148 Quincy Dr. NE, Albuquerque, NM 87108 505-550-1306

Client Registration/Demographics

Client Name: _____ DOB: _____SS #:_____

Address: _____ City/State/ZIP: _____

Home Phone_____ Cell: _____

Work Phone: _____ OK to Contact Work? Y N

Occupation: _____ Employer: _____ Employment Status: _____

E-mail Address: _____

Emergency Contact Person: _____

Relationship: _____ Phone:_____

Reason for entering counseling and treatment: _____

Insurance:

Primary Insurance Co._____ Provider Phone # _____

Policy/ID #:_____ Group #:_____

For Clients on Probation:

Probation Officer's name _____ phone _____

Email _____

I certify that the information on this document is true and correct

Client Signature: _____ Date: _____

For clinical staff only:

ICD 10 diagnosis _____, _____, _____, _____

Program/Start date_____

Staff Signature: _____ Date: _____

Clinician assigned _____

Assessment scheduled✓ All document signed✓

☑ or I acknowledge electronically

☑ or I acknowledge electronically

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Authorization for Release/Exchange of Confidential Information

I _____ authorize Treefrog Counseling to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Client Signature:_____ Date: _____

Staff Signature:_____ Date:_____

I, hereby revoke the above consent effective, _____ for the following reasons:

_____

_____

Client Signature:_____ Date: _____

Staff Signature:_____ Date:_____

☑ or I acknowledge electronically

☑ or I acknowledge electronically

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Client Rights and Responsibilities

Rights as a Person Receiving Mental Health Services

I, _____ have read these rights on the date of _____and have been informed of the following:

Treefrog Adolescent and Family Counseling is owned and operated as a DBA by Perfectly Imperfect, LLC. All references to "Treefrog Counseling" are meant to reflect this relationship.

1. To receive a written description of your rights in English or Spanish when requesting services;
2. To receive appropriate *treatment* or *therapy* for your substance use, emotional or *psychological* problem;
3. To be fully informed about any proposed *treatment* or *therapy,* including its risks and consequences;
4. To a *treatment plan* to meet your special needs, within 30 days of the date you begin receiving services;
5. To participate in designing and updating your *treatment plan;*
6. To confidentiality (see notice of Privacy and Confidentiality).
7. To be treated with respect and dignity
8. To request information about names, location, phones, and languages for local agencies
9. To be free from use of seclusion or restraints
10. To receive age and culturally appropriate services
11. To understand available treatment options and alternatives
12. To refuse any proposed treatment
13. To receive care that does not discriminate against you (e.g. age, race, type of illness)
14. To make an advance directive that states your choices and preferences for mental health care
15. To file a grievance with your agency
16. To have family participate.
17. To change mental health care providers during the first 30 days, and sometimes more often
18. The right to access your records. You have the right to read your *case record, treatment plan* or any information the *facility* or agency has about you and to make copies of that information.

Client Responsibilities

Responsibilities of a Person Receiving Services at Treefrog Counseling

1. Keep your scheduled appointments and let us know as soon as possible if you cannot keep one.
2. Be as honest and open as possible with your counselor.
3. Between sessions, think through the concerns you are addressing in counseling.
4. Follow through on treatment recommendations and complete your counseling homework assignments.
5. We ask that you end your work with us in a termination session, rather than not keeping your appointment. This way you can share and discuss with your counselor what was useful and what could have been improved.
6. If you feel that you might harm yourself or others, during business hours contact Perfectly Imperfectly, crises lines provided at intake or 911. After business hours call crises lines provided at intake or 911.

I am aware my records will be shared with the Treatment Team for Supervision.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

☑ or I acknowledge electronically

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Financial Responsibility Policy

Treefrog Counseling would like to thank you for choosing us to provide your counseling needs. The policies listed below have been approved by management with the goal of providing quality and professional service to our clients.

Treefrog Counseling shall provide service regardless of race, color, creed, handicap, socioeconomic status, sexual orientation and religious beliefs.

Bill Responsibility

All patients or guarantors receiving services are financially responsible for the timely payment of all charges incurred. While Treefrog Counseling will file claims with the patient's designated insurance company as a courtesy, the patients/guarantors shall ultimately be responsible for any outstanding balance not covered by insurance in accordance with the posted counseling fees presently in effect. Not all services are covered by all insurance companies. It shall be understood that by accepting and consenting to services, the patient is responsible for payment regardless of insurance coverage.

Person with financial responsibility _____

Point of service Collections

Payment for services is due upon services rendered. Non-emergency series may be deferred until necessary payment arrangements have been established. Clients unable to comply with Point-of-Service payment policy will be assisted in making necessary arrangements. If patients account is not paid in full or a satisfactory arrangement made within allowable time frames, Treefrog Counseling reserves the right to refer the account to an attorney or a collection agency.

Payment Agreements

Treefrog Counseling will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement or payments shall be at the clinician's discretion based on the amount due.

Acceptance of Insurance

Treefrog Counseling accepts Self pay clients and Medicaid Centennial Full benefits, and Alternative Benefits Packages from Presbyterian, Blue Cross Blue Shield, United Behavioral Health Care, or Molina

My signature below acknowledges that I have read or have been explained this Admission Information Form, I agree that I am financially responsible for all charges incurred that are not covered services of my health insurance company.

Clients Signature/Responsible Party: _____Date: _____

Staff Signature: _____ Date: _____

☑ or I acknowledge electronically

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Client Grievance Procedure

Treefrog Counseling is dedicated to providing the highest quality of services to our clients. We believe to accomplish this; we must provide forums for our clients to give us feedback. The Treefrog Counseling Procedure was developed to establish a method of addressing issues and/or concerns that cannot be resolved informally between you and agency staff. All client grievances will be investigated and resolved promptly in accordance with the New Mexico Counseling and therapy Practice Board.

If you are upset about your program or anything that has happened to you at Treefrog Counseling do the following.

1. Tell your counselor what is bothering you. They will do everything they can to resolve the issue with you.

2. If you are unable to solve your grievance with you counselor, you may meet with the Clinical Supervisor.

3. If the grievance cannot be resolved informally clients will submit their grievance in writing, and will meet with the Director of Operation.

4. The Director will respond to the client's grievance within 7 days.

5. If a member of a Centennial Care Managed Care organization, is dissatisfied with outcomes, they have the right to file a grievance following the CC MCO process.

6. If a Medicaid fee-for-service recipient, they have the right to request a Fair Hearing:

   Fair Hearings Bureau
   P.O. Box 2348
   Santa Fe, NM 87504

   Call: (505) 476-6213
   Toll Free: 1-800-432-6217 (option 6)
   Fax: (505) 476-6215

_____ _____
Print Client Name Date

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

☑ or I acknowledge electronically

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Notice of Privacy and Confidentiality

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.

General Information:

The confidentiality of alcohol and drug abuse client records maintained by Treefrog Counseling is protected by two federal laws: Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 290dd-2, 42C.F.R. Part 2. Generally Treefrog Counseling may not say to a person outside the program that you attend the program, nor disclose any information identifying you as an alcoholic and/or drug user, or disclose any other protected information except as permitted by federal law. Treefrog Counseling must obtain your written consent before it can disclose information about you for payment purposes. For example, Treefrog Counseling must obtain you written consent before it can disclose health information to your health insurer in order to be paid for services. Generally you must also sign a written consent before Perfectly Imperfect can share information for treatment purposes or health care operations. However, federal law permits Perfectly Imperfect to disclose information without your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate:
2. For research, audit or evaluation.
3. To report a crime committed on Perfectly Imperfect premises against Perfectly Imperfect personnel:
4. To medical personnel in a medical emergency:
5. In connection with treatment, payment (insurance company) or health care operations.
6. To appropriate authorities to report suspected child or elder abuse and/or neglect:
7. As allowed by a court order.

Before Treefrog Counseling can use or disclose any information about yo ur health in a manner which is not described above, we must first obtain your specific written consent allowing it to make disclosure. Any such written consent may be revoked by you in writing.

Your Bill of Rights

Under HIPAA you have a right to request restrictions on certain uses and disclosures of your health information. Treefrog Counseling is not required to agree to any restrictions you request, but if it does not agree the it is bound by that agreement and may not use or disclose any information which you have restricted except ass necessary in a medical emergency. You have a right to request that we communicate with you by alternative means or at an alternative location. Treefrog Counseling will accommodate such requests that are responsible and will no request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Treefrog Counseling, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceedings or in other limited circumstances. Under HIPAA you also have the right, with some exceptions, to amend health related information made by Treefrog Counseling during the six years prior to you request. You also have a right to receive a paper copy of this notice.

A. In accordance with Title 6 of Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title 9, Section 10800, and Americans with Disabilities Act of 1990, each person receiving services from an alcoholism or drug abuse recovery or treatment facility shall have rights which include , ut are not limited to, the following:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2 and HIPAA and the right to receive this Privacy Notice.
2. To be accorded dignity in contact with staff, volunteers, board members and other persons. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of admission, which can help in decision making.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs. You have a right to a humane environment that provides reasonable protection from hard and appropriate privacy for your personal needs.
4. To be free from verbal, emotional, physical abuse, inappropriate sexual behavior or contact, exploitation, humiliation, harassment and/or neglect.
5. To be informed by the program of the procedures to file a grievance (without fear of retaliation) or appeal discharge.
6. To be free from discrimination based on ethnic group identification, culture, sexual orientation, religion or spiritual beliefs, age, gender, skin color, socio economic status, language, or disability.
7. To be accorded access to his or her file and the right to own the information within his r her file with the exception of psychotherapy notes.
8. The right to request corrections of erroneous and/or incomplete information.
9. The right to prohibit re-disclosure of client information.
10. The right to request transmittal of communications in alternative manner.
11. The right to obtain an accounting of disclosures.
12. The right to express preferences regarding counselor or services provided.
13. Fiduciary abuse of the participants is prohibited.
14. To be free from any marketing or advertising publicity without written authorization.
15. The right to provision of services will be responsive to the participants' social support and legal advocacy needs, when necessary.

☑ or I acknowledge electronically

16. The right to be free from intrusive procedures (strip searches or pat downs).
17. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law). You have the right not to receive unnecessary or excessive medication.
18. You have the right to accept or refuse treatment after receiving this explanation.
19. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
20. You have a right to be told about the program's rules and regulations before you are admitted. You also have the right to be told what is expected of treatment.
21. You have the right to be told before admission:
22. a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits and side effects of all proposed treatment and medication;
    d. the probable health and mental health consequences of refusing treatment;
    e other treatments that are available, and which ones, if any might be appropriate for you; and
    f. the expected length of stay
23. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan. You also have a right to meet with staff to review and update the plan on a regular basis.
24. You have the right to be told in advance of all estimated charges and any limitations on the length of the services which Treefrog Counseling is aware.
25. You have a right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.

B. Each participant shall review, sign and be provided at admission, a copy of the participants rights specified in A1 through A24 above. The program shall place the original signed bill of rights document in the participant's file.

C. The provider shall post a copy of the participants' rights in a location visible to all participants and the general public.

D. The follow up after discharge cannot occur without the written consent from the participant.

E. Any program conducting research using participants as subjects shall co0mply will all federal regulations for protection of human subjects (Title 45 Code of Federal regulations 46). However, you have a right to refuse to take part in research without affecting your regular care.

Treefrog Counseling Duties:
Treefrog Counseling is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Treefrog Counseling is required by law to abide by the terms of this notice. Treefrog Counseling reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information in maintains. Revises notices will be posted in all Treefrog Counseling offices and website, as well as given to all active clients.

Complaints and Reporting Violations:
You may complain to the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, DC 20201, to NM Counseling and Therapy Practice Board or Board of Social Work Examiners Toney Anaya Building 2550 Cerrillos Road, Santa Fe, NM 87505, (505) 476-4500 or Fair Hearing Buerau PO Box 2348 santa Fe NM 87504 Call: (505) 476-6213 Toll Free: 1-800-432-6217 (option 6) Fax: (505) 476-6215, If you believe your privacy rights have been violated under HIPAA, Treefrog Counseling will take no retaliatory action against you if you file a complaint about our privacy practices.

Contact:
If you have any questions about this notice or any complaints, please contact our Owner and President at 505 220 5481. Violation of the Confidentiality Law by our program is a crime. Suspected violations of thc Confidentiality Law may be reported to the United State Attorney in the district where the violation occurs.

Effective Date: This notice comes into effect on December 1, 2014.
Acknowledgement: I hereby acknowledge that I received a copy of this notice.

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

__ *Client refused to sign acknowledgement.*
__ *Client was unable to sign acknowledgement.*
__ *Client left facility before the end of the assessment and is not entering treatment.*

☑ or I acknowledge electronically

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Consent for Intensive Outpatient Treatment

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, _____, consent that I will participate in a substance abuse and mental health evaluation and/or treatment from the staff of Treefrog Adolescent and Family Counseling. As a condition of that treatment, I acknowledge the following items and agree to them. I understand the following:

Please initial each item.

The Program:

The outpatient treatment program I am agreeing to participate in is based on The Matrix Model for Teens and Young Adults. The program counselors believe that the treatment strategies employed provide a useful intervention for substance use disorders. No specific outcome can be guaranteed.

____a. Treatment consists of one individual session and two group sessions a week. You may change counselors any time after discussing with staff.

____b. Program Hours: 5:30-7:30 Tuesday & 5:30-7:30 Thursday

____c. Be on time. Doors lock at 5:45 until the end of group.

____d. If I relapse, I will attend Relapse Analysis group from 5:30-7pm on Wednesdays. I will discuss any alcohol or other drug use with the staff and group while in treatment.

____e. I will keep track of my absences, clean days, and relapses using the Accountability Calendar.

____f. Group appointments cannot be rescheduled, and attendance at them is extremely important. Absence notifications will be sent to probation officers daily and monthly, if appropriate for Client.

____g. MAT: Individuals participating in medication assistance programs such as suboxone and methadone, or active cannabis card holders must provide documentation.

____h. Individuals who appear intoxicated or beyond their therapeutic dose will be pulled from group and sent home. Credit for that day's group will not be given. This is to ensure the integrity of group is maintained and for the safety of other group members.

____i. Staff: Services are provided by, licensed counselors, licensed social workers, substance abuse, marriage and family counselors, master's-level counselors-in-training, or other certified addiction staff people. All non-independent licensed counselors are supervised by Independent licensed counselors trained in the mental health counseling and treatment of addictions.

____j. I consent to receiving appointment reminders and other healthcare communications /information by email and/or text from Perfectly Imperfect personnel and staff. I understand that: Protected health information may be disclosed or used for treatment, payment, health care operations and probation reporting obligations.

☑ or I acknowledge electronically

____k. Confidentiality: All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside the program staff without the written permission of the client or the client's family. The only exceptions are when disclosures are required or permitted by law. Those situations typically involve substantial risk of physical harm to oneself or to others or suspected abuse of children or the elderly.

____l. Accomplishing treatment goals requires the cooperation and active participation of clients and their families. Very rarely, lack of cooperation by a client may interfere substantially with the program's ability to render services effectively to the client or to others. Under such circumstances, the program may refer the client to higher treatment outside the agency.

Rules of Participation:

Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violations of these rules can result in treatment termination. I agree to the following (please initial):

____a. It is necessary to arrive on time for therapy appointments. Please give 24 hours' notice of cancellation to avoid insurance charges to you.

____b. Upon each visit, I should be prepared to take a urine and/or breath alcohol test.

____c. Conditions of treatment require abstinence from ALL alcohol and other drug use for the entire treatment program. If I am unable to make this commitment, I will discuss other treatment options with the program staff.

____d. I understand that graphic/glorifying stories of alcohol or other drug use will not be allowed.

____e. All matters discussed in group sessions and the identity of all group members is confidential.

____f. All treatment is voluntary. If I decide to terminate treatment, I will discuss this decision with the staff, and do my best to participate in a discharge session with my primary therapist.

____g. Emergency Treatment Release: In case of medical emergencies, I may be assisted through the 911 number.

____h. If I miss three groups in a row I will be required to provide a U.A.

____i. If I miss three groups in a row I will restart the program at 16 weeks.

____j. If I provide a positive U.A, relapse, or am consistently late to group I will be required to meet with a counselor 1:1 where new treatment recommendations will be made.

Reasons for Termination from Program

____a. Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients.

____b. Treatment will be terminated if I become involved romantically or sexually with other clients.

____c. Treatment will be terminated if I become violent with staff or other clients.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

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Treatment Agreement

Accomplishing treatment goals requires the cooperation and active participation of clients and their families. Very rarely, lack of cooperation by a client may interfere substantially with the program's ability to render services effectively to the client or to others. Under such circumstances, the program may discontinue services to the client.

I agree to attend the following program:

I certify that I agree to attend the Adolescent IOP program (Tu, Th 5:30-7:30 for 32 IOP groups). I have read, understand, and accept this Treatment Agreement and Consent. This agreement and consent covers the length of time I am involved in treatment activities at this facility.

I Understand treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

I agree to the following:

a) Arrive on time for all group and individual appointments.
b) Remain abstinent from all drug and alcohol use for the entire duration of the treatment program.
c) Explore lapses and relapses with my counselor and group and complete a Relapse Analysis Chart.
d) Submit to random urine and breath-alcohol tests.
e) Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients.
f) Graphic stories of drug or alcohol use will not be allowed.
g) Not to or attempt to become involved romantically or sexually with other clients or staff
h) Not to or attempt become involved in any business transactions with other clients or staff
i) No co-habitation or work with other clients.
j) Not to or attempt to fraternize with other clients or staff outside of group (this includes rides).
k) All matters discussed in group sessions and the identity of all group members is confidential.
l) All treatment is voluntary. If I decide to terminate treatment, I will discuss this decision with the staff, and do my best to participate in a discharge session with my primary therapist.
m) I will attend 3 AA/NA, mutual self-help group meetings, or outside support activities per week and document it on my accountability calendar.
n) Emergency Treatment Release In case of medical emergencies, I may be assisted through the 911 number.
o) I will notify the counselor in advance if I am going to miss a group or individual session.
p) If I miss three groups in a row I will be required to provide a U.A.
q) If I provide a positive U.A, relapse, or am consistently late to group I will be required to meet with a counselor 1:1 where new treatment recommendations will be made.

Individuals participating in medication assistance programs such as suboxone and methadone, or active cannabis card holders must provide documentation. Individuals who appear intoxicated and beyond their therapeutic dose will be pulled from group, scheduled for a 1 on 1 session, asked to leave group and seek alternative transportation if they have driven to group. Credit for that day's group will not be given. This is to ensure the integrity of group is maintained and for the safety of other group members.

I have read, understand, and accept this Treatment Agreement. This agreement covers the length of time I am involved in treatment activities at this facility.

Client Signature:_____Date: _____

Therapist Signature:_____ Date: _____
Counselor name and credentials

☑ or I acknowledge electronically

148 Quincy Dr. NE, Albuquerque, NM 87108 505-550-1306

YOGA CLASS and ACU-DETOX NADA PROTOCOL CONSENT FORM

YOGA CLASS

If at any time during the class, you feel discomfort or strain, gently come out of the posture. You may rest at any time during the class. It is important in yoga that you listen to your body and respect its limits on any given day.

ACU-DETOX

Treatment Description

Nada Protocol is a specialized form of acupuncture and is performed by placing five thin, sterile, single use needles in your ears. The needles are generally left in place for 35-45 min. Treatment time may need to be altered for clinical training purposes. State Licensed Acupuncturists, Licensed Auricular Detoxification Specialists (ADSes) and/or other persons are training to become Auricular Detoxification Specialists (ADS Trainees) administer the treatments.

Voluntary

I hereby voluntarily consent to be treated by acupuncture, and in particular the NADA Acu-Detox protocol. I understand I may be treated with needles and/or small seeds/beads taped to my ears.

I have not been guaranteed any success concerning the uses and effects of NADA treatment I understand I am free to discontinue treatment at any time.

I, the undersigned, understand that yoga and acupuncture are not substitutes for medical attention, examination, diagnosis, or treatment. I should consult a physician prior to beginning any activity program, including yoga. I recognize that it is my responsibility to notify my teacher of any serious illness or injury before every yoga class OR Acu- Detox Session. I will not perform any postures to the extent of strain or pain.

I accept that Perfectly imperfect, is liable for any injury, or damages, to person or property, resulting from the taking of the class, nor will I pursue legal action against Perfectly imperfect. Those under 18 years of age must have this form signed by a parent or guardian.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian Date

☑ or I acknowledge electronically

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GYM MEMBER WAIVER OF LIABILITY & RELEASE

Because physical exercise and exercise activity can be strenuous and subject to risk of serious injury, Perfectly Imperfect, LLC urges you to use caution before using any exercise equipment or participating in any exercise activity. You (each client, guest, and all participating family members) agree that if you engage in any physical exercise or activity or use any gym amenity on the premises, you do so entirely at your own risk. Any recommendation for changes in diet, including the use of food supplements, weight reduction and/or body building enhancement products are entirely your responsibility, and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and use of these facilities and premises and assume all risks of injury, illness, or death. We are also not responsible for any loss of your personal property.

This waiver and release of liability includes, without limitation, all injuries which may occur as a result of: 1) your use of all amenities and equipment in the facility and your participation in any activity, class, program, personal training or instruction;, 2) the sudden and unforeseen malfunctioning of any equipment; 3) our instruction, training, supervision, or dietary recommendations; 4) your slipping and/or falling while in the building, or on the premises, including adjacent sidewalks and parking areas; 5) contact with other participants; 6) the effects of the weather, including high heat and/or humidity; and all other such risks being known and appreciated by me. We hereby acknowledge my responsibility in communicating any physical and psychological concerns that might conflict with participation in activity. I/We acknowledge that I am physically fit and mentally capable of performing the physical activity I choose to participate in. After having read this waiver and knowing these facts, and in consideration of acceptance of my participation and Perfectly Imperfect LLC furnishing services to me, I agree, for myself and anyone entitled to act on my behalf, to HOLD HARMLESS, WAIVE AND RELEASE Perfectly Imperfect LLC its officers, agents, employees, organizers, representatives, and Instructors from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against the facility for personal injury or property damage. To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of the facility, its agents, and employees.

If any portion of this release from liability shall be deemed by a court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect, and the offending provision of provisions severed her from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

Participant's Name (Please Print): _____

Participant's Signature: _____ Date: _____

In case of emergency, contact: _____ Phone: _____

(Parent's signature if under 18 years of age)
I represent that I have legal capacity and authorize to act on behalf of the minor named herein.

Parent/Guardian Signature: _____ Date: _____

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Client Intake Safety/Risk Reduction/ Relapse Prevention

Please print name: _____

What are some thoughts, images, mood, situations, and behaviors that are warning signs that a crisis may be developing?

1.
2.
3.
4.

What are some things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activities)?

1.
2.
3.
4.

Who are people that provide healthy distractions?

1. Phone:
2. Phone:

What are social settings that provide a healthy distraction?

1.
2.

People whom I can ask for help?

1.
2.
3.
4.

Who are some professionals or agencies I can contact during a crisis?

1. The New Mexico Crisis and Access Line 1 855 NMCRISIS or 1 855 662-7474
2. Agora Crisis Center 505 277-3013
3. National Hope line 1800-442-HOPE or 1800 442 4673
4. National Domestic Violence 1 800 733 3645
5. My counselor
6. My sponsor

How can I make the environment safe?

1.
2.

What is the one thing that is most important to me and always worth living for is?

Client signature: _____ Date: _____

Counselor signature: _____ Date: _____

☐ or I acknowledge electronically

148 Quincy Dr. NE, Albuquerque, NM 87108 505-550-1306

Telehealth consent form

I _____ hereby consent to engaging in telemedicine with Perfectly Imperfect as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in the State of New Mexico.

I understand that I have the following rights with respect to telemedicine:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. 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 expectations 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. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable effo1is on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unautho1ized persons.
- I understand the conditions of telemedicine that would involve my treatment and the restrictions of telemedicine with aspects to the form of communication.

I have read the statements provided above and all of my questions have been answered to my satisfaction.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

☐ or I acknowledge electronically