Soultenders INC.
41 East Foothill Blvd. #102
Arcadia, CA 91006

For Admin Use Only: Patient Name: _____ Date of Birth: _____

Life History Questionnaire - Adult

(All provided information is held in strict confidence)

Date _____ SSN _____ - _____ - _____ Health Insurance Provider _____

First Name _____ MI ____ Last Name _____ Maiden _____

Age _____ Date of Birth _____

Gender Identity ☐ Male ☐ Female ☐ Transmale/Female to Male ☐ Transfemale/Male to Female ☐ Non-binary ☐ Other _____

Home Address	City	State	Zip

Home Phone	☐ May We Leave a Message?	Cell Phone	☐ May We Leave a Message?
Email Address	☐ May We Leave a Message?	Education Level	

Employer Name	Work Phone	☐ May We Leave a Message?

Work Address	City	State	Zip

Ethnicity

☐ Caucasian ☐ Asian ☐ Hispanic/Latino
☐ American Indian/ Alaskan Native ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander
☐ Other _____

Relationship Status

☐ Single ☐ Engaged ☐ Married
☐ Separated ☐ Divorced ☐ Widowed
☐ Other _____

Please indicate how you were referred to Soultenders

☐ Friend ☐ Other Therapist ☐ Healthcare Provider ☐ Ads/Media ☐ Other _____

Name of Referral Source(s) _____

Please select and complete the questions to which you respond "yes"

☐ Have you previously been involved in counseling?
Therapist Name _____ Date _____
Reason _____
Outcome _____

☐ Were you ever hospitalized for mental health reasons?
Hospital Name _____ Date _____
Reason _____
Outcome _____

☐ Are you currently taking allergy medication?
What _____
Amount/How Long _____

☐ Are you currently taking prescription medications?
What _____
Amount/How Long _____
Prescribing MD _____

☐ Do you currently use alcohol or non-prescription drugs?
What _____
Amount/How Long _____

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☐ Is there a history of mental health problems in your family?
☐ Have you ever been in legal trouble?
☐ Have you ever been physically abused?
☐ Have you ever been sexually abused or assaulted?
☐ Have you ever been emotionally abused?
☐ Is there a family history of alcohol/drug problems?
☐ Are your concerns interfering with your daily life?
☐ Have you ever attempted suicide?

Briefly explain your need for counseling now:

How long has this situation/issue persisted?	Under what condition do you feel worse? better?

Please use the following scale to answer the next three questions:

		1 Not at all	2 Mild	3 Moderate	4 High
1.	How serious do you consider your present concern(s)?	☐	☐	☐	☐
2.	How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3.	How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History

Mother's Age ___ If deceased, your age when she died? ___ Father's Age ___ If deceased, your age when he died? ____

If your parents are separated, how old were you when they separated? _____

Number of siblings _____

Name: _____ Age _____ Name: _____ Age _____
Name: _____ Age _____ Name: _____ Age _____
Name: _____ Age _____ Name: _____ Age _____
Name: _____ Age _____ Name: _____ Age _____

Name of Spouse/Significant Other: _____ Years Together: _____

Age _____	Date of Birth _____	Gender:	☐	Male	☐	Female

Education Level	Occupation

Previous Marriages: _____ Name of Previous Spouse: _____ Years Married _____

Nature of Relationship (i.e. friendly, distant, physical/emotional abuse, loving, hostile:

_____

_____

_____

Number of Children _____ What are their ages? _____ _____ _____ _____ _____ _____

Names: _____

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Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest
- ☐

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring Yourself
- ☐ Compulsivity
- ☐ Career/Major Decisions
- ☐ Acting Out Sexually
- ☐ Acting Out Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Nightmares
- ☐ Body Image Issues
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness in Chest
- ☐ Dizziness or Light-Headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heartbeat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you?

Emergency Contact Information

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____City: _____ State: _____ ZIP: _____

Primary Care Physician Information

Name of Physician: _____ Phone: _____

Address: _____City: _____ State: _____ ZIP: _____

Signature

_____ _____

Signature Date

Soultenders INC.
41 East Foothill Blvd. #102
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RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize my Soultenders provider and/or **SOULTENDERS, Inc.**, a practice management company, to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to my Soultenders provider and/or **SOULTENDERS, Inc.**, a practice management company.

I (we) understand that access to this information is limited to determining insurance benefits and is accessible only to persons whose employment responsibilities involve the determination of payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice. Additionally, this consent expires after one year from the date of signing this form. I (we) are informed about the information that is provided, its purpose, and who receives it.

I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/____

Person(s) receiving services: _____ Date: ____/____/_____

Person(s) receiving services: _____ Date: ____/____/_____

Soultenders INC.
41 East Foothill Blvd. #102
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NOTICE OF PRIVACY PRACTICES
YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Please know that this notice is a summary only, and that applicable law places requirements on us, and limiters/expanders on the issues discussed in this notice (including our uses/disclosures), that may not be obvious. For example, HIPAA's definitions of "marketing" and "sales" and "breach" and "healthcare operations", and the related restrictions, are technical, include exceptions, and do not apply to all situations you may personally consider to be within those definitions. So, for instance, if HIPAA allows, we may use/disclose your information for healthcare operations purposes that you may personally believe to be marketing or sales, without your authorization being necessary. This notice is not intended to be more restrictive than applicable law, unless explicitly noted.

Your Rights

With your health information, you have certain rights. This section generally explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request. We'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (e.g., home or office phone) or send mail to a different address.
- We say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We do not have to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires/allows us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, we'll follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you cannot tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we use or share your health information? We typically use or share your health information in the following ways:

Treat you. We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues. We can share health information about you for certain situations such as: (i) preventing disease; (ii) helping with product recalls; (iii) reporting adverse reactions to medications; (iv) reporting suspected abuse, neglect, or domestic violence; or (v) preventing or reducing a serious threat to health or safety

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ/tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: (i) for workers' compensation claims; (ii) for law enforcement purposes or with a law enforcement official; (iii) with health oversight agencies for activities authorized by law; or (iv) for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena (only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested).

Other Ways We Can Use/Disclose Information. Applicable law allows for additional uses and disclosures which are not all enumerated and explained above, and we will use/disclose information in any manner allowed by applicable law, including, without limitation, uses and disclosures: made at your request; for appointment reminders; to recommend treatment alternatives and healthcare related products and services; limited data sets in certain circumstances; to avert a serious threat to health or safety; for certain public health and safety issues; to third party business associates who assist us; to coroners, medical examiners, and funeral directors if death occurs; to aggregate data and de-identify data (at which point it is not subject to HIPAA); sharing within an Organized Healthcare Arrangement we may participate in, within accountable care organizations, regional health information organizations, blue button project, or other health information exchanges (in these situations, there may be an "opt-out" right or other rights you may have); and uses and disclosures that are incidental to other permitted uses and disclosures.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Nondiscrimination

Soultenders, Inc., complies with applicable Federal civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, sex, or other legally enumerated protected classes. We, as necessary, provide free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), language services to people whose primary language is not English (*e.g.*, qualified interpreters, information written in other languages). If you need these services, contact **Virginia Arias**. If you believe that Soultenders, Inc., A Private Practice Management Company has failed to provide these services or discriminated in another way on the basis of a protected class, you can file a grievance with: **Virginia Arias, 41 E. Foothill Blvd., Suite 102, Arcadia, CA 91006, 626.701.4249, Fax: 626.737.6034, Virginia@soultenders.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a

grievance, Virginia Arias is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically via the Office for Civil Rights Complaint Portal, https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at the following: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Changes to the Terms of this Notice

We can change this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other

- We are advising you in this notice that, if you email or text us health information, or request that we provide you with information in these or similar mediums, that these are unsecure mediums for transmitting information and that there is some risk to using these mediums. Information transmitted is more likely to be intercepted by unauthorized third parties than more secure transmission channels. If you want to communicate with us in these mediums, you are accepting the risks we notified you of, and you agree that we are not responsible for unauthorized access of medical information while it is in transmission to you based on your request or after information is delivered.
- Besides potentially applicable Federal HIPAA law, there are other federal or state health information privacy laws. In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. Laws may, for instance, occasionally require your specific written permission prior to disclosures of certain sensitive information (such as mental health, psychotherapy, genetic testing, drug/alcohol/substance abuse, pregnancy, or HIV/AIDS/ARC information) in circumstances that the HIPAA regulations would permit disclosure without your permission. We comply with all applicable laws that apply stricter nondisclosure or other requirements. or other types of highly sensitive/protected information. E.g., with regard to mental health records, Soultenders complies with Lanterman-Petris-Short Act, to the extent applicable. Please note, that psychotherapy notes are narrowly defined under HIPAA and don't include all mental health records.
- This notice applies to any entity/member of an organized healthcare arrangement in which we might participate, including, without limitation, our affiliated entities, practices that we manage, psychologists, and therapists.

4849-1537-8105, v. 1

Soultenders INC.
41 East Foothill Blvd. #102
Arcadia, CA 91006

For Admin Use Only: Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Soultenders, Inc. ("**Soultenders**"). Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at: www.soultenders.com; or contacting our organization at: **Virginia Arias, Privacy Officer, 41 E. Foothill Blvd., Suite 102, Arcadia, CA 91006, 626.701.4249**.

If you have questions about our Notice of Privacy Practices, contact **Virginia Arias, Privacy Officer Contact, 41 E. Foothill Blvd. Suite 102, Arcadia, CA 91006, 626.701.4249**.

I acknowledge receipt of Soultenders' Notice of Privacy Practices:

Date: _____ **Signature**: _____

(patient/legal representative)

If signed by someone other than patient, indicate relationship:_____

Print name: _____

Signature:_____

(legal representative)

INABILITY TO OBTAIN ACKNOWLEDGMENT

(Note: Provider Completion Only)

If not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain acknowledgment and reasons why acknowledgment was not obtained.

Patient Name: _____

Reasons why the acknowledgment was not obtained:

- ☐ The patient refused to sign this acknowledgment even though the patient was asked to do so, and the patient was given the Notice of Privacy Practices.
- ☐ **Other**: _____

Date: _____ **Signature**: _____

(Office Personnel)

Print Name: _____

4813-6622-8921, v. 1

OFFICE POLICY AND PROCEDURES (OPP)

TREATMENT PHILOSOPHY: During the initial evaluation period, which can last for weeks, you and your therapist will clarify the nature of the problems for which you are seeking treatment. Your therapist will work with you to create a treatment plan to address your concerns. You can facilitate progress during therapy by maintaining motivation to change, complying with treatment recommendations, and communicating openly and honestly with your therapist. The length and frequency of sessions, as well as the duration of therapy, can vary significantly. Progress in therapy is an issue that can be discussed with your therapist at any time throughout the course of therapy.

Because success or satisfaction with treatment cannot be guaranteed, you are requested to inform your therapist if you do not feel satisfied with your progress. You and your therapist may then be able to work through the issues, modify treatment, or negotiate a new therapeutic contract. In some instances, this may involve your therapist making an appropriate referral or you or your therapist terminating therapy. You may choose to leave therapy at any time; however, leaving therapy is best accomplished in consultation with your therapist

WHAT TO EXPECT: There are benefits and risks in seeking individual, marital, or family therapy. Some of the potential benefits include, but are not limited to, developing your ability to handle or cope with life events and personal relationships and providing you with greater insight into your personal goals and values. In working to achieve these benefits, however, you may experience distressing thoughts and/or emotions. Risks of therapy include, but are not limited to, feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of hallucinations or dissociations; changes in perception or behavior; and changes in occupational, social, or personal relationships. In short, treatment may be emotionally painful. You must tell your therapist about **any** changes in your thoughts or feelings.

EMERGENCIES: If you feel that you might harm yourself or others physically, call 911 immediately, or go to your nearest police department or emergency room.

CONFIDENTIALITY: In general, information communicated between you and your therapist during therapy is confidential and protected by the psychotherapist-patient privilege. Although it is the policy of this agency to obtain written authorizations from patients before disclosing any patient information, there are certain mandated and permitted exceptions to confidentiality and privilege that require or allow certain information to be disclosed without your permission. For instance,

1. Your therapist is required by law to report certain incidents to governmental authorities, including law enforcement, that cause your therapist to reasonably suspect that child, elder, or dependent adult abuse has occurred.

2. Your therapist is allowed by law to contact third parties, including law enforcement, if you are deemed by your therapist to be dangerous to yourself or to others.

To safeguard your right to privacy and your ability to assert the psychotherapist-patient privilege, you should not discuss your therapy with a third party unless such party is necessary to further your therapy (for example, discussing your therapy with a parent or guardian who is assisting you in the process).

For therapy to be successful with minors, they must trust their therapists to keep certain information confidential, even from their parents. California law allows psychotherapists to withhold information from parents if they believe that disclosing it would harm their patient physically or emotionally or would harm the integrity of the professional relationship. Consequently, your child's therapist will likely not tell you everything that is occurring during therapy.

RECORDS: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress notes. These progress notes will contain enough information about your treatment to justify its' necessity, should such justification ever become an issue.

PROVIDERS: Counseling is provided by licensed clinical psychologists, licensed clinical social workers, and licensed marriage and family therapists. It is also provided by registered associate marriage and family therapists (also referred to as "associates" or "associates in training"), who are not yet licensed but who are in training to become licensed marriage and family therapists. Your therapist will clarify their licensure or registration status with you before beginning treatment. Associates in training are supervised weekly by licensed marriage and family therapists who have been licensed for at least two years and who take regular continuing education courses in supervision. If you have any further questions or concerns, contact your provider.

YOUR RIGHTS: Treatment is entirely voluntary, and you have the right to terminate treatment at any time. If for any reason your treatment has been ordered by a third party, you will be fully informed of this. In all cases, professional treatment never includes sexual contact with the treatment provider. We would ask that prior to terminating therapy you discuss any issues relating to the reason for your termination with your therapist and/or his or her supervisor.

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ELECTRONIC COMMUNICATIONS POLICY

EMAIL COMMUNICATIONS: We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email us about clinical matters because email is not a secure way of contacting us or an efficient way of communicating complex information. If you need to discuss a clinical matter with your provider, please feel free to call him or her to discuss it on the phone or wait so you can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

TEXT MESSAGING: Because text messaging is a very unsecure and impersonal mode of communication, providers do not text message to nor do respond to text messages from anyone in treatment. So, please do not text message providers unless other arrangements have been made or you are using a texting application specifically recommended by your provider or SOULTENDERS, INC., a practice management company.

SOCIAL MEDIA: We do not communicate with, or contact, any of our clients through social media platforms like Twitter or Facebook. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

CONSENT FOR TREATMENT/ACCEPTANCE OF POLICIES

Your provider has attempted to answer your questions about treatment satisfactorily. If you have further questions or concerns, your provider will do his or her best to answer them or find answers for you.

Your signature represents a statement that you have read and understood the information above (and as outlined by your provider), have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this office, agree to comply with fees and policies, and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

Print patient name: _____

Signature of patient: _____ Date: ___/_____/_____

Signature of guardian(s): _____ Date: _____/_____/_____

Signature of guardian(s): _____ Date: _____/_____/_____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

SOULTENDERS, Inc., a practice management company, and all Soultenders providers are committed to providing caring and professional mental health care to our clients. As part of the delivery of mental health services, we have established a financial policy that provides and clarifies payment policies and options for clients, as determined by the management of **Soultenders, Inc.**, a practice management company.

PROFESSIONAL FEES: The hourly fee is $_____. In addition to weekly appointments, this amount is charged for other professional services you may need. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized to attend on your behalf, preparation of records or treatment summaries, and the time spent performing any other service you may request of your provider and/or Soultenders, Inc., a practice management company. In addition, if you become involved in legal proceedings that require your provider's participation, you are expected to pay for the provider's professional time even in cases where the provider is called to testify by another party. [Because of the difficulty of legal involvement, the charge is $_____ per hour for preparation and attendance at any legal proceeding.]

CANCELLATIONS/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. **A fee of $_____ is charged for missed appointments or cancellations with less than 24-hour notice**. Frequent cancellations may result in termination of treatment; your compliance in keeping appointments and active participation in the treatment process are vital.

BILLING AND PAYMENTS: You are expected to pay for each session at the time it is held, unless you and your provider agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services are agreed to when they are requested.

If your account is not paid for more than 60 days and arrangements for payment have not been agreed upon, **SOULTENDERS, Inc**., a practice management company, has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, the costs are included in the claim.] In most collection situations, the only information **SOULTENDERS, Inc**., a practice management company, releases regarding patient treatment is the patient's name, that services were provided, and the amount due.

INSURANCE REIMBURSEMENT: For your provider to set realistic treatment goals and priorities, it is important that you evaluate the resources you have available to pay for your treatment. If you have a health insurance policy, it usually provides some coverage for mental health treatment.

Your provider and/or **SOULTENDERS, Inc**., a practice management company, may provide you with assistance (filling out forms, etc.) to help you receive the benefits of your insurance; however, you (not your insurance company) are personally responsible for full payment of all fees. Consequently, it is very important for you to understand exactly what mental health services your insurance policy covers and keep up to date with your insurance coverage and any changes made to your policy. It is your responsibility to inform your provider and/or **SOULTENDERS, Inc**., a practice management company, when changes to your mental health benefits occur.

You should carefully read any and all information provided by your insurance carrier that describes mental health services. If you have questions about your mental health coverage, call your insurance plan administrator directly. While Your provider and/or **SOULTENDERS, Inc**. a practice management company, can provide you with useful information based on our own experience and help you in understanding the information you receive from your insurance company. Depending on the situation at hand, and if it is deemed necessary and helpful to clear confusion, your provider and/or **SOULTENDERS, Inc**., a practice management company, may be willing to call the insurance company on your behalf. However, please keep in mind that our professional fees outlined in the section above may apply (i.e., any conversations we have with your insurance company are billed as a professional service after fifteen minutes).

As a service to you, your provider and/or **SOULTENDERS, INC**. a practice management company, submits bills to insurance companies and other third-party payers, but cannot guarantee payment, your benefits, or the amount covered, and is not responsible for the collection of such payments. In some cases, insurance companies and other third-party payers may determine that services are not reasonable or necessary or may determine that services are not covered. In such cases, the person responsible for payment of the account is responsible for payment in full for these services. Charges for services are based upon the usual and customary rates for the local service area. Clients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payment for the child at the time of service.

Payments, co-payments, and deductible amounts are due at the time of service. Balances remaining for more than one month assess a $25 late fee. Payment methods include check, cash, or the following charge cards: Visa or Mastercard. There is a $25 fee for returned item checks

Soultenders INC.
41 East Foothill Blvd. #102
Arcadia, CA 91006

For Admin Use Only: Patient Name: _____ Date of Birth: _____

CLIENTS USING INSURANCE AS PAYMENT FOR SERVICES, PLEASE COMPLETE THE FOLLOWING:

Name of insured: _____ Birthdate:_____ SS#: _____ - ____ - _____

Employer of insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: ( ) _____ — _____ Work phone: ( ) _____ —_____

Relationship to patient: _____

Primary insurance name: _____

Insurance phone: ( ) _____ — _____ Identification #: _____

Group #_____ Authorization number: _____

IF SECONDARY (ADDITIONAL) INSURANCE EXISTS, PLEASE COMPLETE THE FOLLOWING:

Name of insured: _____ Birthdate:_____ SS#: _____ - ____ - _____

Employer of insured: _____

Address: _____

City:_____ State: _____ Zip: _____

Home phone: ( ) _____ — _____ Work phone: ( ) _____ — _____

Relationship to patient: _____

Secondary insurance name:_____

Insurance phone: ( ) _____ — _____ Identification #: _____

Group # _____ Authorization number: _____

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature of Person Responsible for Account: _____ Date: _____/____/____