Face Sheet/Electronic Communication Consent (Adult)					
Client Name:		Age:		DOB:	
Address:					
Sex Assigned at Birth:					
Email:					
Phone Number:					
Gender Identification:					
Preferred Pronouns:					
Sexual Orientation:					
Ethnicity:					
Insurance Name/ID:					
Co-Pay Amount:					
Emergency Contact			Phone Number:		

*Please note that emergency will be contact in the event of a true emergency. Medical record and/or information will not be released to this contact unless a release of information has been completed.

Empower Mental Health requires your consent to communicate your confidential information through electronic means (i.e., telephone, text, email, etc.). As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Empower Mental Health, or it's providers, shall not have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information by Empower Mental Health to me. I agree that Empower Mental Health may communicate with me electronically unless and until I revoke this authorization by submitting notice to Empower Mental Health in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I authorize Empower Mental Health, LLC to communicate confidential information to me by the means indicated above and understand that Empower Mental Health, LLC is not responsible for any re-disclosure based upon the consent provided. Please check all approved methods of electronic communication:

☐ Phone ☐ Text ☐ Email

PROFESSIONAL CREDENTIALS

I understand clinical staff at Empower Mental Health, LLC is comprised of Licensed and Intern Clinical Social Workers, contracted licensed Psychologists, and Marriage & Family Therapist Interns and Licensed, and Clinical Professional Counselor Interns and Master-level students in their practicum stage of learning. I understand *ALL* clinicians adhere to their respected professional ethical standards. Additionally, they maintain confidentiality of the clients according to HIPAA and Empower Mental Health LLC policies and procedures.

COMPREHENSIVE SERVICES

I understand services may include, but are not limited to assessment, formulation of recommendations, treatment planning, psychotherapy, and referrals to community organization; and agree to services as determined necessary for care. I understand that the Provider may work with family members of the above-named person, including, but not limited to parents, stepparents, siblings, grandparents, or children of the above-named person. Empower Mental Health is also part of a team and collaborates with Empower providers for on-call Crisis Management. I understand, however, additional consent may be required for such participation.

SUPERVISION AND COLLABORATION:

I understand my case may be staffed verbally or documentation viewed by clinicians/professionals within the agency, or as under contract, for the purpose of supervision and/or collaboration for treatment planning. I understand video or audio tape recording may occur during therapy sessions with the Provider for use in supervision and treatment planning. If this is to occur, I will be notified prior to the session, and my consent will be obtained.

DOCUMENTATION AND RECORDS

I understand that the Provider may write assessments or other formal reports, progress notes, treatment plans, etc. for the purpose of treatment planning, coordination of care, authorization for payment of services, including for local and state agencies which may be involved in my care. I understand that I will need to sign an authorization for release of information form for records to be released to other parties including spouse, other agency providing services, etc. However, information may be released to insurance provider(s) to ensure authorization, continuity of care, etc. through this consent. I understand that Empower Mental Health has the direct responsibility for the care of my records and treatment. Should my provider not be available to me due to unforeseen circumstances, I authorize, upon my written request, for appropriate records to be provided to another provider/agency of my choosing.

MANDATED REPORTING

I understand that most information disclosed to the Provider is protected by federal and state regulations governing confidentiality and cannot be disclosed to others without my consent. However, as stated in Nevada State Regulations, there are legal exceptions in which my consent is not necessary to disclose information to others, including:

- In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services no later than 24 hours after the information is revealed. In cases of abuse or neglect of a person older than 60 or of a disabled person or legally incompetent person, a report must be made to local law enforcement agencies. In cases where a client is in imminent risk of harming self or others, or when a person with mental illness needs hospitalization, confidentiality may be suspended for the protection of self-and/or others and/or treatment of mental illness. In cases when a person appears to have been injured by a knife, firearm or burn, this information must be reported to local law enforcement or local fire department officials respectively.

- Confidentiality may also be suspended when a client's treatment is part of a legal claim or defense, or when required by federal or state laws; when information about a deceased person's mental health services is necessary for determining the validity of a will; when a person is court ordered for a psychological evaluation; and in situations where a client's case is investigated by the Board of Examiners as part of an investigation or hearing.

RISK MANAGEMENT

I understand there are risks associated with receiving mental health services. I understand that as I experience and confront issues, it may cause feelings of sadness, anxiousness, or other emotional pain. I understand the effort I put forth into treatment will determine positive change and that I am responsible for all lifestyle choices and changes that may occur. I understand the assigned provider is not available 24 hours a day/7 day a week, and that there are other options to receiving emergent care. If I, am feeling suicidal, homicidal, or otherwise needs immediate urgent care, one individual is to call 911 immediately and/or report to the nearest hospital emergency room.

APPOINTMENTS

I understand the scheduled appointment time is set-aside for me. Should I be late, I realize that the scheduled session will be shortened, or, if after 15 minutes will be considered a "no-show" and appointment will need to be rescheduled (even if I show after 15 minutes). I understand that if I miss multiple or excessive appointments as determined by the Provider, the case can be terminated and an appropriate referral to another provider will be made.

SERVICE FEES/Fee agreement FOR NON-MEDICAID CLIENTS

All payments/co-pays are required in full at time of service. If I have a deductible, I agree to pay the cash fee designated by my insurance company and pay my provider the full rate until the deductible is met. If requested, a HICFA will be provided after the first visit and once a month thereafter for your convenience to provide to your insurance company. Cash fees range from $65.00 to $200.00 per session. I understand that at my providers or Empower Mental Health's discretion, further appointments may not be allowed if my account is in arrears. I also understand that if my account is not paid in full within a reasonable period, a collection agency will be retained and that my credit score could be negatively impacted. I agree to pay all late fees, bounced check fees and collection costs, and if a suit is filed, attorney fees, interest, and courts costs. The credit card on file will automatically be charged for these fees.

- Missed Appointments: To ensure that we can accommodate all our clients and maintain our schedule efficiently, there is a $50.00 fee for all cancellations/no-shows (appointments missed without notice) made less than 24 hours before the appointment. This fee is charged directly to the card on file. Insurances do not pay these fees. We understand that unexpected situations can arise, and we encourage you to reach out as soon as possible if you need to adjust your appointment.
- Phone Calls: If it is necessary to provide crisis intervention by phone, calls with be billed at the rate of $20.00 per 15 minutes. PLEASE NOTE: Insurance companies do not pay for sessions conducted over the telephone.

- Special Requests: Special requests for letters to employers, attorneys, physicians, court, etc. will be billed at $50.00 per hour of preparation.

I understand that at my provider or Empower Mental Health's discretion, further appointments may not be allowed If my account is not paid in full within a reasonable period. I also understand that a collection agency will be retained and that my credit score could be negatively impacted. I agree to pay all fees associated with my account being arrears.

TELEHEALTH SESSIONS

Telehealth involves the delivery of mental health services through secure video or audio technology. During sessions, you and your provider will not be in the same physical location, but communication will occur in real time using HIPAA-compliant platforms. While telehealth can increase accessibility and convenience, it may limit the ability to observe non-verbal cues, and technical difficulties—such as poor internet connection—may impact the quality of services. Telehealth is not recommended during a crisis, emergency, or for individuals experiencing active suicidal or homicidal thoughts.

To protect your privacy and ensure the effectiveness of services, sessions should be conducted in a private, quiet, and distraction-free space within the state of Nevada. Clients are expected to dress appropriately, avoid multitasking (e.g., driving), and not allow others to be present without first discussing it with the clinician. For safety purposes, you may be asked to provide your physical location, emergency contact information, and details of the nearest hospital at the start of your telehealth services.

Clients are responsible for refraining from the use of substances that impair judgment prior to sessions, avoiding the presence of weapons, and not recording sessions without express permission. If at any time you feel unsafe or unable to continue, you are encouraged to notify your provider.

While Empower Mental Health uses encrypted platforms to protect your information, the use of electronic communication always carries some risk of unauthorized access. Clients are expected to take reasonable steps to ensure privacy on their end, such as using secure Wi-Fi and private devices.

You may choose to discontinue telehealth services at any time and request an in-person alternative when appropriate. If you have any questions or concerns, or if you would like a copy of this form, you may contact Empower Mental Health at admin@aspiremhnv.com.

ACKNOWLEDGEMENT AND CONSENT

I voluntarily agree to receive or allow (in the case of a minor which I have legal custody), mental health and/or substance abuse treatment (if applicable) assessment, care, treatment, or services and authorize the Provider and/or Empower Mental Health, LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services at any time. By signing this consent form, I acknowledge that I have both read and understood all the terms and information contained herein and have been provided ample opportunity to ask questions and seek clarification of anything unclear to me.

HIPAA Notice of Privacy Practices: Receipt and Acknowledgement of Notice

Your Information. Your Rights. Our Responsibilities.

This Notice explains how your protected health information (PHI) may be used and disclosed, and how you can access your information. We are required by law to protect your privacy under the Health Insurance Portability and Accountability Act (HIPAA).

You have the right to:

- Get a copy of your mental health record.
- Request corrections to your record.
- Ask us to limit what we share.
- Ask us to contact you confidentially (e.g., at a different address or phone number).
- Get a list of those with whom we've shared your information.
- File a complaint if you believe your privacy rights have been violated.
- How We May Use or Share Your Information

We may use or share your information:

- To provide mental health care and coordinate your treatment.
- For billing and payment purposes.
- To run our practice and improve services.
- When required by law (e.g., court orders, mandatory reporting of abuse or threats).
- To prevent serious harm to you or others.
- We will not share your information without your written permission, except as described above.

Our Responsibilities:

- We are legally required to protect your privacy.
- We will notify you if your information is compromised in a breach.
- We will not use or share your information for marketing or fundraising without your written permission.

HIPAA Acknowledgment of Receipt:
By signing below, I acknowledge that I have received and reviewed this Notice of Privacy Practices for Empower Mental Health, LLC. I understand my rights and how my health information may be used. I hereby acknowledge that I have received and have been given an opportunity to read a copy of Empower Mental Health's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my providers at Empower Mental Health, LLC.

"NO SURPRISES ACT" GOOD FAITH ESTIMATE	
Empower Mental Health, LLC	
2980 S. Rainbow Blvd. #200B Las Vegas, NV 89146	
P: 702-673-7462	
Provider Tax ID#: 463755490	NPI: *1912310368*

General Services (CPT Code):

- 90791: Psychiatric diagnostic evaluation
- 90834: Psychotherapy, 45 minutes with patient and/or family member
- 90837: Psychotherapy, 60 minutes with patient and/or family member
- 90839: Psychotherapy Crisis Session with patient and/or family member
- 90847: Family psychotherapy (conjoint therapy) (with patient present)
- 90846: Family psychotherapy (without the patient present)

You are entitled to receive this Good Faith Estimate of what the charges could be for psychotherapy services provided to you. While it is not possible for a therapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

Empower Mental Health anticipates your treatment will require [weekly/semi-monthly/monthly/quarterly] 50 -minute psychotherapy (in person or via telehealth) sessions throughout the next 12 months at $70-175 per session for a total of 52 weeks taking into consideration acuity of symptoms, progress/regression towards treatment goals and availability (reduce as appropriate for things like vacations, holidays, emergencies, sick time). Based on that fee, the following are expected charges for client's receives services from licensed providers (LCSW/MFT/CPC):

Number of Weeks	Total estimated charges: 1 session per week	Total estimated charges: 2 sessions per week
1 Week of Service	$100-175	$200-350
13 Weeks of Service (Approx. 3 months)	$1300-$2275	$2600- $4550
26 Weeks of Service (Approx. 6 months)	$2600-$4550	$5200-$9100
39 Weeks of Service (Approx. 9 months)	$3900-$6825	$7800-$13650
52 Weeks of Service (Approx. 12 Months)	$5200-$9100	$10,400-$18200

Based on that fee, the following are expected charges for client's receives services from clinical intern providers (CSW-Intern, CPC -Intern, and MFT-Intern):

Number of Weeks	Total estimated charges: 1 session per week	Total estimated charges: 2 sessions per week
1 Week of Service	$70-100	$140-200
13 Weeks of Service (Approx. 3 months)	$910-1300	$1820-2600
26 Weeks of Service (Approx. 6 months)	$180-2600	$3600-5200
39 Weeks of Service (Approx. 9 months)	$2730-3900	$5460-7800
52 Weeks of Service (Approx. 12 Months)	$3640-5200	$7280-10,400

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time. You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. There may be additional items or services recommended as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute resolution process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

Consent Form

By signing below, I acknowledge that I have received, reviewed, and understand all consent forms and informational documents provided by Empower Mental Health, LLC, including but not limited to:

- Electronic Communication Consent
- Informed Consent and Disclosures for Treatment
- HIPAA Notice of Privacy Practices
- Good Faith Estimate Disclosure

I understand the content of these forms, have had the opportunity to ask questions, and agree to abide by the terms and conditions stated therein. My signature below confirms my consent for Empower Mental Health, LLCand its providers to proceed with treatment and related services in accordance with these agreements.

Client Name	Date
Client Signature	Date

Credit Card Authorization Form

Empower Mental Health, LLCis offering a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible. This would include co-payments, co-insurance, and cash payment. Your credit card information will be kept confidential and secure, and payments to your card are processed by administration with 7-10 days of your session date.

I, _____, authorize Empower Mental Healthto capture my credit card information and to charge my credit card as payment for any balance, such as, payment for service, late cancellation/no show fees, and outstanding co-pay/deductible). Empower Mental Healthwill also provide me with a receipt as proof of payment.
I understand and agree that this form is valid until I give a 30-day written notice via email to cancel the authorization to Empower Mental Health, LCC (admin@aspiremhnv.com).

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Client Name:		
Card Holder's Name (as shown on card):		
Credit Card Number:		
Card Type:	□ Visa □ Master Card □ Discover □ American Express	
Expiration Date:		
CVV:		
Card Holder's Signature:		
Preferred Receipt Method:	□ Text:	□ Email:

Credit Card on File Billing Authorization FAQ

Q: What is a deductible?
A: A deductible is the annual amount you are responsible for paying out-of-pocket before your insurance begins covering eligible medical expenses. For example, if your plan has a $1,000 deductible, you must pay the first $1,000 of approved expenses before your insurance will begin to contribute. Your insurance company must receive and process a claim to apply any payments toward your deductible. Q: Is my credit card information secure?
A: Yes. Your credit card information is stored securely within our HIPAA-compliant Electronic Medical Record and Billing System and processed through an encrypted payment gateway.
Q: What if I have questions about my bill?
A: We are committed to working with you to resolve any billing concerns. If a billing error is identified, we will promptly issue a refund. We will only charge the amount indicated as your patient responsibility on the Explanation of Benefits (EOB) provided by your insurance carrier. Our Admin Department can be reached at 702-673-7462. If you disagree with how your insurance carrier processed a claim, please contact their customer service department directly.
Q: What if my co-pay changes?
A: Co-pays may vary based on the type of service provided (e.g., initial assessment, 45-minute session, 60-minute session). If your co-pay changes after we receive updated claim information from your insurance carrier, you will be notified, and an additional refund or charge will incur.

Treatment Plan Signature Form	
Client Name:	
Initial/Review Date:	

My signature below means that I have participated in the formulation of this treatment plan, understand, and approve of it, and accept the responsibility to carry out my part of the plan actively. I understand the need for services and each element of the treatment plan as presented. I understand this plan will be reviewed at least every 90 days or as requested if needs change. I understand I have a right to receive a copy of the plan and have been offered a copy of the plan. As the identified client, I acknowledge the right to choose my provider and agree to the current providers assigned.

(This is a strictly confidential patient medical record. This report reflects the patient's condition at the time of consultation or evaluation. It does not necessarily reflect the patient's diagnosis or condition at any subsequent time.)

Client Name _____ Date _____

Client Signature _____ Date _____

Signature of QMHP, License number

Date