Waiver of Medical Consultation

I understand that under the provisions of KSA 65-6319 (b) and KSA 65-6404 (3)(4), my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental health illness/disorder. In the event that I do not have a primary care physician, I acknowledge that my therapist has recommended that I seek medical consultation.

☐ -- I hereby have read and understand the section entitled "**Waiver of Medical Consultation**", I have had the opportunity to discuss this section with my therapist and I am satisfied my questions have been answered to the best extent possible. I have provided my therapist with a release of information signed by me for my primary care physician and/ or prescribing medical professional.

OR

☐ -- I hereby have read and understand the section entitled "**Waiver of Medical Consultation**", I have had the opportunity to discuss this section with my therapist and I am satisfied my questions have been answered to the best extent possible. **After reviewing my options, I hereby waive my right to such consultation** and that I am aware that this waiver will be part of my clinical record.

______________________________ ________________
Client's signature Date

______________________________ ________________
Parent/guardian of minor OR of legally disabled recipient Date

______________________________ ________________
Therapist's signature Date

Consent & Statement of Understanding: Audio/Visual Sessions (A.K.A TeleTherapy/TeleHealth)

Client Information
Name ____ Date of Birth_________________

I hereby authorize Willow Tree Wellness, LLC and its associates to use Doxy.me as a means for psychotherapy. Doxy.me is a HIPAA compliant platform for telecommunication. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.
I understand that I may revoke this authorization at any time by giving written notice, except to the extent Willow Tree Wellness, LLC has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

____ __________________________
Client's signature (age 12 and older) Date

____ __________________________
Parent/guardian of minor OR of legally disabled recipient Date

____ __________________________
Therapist's signature Date

Willow Tree Wellness, LLC
7348 W 21st St N STE 107
Wichita, KS 67205
P: (316) 779-2560
F: (316) 854-2303
www.willowtreewichita.com

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION.

I, ______________________________, whose Date of Birth is ___________, authorize Willow Tree Wellness, LLC to disclose to and/or obtain from:

____
____
____
[Insert Name of Person or Title of Person or Organization and contact information]

the following information:

Description of Information to be Disclosed (Patient/Client should check mark each item to be disclosed)

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Medication Management Information
- ☐ Presence/Participation in Treatment
- ☐ Nursing/Medical Information
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Demographic Information
- ☐ Other_______________________
- ☐ Other_______________________
- ☐ Other_______________________

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

____.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my therapist or Willow Tree Wellness, LLC. I understand that I will be asked to sign a statement confirming my wish to revoke this release and disclosure. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: ________________or as otherwise indicated:____.

Conditions: I further understand that Willow Tree Wellness, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ____

____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is stricter than HIPAA and provides additional privacy protections.

You can request a copy of this authorization at anytime.

____

Signature of Patient/Client Date

____

Signature of Parent, Guardian or Personal Representative Date

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

_____Check here if patient/client refuses to sign authorization

____

Signature of Therapist Date

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure. This authorization is hereby revoked starting on ___/____/______.

____

Signature of Patient/Client, Parent, Guardian or Personal Representative Date

Informed Consent Form for Therapy Outside the Office

___I give consent to receive therapy services outside of the office setting, a service offered through Willow Tree Wellness, LLC. Services rendered outside the office include walk and talk therapy and/ or Exposure and Response Prevention (ERP). I recognize that complete confidentiality cannot be maintained in this venue, and I accept the possibility that other people may hear parts of my conversation. I recognize that this form of therapy may involve strenuous physical activity including, but not limited to, cardiovascular activity. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this form of therapy. I acknowledge that my enrollment and subsequent participation is purely voluntary and in no way required by Willow Tree Wellness, LLC.

______ In consideration of my participation in this form of therapy, I hereby release Willow Tree Wellness, LLC from any claims, demands, and/or causes of action as a result of my voluntary participation and enrollment.

______I understand that I will not be forced to face any feared stimuli without agreeing to it. *

______I understand that the therapist will provide the rationale for the treatment itself and for each exposure in general.

______It has been explained to me that sometimes exposure therapy can require more time than the typical 50-minute session. Exposure sessions that occur outside the office will be billed at the same rate as treatment that is provided in the office. Some insurances do not cover therapy outside of the office, in which case I owe the full fee of $165 per hour session. *

______It has been explained to me that there are risks associated with ERP, including increased anxiety, fear, negative thoughts, and feelings (symptoms may initially worsen.) *

______It has been explained to me that there are no absolute guarantees in Exposure and Response Prevention. *

______I can choose not to participate in this therapy, now or at any time in the future. I can revoke my consent to this type of therapy at any time.

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

____

Client signature Date

____

Guardian signature Date

____

Therapist's signature Date

* For Exposure and Response Prevention(ERP) only (not walk and talk therapy)

CREDIT CARD ON FILE

Payments are due at the time of service. Willow Tree Wellness, LLC recommends a credit, debit, or flex spending/HSA card on file. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (the credit card on file will be charged our $50.00 on the day of scheduled session for no-show and late cancellations - See pg. 3). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

<table>
<tr><td colspan="3">Client Name:</td></tr>
<tr><td colspan="3">Cardholder Name:</td></tr>
<tr><td colspan="3">Credit Card Number:</td></tr>
<tr><td>Expiration Date:</td><td>Billing Zip Code of Credit Card:</td><td>Security Code:</td></tr>
<tr><td colspan="2">Cardholder’s Signature:</td><td>Date:</td></tr>
</table>

I understand that by signing above, I am authorizing Willow Tree Wellness, LLC to charge my card in the manner indicated by my initials above. These balances may include copays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.