PRACTICE IMPROVEMENT RESOURCES, LLC
Ben Carrettin / 5959 West Loop South / Bellaire, Texas 77401
PHONE 832-498-7071 / WWW.LIVEBETTERLIVENOW.COM

Client Information

Please*PRINT All Responses:

Client's Name _____ Pt's Date of Birth _____

Client's Address (complete/full) _____

_____

Client's Telephone #s
h : _____ w / c : _____ Contact Email _____

Client's Relationship to the Insured (Self/Spouse/Child/Other) _____

Client's Status (Single/Married/Other) _____

Client's Physician (First / Last Name and area of town)

_____

Insurance Company/Plan Name _____

Insured's ID # _____ Insured's Group # _____

Phone Number for Insurance Company (back of card) _____

Client's Employer _____

Please Complete the Following IF Client is not the Primary Insured:

Insured's Name (if different from client) _____

Insured's Address (complete/full) _____

_____

Insured's Telephone # _____ Insured's Date of Birth _____

Insured's Employer or School Name _____

I understand that this office has a Late Cancellation / Missed Appointment fee is equivalent to a full, fee-for-service rate ($95.00) and that I am solely and fully responsible for payment of this fee for any and all scheduled appointments that are missed without a minimum of 48 hours prior notice. This fee must be paid in full before my next appointment. This is also stated in the Services Agreement which must be signed prior to any services.

Signature _____ Date _____

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2-Way Release of Information

I, _____, have provided a complete and up to date list of all of my current physicians in the list below along with their phone numbers and specialty. I am authorizing Practice Improvement Resources, LLC / Live Better Live Now / Ben Carrettin and all of the physicians and other individuals or groups listed to consult and communicate freely regarding my progress, prescriptions and any issues that may affect my health, safety, recovery progress as deemed appropriate by Ben Carrettin and/or the physicians and/or other approved contacts I have listed below. I understand that this supports my continuity of care and may increase the quality of service I receive as a whole. I may also list any family members or other service providers whom I wish to be included for continuity of care.

I understand that I do not have to sign this release and if I choose not to I may speak with my physician or contact my insurance company for alternate referrals. I also understand that providing this information *is a requirement* and that declining to provide it may prevent me from obtaining services with this provider. Falsifying or omitting information is grounds for immediate termination of services.

PHYSICIAN	SPECIALTY	PHONE

FAMILY/OTHER SUPPORT	HOW RELATED	PHONE

_____
Client's Name (PRINTED)

_____ _____
Client's Signature Date

_____
Witness Name (PRINTED)

_____ _____
Witness Signature Date

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LATE CANCELLATION / NO-SHOW POLICY

I understand that the cancellation policy for this office is a minimum of ***48 hours*** prior notice to the scheduled appointment. If I/or the client am unable to or am unsuccessful in notifying the counselor that the appointment will be missed, I will be solely and fully responsible and agree to pay the Late Cancellation/No-Show fee of $95.00 I understand that this charge must be paid in full before my next appointment.

_____ _____
SIGNATURE DATE

_____
PRINTED NAME

RECEIPT POLICY

I understand that I may request or decline a receipt ***at the time of payment***. For cash or check a written paper receipt can be provided. I am aware that this provider uses Square – a digital credit card processing service to process credit card payments. For credit cards, the receipt will be sent to me directly to either my cell phone or email, as I direct at that time. An account of any/all payments made and/or past receipts will ***not*** be available at a later date. It is my responsibility to manage my financial accounting and request the receipts I may need at the time of payment. There are NO Exceptions to this policy.

_____ _____
SIGNATURE DATE

_____
PRINTED NAME

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SERVICES AGREEMENT

I. DIVERSITY OF SERVICES (all services)
I understand that the clinical experiences, professional training, and therapeutic styles of private practitioners ("providers") are both varied and quite diverse. Some styles may be more effective and/or appealing for some clients. My provider has discussed with me the styles and approaches he/she uses. This provider offers a variety of services; psychotherapy (clinical), consultations (non-clinical), support groups (non-clinical), critical incident (non-clinical, event driven) and coaching / training (business, non-clinical).
I understand and agree that the service type that I am requesting to receive is_____.
(**Please wait to fill out the above until you have spoken with the provider to ensure correct / appropriate*).

II. CONDITION OF SERVICES (all services)
a. I understand that if at any time, for any reason, I should decide that I do not want to continue seeing this provider for services I can stop. I participate and attend these services voluntarily and do so completely of my own free will. Likewise, if at any time my provider feels that I would be better served by a different provider/service or that we have reached the maximum expected benefit from the services being provided, he/she may decide to terminate services. Should this be the case, my provider will discuss this and the transition process with me, and will provide me with a minimum of three referrals that may be more appropriate to my cognitive/emotional health needs. I understand that services with this provider may be terminated and referrals for other providers sent to my address on file if I miss 3 or more scheduled sessions without calling to cancel as listed in VII / re: the cancellation policy.

III. TERMINATING SERVICES (all services)
If I should decide to terminate services, I agree to notify my provider, preferably in person/session, but at least within the bounds of the cancellation policy noted herein. At the time I choose to terminate services, my provider can provide me with alternate referrals at my request.

IV. ALCOHOL & DRUGS (all services)
I will not attend any session while under the influence of alcohol or drugs, including prescription medications used other than expressly directed by my prescribing physician and over-the-counter medication used other than as directed by the container and/or pharmacist.

V. WEAPONS (all services)
I will not bring any weapon; firearm or other, into the building, even if I hold a concealed handgun permit or other permit granted under my profession. This includes pocket knives and pepper spray or "mace". I understand that bringing any weapon into the building is grounds for immediate termination of services, contacting the authorities, and filing of formal charges. I also understand that the building management may also independently pursue legal action re: weapons on the property.

VI. RELEASE OF INFORMATION & PRESCRIPTIONS (all services)
I understand that for continuity of care purposes, I will be requested to provide a listing of all medications I am currently taking, the physician prescribing them, and to sign a 2-way release of information (ROI) for my provider to speak with them. Refusal or misrepresentation of information re: medical professionals and

prescriptions/medications will result in immediate termination of any further services from this provider.

VII. CANCELLATION POLICY (all services)
I understand that the cancellation policy for this office is a *minimum* of **48 hours prior notice** to the scheduled appointment time. If I am unable to or unsuccessful in notifying my provider that I will not make an appointment, I will be charged a **Late Cancellation/No-Show fee of ($95.00).** I will be billed at my address on file. This charge must be paid in full *before* my next appointment. If I have not scheduled my next appointment, I will be responsible to make this payment, in full, to the provider's practice address within 15 business days of the missed appointment.

VIII. EMERGENCY SERVICES (all services)
I understand that my provider does *not* provide emergent / on call services. For emergency/crisis situations I understand that I will need to call 911 or proceed to the nearest emergency room.

IX. PARENTS, GUARDIANS & MINORS (clinical services only)
I understand that it is only in rare cases and with a special request from a physician or colleague that my provider will accept a minor as a client. I understand that this provider may decline to provide services to any minor without the parent/legal guardian present *in the sessions*. It is my provider's contention that in most cases, treating a minor without the involvement of the family/parent/guardian does not often provide long term improvement gains for the minor. This can be discussed more in depth on an individual basis with my provider.

X. OTHER PARTIES & MINORS (all services)
a. I understand that I may not bring any other party into a session without prior discussion with my provider. This includes family and significant others.
b. I understand that I cannot leave any minor unattended in the hallways or waiting area and will need to make prior arrangements for their supervision or care. Minors may not be brought into a session unless they are receiving services and only in accordance to the above stipulation re: the treatment of minors.

XI. BILLING FOR SERVICES (all services)
The standard rate for an Initial Interview/Assessment (first appointment) is $165.00 and lasts 90-120 minutes. The standard rate for regular, follow-up Psychotherapy/Counseling Sessions by my provider is $150.00 and runs 50-55 minutes. Individual Life-Recovery Consults (*not* psychotherapy/counseling) is at a rate of $95.00 for 50-55 minutes. Addiction Recovery Educational/Assessment Consults (for family/spouse) are $250.00 for 90-120 minutes. (Other services not listed herein may have different rates/fees. Should I decide to receive these services, it is my responsibility to discuss the rates with my provider prior to accepting the services.) I understand and agree to pay the fee for the services rendered. Rates are subject to change and current rates are viewable at any time via the website/landing page; www.livebetterlivenow.com.

XII. DECLINING TO USE MY INSURANCE (clinical services only)
Whether my benefits cover this provider either in or out of network, I understand that *if* I should choose not to use it, *for any reason*, I hereby release any right to retrospectively submit claims to my insurance at a future date. This poses a significant hardship for the provider's office and many hours to conclude. By signing this agreement I understand that unless I alert my provider, *in writing*, and provide him with a copy of my active and correct

benefit information I will be fully liable for all fees and waive all rights to retrospectively bill to my insurance.

XIII. INSURANCE STATEMENTS, RECIEPTS AND "SUPER BILLS" (all services)
If my provider does not accept my insurance, I can request a "Super Bill"/ Insurance Statement at the time of payment which I may submit to my insurance to seek reimbursement; in full or part for the service, as my policy may allow.. My provider will ONLY provide these Insurance Statements/receipts for services and dates actually provided and *only at the time of service*. It is my responsibility to manage my finances and accounting. Receipts/Insurance Statements/Super Bills will **not** be provided for past dates of services for which no receipt was requested at the time of payment, wherein they were lost, misplaced, etc by payee, or for other cause. There are no exceptions to this policy.

XIV. DOCUMENTATION REQUESTS (all services)
My counselor does not routinely provide documentation/signature services. In the event an exception is made, the fee for the first page of the document is $225 and subsequent pages are $75 per page. *This includes all documentation requiring signatures.* These services may only be paid for in cash or via credit card, if applicable, and must be paid at the time documents are received. Documentation for legal/court purposes may only be delivered by courier and must accompany a signed release and payment at time courier arrives which must be pre-scheduled with my counselor – and legal/court service fee rates may be different as indicated below in the LEGAL/COURT section.

XV. DISABILITY (all services)
My counselor will *not* be available to sign any documents re: disability – these will need to be addressed through your physician (MD / DO) and/or a fully licensed psychologist (PhD). If required to do so, I understand I will be responsible for payment as per section XVI. Reports & Summary Writing.

XVI. REPORTS & SUMMARY WRITING (all services)
Report / Summary writing is a specialty skill and requires both clinical knowledge and significant investment of time. The initial page of *any* such written document is at a fee of $375, subsequent pages are $75 per page. I understand that , regardless of the source requesting, by legal order or by my authorization, I am solely and fully responsible for the entire cost. This service is not covered under insurance and I am responsible for the full amount. Payment in full must be made before or at the time report is delivered.

XVII. LEGAL / COURT (all services)
Any and all time spent by the provider in relation to *any legal issue* is at a rate of $2500 for the first 4-hour block or any part thereof. Every subsequent hour, or part thereof, *in the same* day is at a rate of $325. Each additional day begins this fee cycle again:$2500 for the first 4-hour block or any part thereof and every subsequent hour beyond the initial four, or part thereof, in the same day, at a rate of $325. This begins at the time provider leaves office and continues until the time they return. By signing this agreement, you agree to be solely and fully responsible for all payments due, should the clinician or any other member of this office, be required or requested to be involved in any legal proceeding; including but not limited to mediation, court/trial, depositions, phone conferences, meetings and consultative services. You are still responsible for these, under contractual law, even if the provider is summoned under a subpoena. This payment must be made, in full, on each day the provider spends such time in relation to *any legal issue.*

XVIII. PHONE-BASED SERVICES / CALLS (all services)
a. With Other Than Client:
I understand that any calls or time spent with legal counsel/representatives, probation/parole, or any other outside source at my request is billed as indicated in the Legal / Court section and must be paid in full, accordingly.
b. With Client Only:
I understand that my provider does not routinely provide "phone-based services". Routine calls and texts *for scheduling purposes only* are part of the business and expected. Non-scheduling phone calls are considered "Non-Clinical Consultative" sessions which are billed at $2.50 per minute, must be paid in full prior to next appointment and are *not* covered by, billed to or reimbursable by managed care / insurance plans.

XIX. EMAIL AND TEXT POLICY (all services)
I understand that email and text to this provider is only for scheduling purposes. Email and texts containing non-clinical content may not be responded to and by sending it I may be placing my own Personal Health Information / Confidentiality at risk. For any and all non-scheduling communication, I need to speak directly to my provider by phone or in person.

XX. SOCIAL MEDIA / INTERNET POLICY (all services)
I understand that due the nature of a professional provider/client relationship and to preserve my confidentiality, my provider will not respond or accept connections or communications from my by way of social media. This includes, but is not limited to, Facebook, Twitter, MySpace, Tumblr, Instagram and so on. My provider may have business/company profiles in social media and a blog. These are "bulletin-based" and are for information-out and marketing purposes only.

XXI. BRAND AWARENESS (all services)
I understand that Live Better Live Now is a marketing brand only, it is not a clinical service and does not provide any of the services I am receiving. All of my services are being provided through Practice Improvement Resources, LLC.

By signing this document, I attest that I have read and understand, or have had it read to me and fully understand, all four pages of this Services Agreement and agree to abide by it in its entirety, including any future addendum's which may be found on the website at any time. I attest that I have signed this document only after discussing any/all questions regarding the above statements with my provider to my full satisfaction.

_____ _____
Signature Date

_____ _____
Witness Date

_____ _____
Parent/Guardian *(if client is a minor)* Date

----------*Between Dotted Lines To Be Filled Out By Provider*----------

OP/Indv/Psy OP/PrvCnslt OP/R2R OP/CISM

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CLIENT SELF-REPORT

Thank you so much for looking to my practice for your counseling. I am confident we will be able to provide the support you are seeking. Please take a few moments to fill out this form. Please, take your time and be as candid as possible.

CLIENT NAME

DATE COMPLETED

DATE OF BIRTH

CONTACT PH#

EMAIL ADDRESS

(*If Minor, Legal Guardian must complete this form and sign and date at end of form).

DEMO & INITIAL INFO

EMPLOYER

OCCUPATION

REFERRAL SOURCE
HOW DID YOU HEAR ABOUT US ? (Internet Source, Friend, Family, Doctor, etc)

WHY ARE YOU SEEKING COUNSELING AND WHY NOW ?

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH COUNSELING ?

PLEASE LIST YOUR CURRENT FAMILY AND CLOSEST FRIENDS WHO ARE YOUR GREATEST SOURCES OF SUPPORT.

HAVE YOU HAD ANY RECENT / INTENSE LOSSES IN PAST 18 MONTHS ?
(DEATHS, LAYOFFS, DIVORCE, TRAGEDY, ETC)

SCHOOL/LEARNING OR BEHAVIORAL PROBLEMS AS A CHILD OR TEENAGER ?

LEGAL PROBLEMS (indicate past / present)

MEDICAL / EMOTIONAL HEALTH TREATMENT

PREVIOUS TREATMENT – **MEDICAL** / DATES
(indicate dates, condition, level of care, provider name)

PREVIOUS TREATMENT – **MENTAL HEALTH & SUBSTANCE ABUSE** / DATES
(indicate dates, condition, level of care, provider name)

SUBSTANCE ABUSE HISTORY

YES ☐ (*if Yes, continue with below*)

NO ☐ (*if No, skip to Family History of SA/Dependence*)

SUBSTANCE ABUSE HISTORY IN PAST & WITHIN PAST 12 MONTHS
(substance / amount / freq / age began / last use)

FAMILY HISTORY OF SUBSTANCE ABUSE / DEPENDENCE
(family member, substances, amount, frequency, still using today?)

SUBSTANCE ABUSE / DEPENDENCE

LONGEST PERIOD OF SOBRIETY?

_____

_____

WHAT SYMPTOMS DO YOU EXPERIENCE WHEN IN WITHDRAWAL ?
(TREMBLING, AGITATION, NAUSEA, SLEEP PROBLEMS)

_____

SUPPORT SYSTEM / PEERS CONCERNED ABOUT YOUR USE? ☐
USE TO RELIEVE UNPLEASANT FEELINGS OR STRESS? ☐
PREOCCUPATION WITH ALCOHOL AND DRUGS USE? ☐
EXPERIENCED PHYSICAL DISCOMFORT AFTER USE OR A DAY AFTER USE? ☐
INCREASED TOLERANCE OF ALCOHOL AND/OR DRUG OF CHOICE? ☐
CONTINUED USE DESPITE NEGATIVE LIFE / WORK IMPACT? ☐
EVIDENCED MEDICAL/PHYSICAL SYMPTOMS RELATED TO USE? ☐
MINIMIZATION/INCONSISTENCY IN REPORTING USE PATTERNS/HISTORY? ☐

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO INCLUDE:
(please continue on back of this page if you need additional space)

MEDICAL INFORMATION

NAME OF PCP *on the Release of Information Form

PHONE NUMBER OF PCP *on the Release of Information Form

LAST VISIT TO PCP AND REASON

MEDICAL CONDITIONS – *CURRENT & CHRONIC

ALL CURRENT PRESCRIPTIONS *AND* OVER THE COUNTER MEDICATIONS

MEDICATION	*DOSE*	*FREQUENCY*	*PRESCRIBING MD*

PREVIOUS COUNSELING / TREATMENT

WHAT KIND OF COUNSELING SERVICES HAVE YOU HAD IN THE PAST AND WHAT ABOUT IT DID YOU FIND HELPFUL ? WHAT ABOUT YOUR PREVIOUS COUNSELING EXPERIENCES WERE NOT HELPFUL ?

_____
_____
_____
_____
_____
_____
_____
_____

PROBLEMS AT WORK

ABSENTEEISM ☐
SAFETY ISSUES / ACCIDENT ☐
PRODUCTIVITY ISSUES ☐
CUSTOMER COMPLAINT ☐
POLICY VIOLATIONS (HARRASMENT, VIOLENCE, ETC) ☐
TARDINESS ☐
POSITIVE UDS ☐
CONFLICT AT WORK ☐
TRANSFERS / DEMOTIONS ☐
ANGER MANAGEMENT ☐

DETAILS OF WORK-RELATED PROBLEMS:

_____
_____
_____
_____

SCHOOL PROBLEMS

(*if minor or if adult in college/tech/trade*)

NAME OF SCHOOL: _____

SUSPENSION / PROBATIONARY STATUS?:

COUNSELOR / SCHOOL CONTACT

DETAIL OF SCHOOL-RELATED PROBLEMS:

_____
_____
_____

Information Source

This Self-Report was completed by: (Printed Name) _____

Relation to the Client: _____

Signature: _____ Date: _____

IF CLIENT IS A MINOR

Legal Guardian's Name & Phone Number :

_____
_____

I do hereby swear and attest that I am the sole and/or *primary* legal guardian for the minor named as “client” on this form and further swear that I have the completed this form in it's entirety and have the full and complete legal authority to access counseling services for the client as I deem may be needed. I understand that falsely representing myself as the full and/or primary legal guardian of a minor is a criminal offense.

Printed Name: _____

Signature: _____ Date: _____