit/Debit/Flex Spending/HSA Card Payment Authorization/Consent Form

By signing below, I authorize Lotus Therapy Solutions, LLC to draft my credit card on file for counseling or related services including payments/copayments and Late Cancellation or No Show fees as described in the Fees & Payment Section of the Informed Consent Statement. I also authorize the provider to send email or text receipts of payments made either in-person or electronically.

Credit/Debit/HSA/Flex Spending Account Information

Please complete the information below

- ☐ Name on Card
- ☐ Card Number
- ☐ Expiration Date
- ☐ CVV
- ☐ Billing Zip Code

Signature

Signature Date

Date