Therapeutic Oasis

CLIENT INFORMATION

(Please Print)

Today's Date _____/_____/_____ **Therapist**_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Cell Phone No. ( ) May we leave message? Y N
Mailing/Billing Address (if different)	City	State	ZIP Code	Home Phone No. ( ) May we leave message? Y N

Occupation	Employer	Work Phone No. ( )

Who referred you to our office?

Email Address:	☐ Check here if you do NOT want to receive email reminders for upcoming appointments

PAYMENT INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

MEDICAL PROVIDERS

List your Primary Care Physician and any other doctors/therapists you are seeing:	Specialty	Phone No.
	Primary Care Physician	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Cell Phone No.	Work Phone No.

IMPORTANT MEDICAL INFORMATION

Please list all known allergies and any important medical information here:

851 Broken Sound Parkway NW, Suite 250
Boca Raton, FL 33487
P- 561-278-6033/ F- 561-278-6023

600 Heritage Drive, Suite 130
Jupiter, FL 33458
P- 561-766-1072/ F- 561-766-1097

Therapeutic Oasis

Client Name: _____ **Date:** _____

Please check any of the following that apply to you:

	Headaches		Difficulty Sleeping		Less energy than usual
	Palpitations		Hard to concentrate		More energy than usual
	Don't like weekends		Quick change of moods		Can't relax
	Problems with my breathing		Nervous/tense		Restless/can't sit still
	Marital stress		Hard to control anger or urges		Shaky/trembling
	Family problems		Feeling suicidal		Hard to trust anyone
	Relationship problems		Feeling worthless		Hard to control my thoughts
	Problems at work/school		Drawing away from people		Stomach or bowel problems
	Health problems		Lack of interest/enjoyment		Sweating
	Financial problems		Too many drugs		Lightheaded/dizzy
	Legal problems		Too much alcohol		Worry too much
	Sad/depressed		Feel negative about the future		Too many fears
	Loss of appetite		Hard to make friends		Feel guilty
	Loss of weight		Feeling lonely		Feeling angry/frustrated
	Gaining weight		Sexual problems		Nightmares
	Other (please describe):				

Medical History: Have you ever had or do you now have any of the following? (Check all that apply)

	Chronic Pain		Communicable disease		Stomach problems
	Back or neck problems		Headaches		Sexual problems
	Anemia		High blood pressure		Surgery
	Pneumonia		Asthma		Diabetes
	Tuberculosis		Arthritis		Night sweats
	Skin problems		Sexually transmitted disease		Weight loss/gain
	Auto or other accident		Cancer		Allergies
	Tachycardia (increased pulse rate)		HIV		Convulsions
	Withdrawal symptoms or blackouts		Miscarriage		Kidney trouble
	Heart problems		Hepatitis		Rheumatic fever
	Stroke		Parkinson's disease		
	Other (please describe):				

Please briefly describe any previous counseling, psychological, or psychiatrist services:

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Therapeutic Oasis

OFFICE POLICIES AND CONSENT FOR TREATMENT

Please read, initial each page, and sign at the end stating you read and understand the information contained in this document.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Therapeutic Oasis offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, registered dietitians, licensed clinical social workers, doctors of psychology, and interns. Effective therapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if you both agree that your Therapist can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Therapeutic Oasis is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

PROFESSIONAL CONSULTATION: If you are seeing multiple service providers at Therapeutic Oasis, those providers may consult with one another as needed about your care in order to provide the level of services necessary for your treatment.

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YOUR APPOINTMENT: Appointments are typically scheduled on a weekly basis and are approximately 45-60 minutes long. Nutrition Therapy sessions are typically 60 minutes for the initial session and 30-45 minutes thereafter. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist.

Please plan on arriving at least 5 minutes before your scheduled appointment time so that you can make payment and take care of any administrative items. Please turn your cell phone to silent mode and finish your phone calls before you enter the building. It should go without saying that weapons of any kind are not permitted on the premises. Furthermore, alcohol or drugs are not permitted, nor should you arrive to your appointment under the influence.

CANCELLATION POLICY: In fairness to both our clinical providers and other clients we kindly ask that should you need to cancel or reschedule your appointment, you do so no less than **48 business** hours before your scheduled appointment time (Friday by 12:00pm for Monday & Tuesday appointments). To cancel or reschedule your appointment, we ask that you call the front desk as soon as possible and inform the front desk. This will free your appointment time for another client. **If your appointment is missed or cancelled with less than 48 hours notice, we will charge your credit card on file for the full rate of the scheduled appointment. Please note that insurance will not cover missed appointments.**

GROUP THERAPY: A commitment is required for all Group Therapy. Groups must be is pre-purchased for a pre-determined number of consecutive weeks. Missed groups cannot be made up, nor can they be refunded.

CREDIT CARDS ON FILE: After the initial appointment, all clients must put a credit card on file to cover missed appointments, late cancels, and any phone sessions should they be required. It is your responsibility to inform the Front Desk staff should your credit card information change at any time during your treatment here. You may also authorize Therapeutic Oasis to use the credit card on file for regularly scheduled office visits or other services if you desire.

APPOINTMENT REMINDERS: Therapeutic Oasis sends email reminders to clients as a courtesy. It is your responsibility to keep your appointment whether or not you receive any reminder from us.

LATE APPOINTMENTS: If you are more than 15 minutes late, your appointment may be forfeited and a late cancel fee will be charged.

Please note that frequent cancellations, no-shows or late appointments will require pre-payment of future appointments.

PHONE CALLS: Occasionally, you may need to contact your therapist for a brief consultation or to ask a question about your treatment. Such phone calls will be returned as soon as practical during regular business hours. Phone calls lasting more than 10 minutes will be considered a phone appointment and will be billed at the regularly scheduled hourly fee. Most insurance companies (including Medicare) do not cover phone appointments.

REFERALS: Upon request we may suggest you seek treatment from a clinical professional outside of Therapeutic Oasis. Should we provide you with the name and number of another professional, it is merely a suggestion. We do not endorse or recommend these professionals nor do we receive any compensation for referring to them.

EMAIL & TEXT MESSAGES: Email and text messaging are not recommended as an effective method of communication between you and your therapist. It may take up to 72 hours for your therapist to respond to an email or text message. Furthermore, it is important to understand that in spite of your therapist's best efforts to maintain confidentiality, any email or text message may be intercepted by outside sources and therefore may not be completely confidential and cannot be guaranteed as such.

PAYMENT: Payment of fees, including any Medicare copayment, is expected at the time of each appointment. We request that payment be made before your session begins. Full payment for group therapy must be made before attending the first session. Refunds will not be issued for individual or group services.

INSURANCE BENEFITS: Therapeutic Oasis does not participate in any insurance plans. If you have out-of-network insurance benefits, Therapeutic Oasis will either submit claims on your behalf to your insurance company or provide you with a monthly Superbill that contains the necessary information to file a claim with your insurance company.

EMERGENCIES: At some point, you may encounter a situation that requires prompt attention. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. Otherwise, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: Therapeutic Oasis follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. Additionally, we may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name(s) Telephone Number

_____ _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of my Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this document. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Therapeutic Oasis will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____

CLIENT NAME – PLEASE PRINT

_____ _____

Signature – Client or Parent/Legal Guardian Date

_____ _____

Signature – Spouse/Partner/Parent Date

Therapeutic Oasis

INFORMED CONSENT ADDENDUM FOR TELEHEALTH

This is to be used in conjunction with, but does not replace, the Consent for Treatment that is required of all clients prior to starting therapy services.

What is Telehealth?

Telehealth includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing. Telehealth services may include psychological health care delivery, group therapy, nutrition therapy, consultation, coaching, and/or counseling. Telehealth will occur primarily through interactive audio, video, and telephone communications.

Therapeutic Oasis delivers Telehealth to individuals located within the State of Florida. It is the duty of the client to inform the Clinician if they are or will be located in another state within 48 hours of the scheduled appointment time.

The current laws that protect privacy and confidentiality also apply to Telehealth. No permanent video or voice recordings are kept from Telehealth sessions. Clients may not record or store videoconference sessions or face-to-face sessions. Additionally, all existing laws regarding client access to mental health information and copies of mental health records apply.

Telehealth may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate referral will be made.

Risks and Benefits

The main advantage of Telehealth is that it provides flexibly for continuity of care when in-person sessions cannot be conducted. Telehealth by videoconference allows for both verbal and non-verbal communication in a way that is similar but not identical to in-person communication.

Telehealth is not a universal substitute, nor the same as in-person psychological or nutrition counseling services. Some report that Telehealth services do not provide the same level of ease, comfort and connection, and may not seem as "complete" when discussing personal and private matters. Body language isn't as fully visible. Misunderstandings may occur more

Initial Here: _____

easily. These differences may impact the quality of the professional therapeutic relationship. Just as with in-person psychotherapy, the effectiveness of Telehealth services cannot be guaranteed. Discuss any concerns as they arise.

Scheduling

Telehealth groups and individual sessions are scheduled ahead of time. These appointments reserve time specifically for our Clients. Just as with in-person appointments and groups, clients are responsible for keeping and paying for all Telehealth appointments. Groups and appointments will start and end on time. In all Telehealth sessions, the Clinician will initiate the Telehealth session, unless other arrangements are made in advance. A window of 15 minutes will remain open after the start time of the scheduled session. Cancellations and missed Telehealth appointments are handled in the same way as in-person cancellations and missed groups/appointments. The Clinician cannot be responsible for the Client's inability to participate in sessions, including technological difficulties or disruptions.

Expectations of client during each session

1. Test the account connection before the scheduled appointment time.
2. Adjust lighting and seating to ensure a clear image of each party's face.
3. Dress and environment must be appropriate to an in-office visit.
4. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
5. Valid ID must be presented by the client during the initial consultation. In addition, a copy must be provided by the client for the medical file.
6. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session.
7. The client shall also provide a phone number where they can be reached in the event of service disruption.
8. For Group Therapy conducted via Telehealth, the same Guidelines for Group Participation apply.

Emergency protocol

Client is to provide the name and contact information for an additional person in case of emergency. In addition, in the event of a medical or mental health crisis event, the Clinician will contact the client's local emergency services. The contact information for the client's nearest hospital will be on record in the event an admission is necessary to address a client

emergency. The information provided will include the nature of the crisis and immediate needs of the client.

Security

No electronic transmission system is considered completely safe from intrusion. Therapeutic Oasis uses software with encryption to maximize your confidentiality, however, Interception of communication by third parties remains technically possible. Clients are responsible for information security on their own computer, laptop, tablet, or smartphone. Due to the complexities of electronic media and the internet, the risks of Telehealth include the potential for the release of private information, including audio, written materials and images which may be disrupted, distorted, interrupted or intercepted by unauthorized persons, despite your therapist's reasonable efforts. Consequently, Therapeutic Oasis cannot fully guarantee the security of Telehealth sessions.

Response to technical difficulties

Should technical difficulties cause session disruption, the Clinician will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

Payment

The cost of a Telehealth is the same as an in-person visit. Payment for Telehealth services is to be made prior to the time of service. See the Office Policies and Consent for Treatment for a more detailed discussion of session cost and payment.

Clients relying on insurance reimbursement are responsible for contacting their insurance company immediately and well in advance to ensure that Telehealth is covered by their policy. Telehealth must be coded differently for insurance billing purposes. Even when health insurance covers in-person services, health insurance may limit or deny coverage of Telehealth services. If your insurance does not cover Telehealth services, you will personally be responsible for full payment.

Initial Here: _____

Contact between sessions

Telephone contact can be made in between sessions for the purposes of scheduling or other needs. Videoconference technology is reserved for therapy sessions only. Please refer to the Office Policies and Consent for Treatment for costs and policies related to contact outside of scheduled sessions.

Consent For Treatment

I voluntarily agree to receive Telehealth assessment, care, treatment, or services and authorize Therapeutic Oasis to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Therapeutic Oasis at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Print Name of Client or Legal Representative Relationship to client

_____ _____

Signature of Client or Legal Representative Date

Email Address to send link for Telehealth Appointment:

_____

Physical Address from which I will be communicating privately for Telehealth Sessions:

_____ _____ _____

Street Address State Zip

Please notify your Health Care Provider if you will be receiving Telehealth at a different location.

Therapeutic Oasis

NOTICE OF PRIVACY PRACTICES

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

Therapeutic Oasis of the Palm Beaches and Therapeutic Oasis of the Treasure Coast cooperate with each other under an Organized Health Care Arrangement (OHCA). An OHCA is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more Covered Entities who participate in joint activities to share the PHI about their patients in order to manage and benefit their joint operations. We will share information with each other as necessary for treatment, payment and health care operations.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a

written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Breach Notification. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself

Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to: Privacy Officer, at 851 Broken Sound Parkway NW, Suite 250, Boca Raton, FL 33487 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257.
We will not retaliate against you for filing a complaint.

The effective date of this Notice is March 24,2021.

Receipt and Acknowledgment of Notice of Privacy Practices

Client Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Therapeutic Oasis' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at the address or phone listed in that document.

_____ _____

Signature
Client, Parent, Guardian or Personal Representative*

Date

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

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Therapeutic Oasis

CREDIT CARD ON FILE AUTHORIZATION AGREEMENT

For Client: _____ **Date:** _____

I authorize *Therapeutic Oasis* to hold the credit card information listed below "on file" for the purposes listed in this agreement. *Therapeutic Oasis* may not use this card for any other purpose unless instructed to do so in writing.

I, the cardholder named below, authorize *Therapeutic Oasis* to charge the designated credit card for the purpose(s) listed below. I understand that if a scheduled appointment is missed or cancelled less than 48 business hours in advance, I will be charged the full fee for the scheduled appointment. This agreement may be rescinded at any time, however appointments falling within the 48-hour cancellation period may be charged if a replacement card has not been provided.

- ☑ Regularly scheduled office visits
- ☑ Phone sessions with Therapeutic Oasis Staff
- ☑ Appointments missed or cancelled with less than 48 business hours notice
- ☑ Group therapy sessions at Therapeutic Oasis
- ☑ Books and services from Sacred Treehouse

Print name exactly as it appears on credit card:

_____

Card Number: _____ - _____ - _____ - _____

Security code: _____ Expiration Date: ____ /_____

Address where CC bill is mailed:

_____ _____ _____ _____

Street *City* *State* *Zip*

This agreement is valid until _____ or until the expiration date listed above. I agree to inform Therapeutic Oasis within 14 business days should my credit card information change during this time.

I agree to the terms and conditions of this agreement:

_____ _____

Signature of Cardholder *Date*

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