Client's Information

Name: _____
(Last) (First) (Middle Initial)

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Work Phone: _____ Other/Cell: _____

Email _____

Date of Birth: _____ Sex: Female Male Social Security Number: _____

Employer & Occupation: _____

Other Household Members (names and ages): _____

_____

Emergency Contact (name, relationship, and phone number): _____

_____

How did you hear about our services? _____

Who referred you to us? _____ May we thank them? Yes No

Please fill out if client is a minor child.

Guardian's Work #: _____ Guardian's Cell: _____

School Name: _____ Grade: _____ City: _____

Parent/Guardians: _____ Parent's Legal Guardianship: _____
(Names and relationships) (Sole/ Joint Custody or Non-Custodial)

Parent/Guardian Date of Birth: _____ Parent/Guardian Social Security #: _____

Type of Service(s) Requested:

- ❑ Individual Psychotherapy
- ❑ Couples/Marital/Family Therapy
- ❑ Coaching/Yoga
- ❑ Group Therapy

Statement of Understanding

I, the undersigned, understand and accept professional services as provided by One Life Holistic Health. I understand that rights of privacy and confidentiality are respected and that the information provided is protected under federal and state laws, with the following exceptions: if there is expressed intent to harm self or others and in cases of abuse and neglect. I acknowledge that the policy manual which includes program descriptions, fees for services, and client's rights, including the right to terminate services at any time, has been made available to me. In addition, I have been provided with a copy of and understand policy regarding my health records (HIPPA). I understand and agree to the fees for service. And, I understand and agree to the fee of $45.00 for canceling an appointment less than 24 hours in advance and the fee of $55.00 for failing to appear for an appointment.

I also, hereby, authorize One Life Holistic Health to release the information necessary to process this claim and authorize payment of benefits to One Life Holistic Health.

Lastly, I give permission to contact my emergency contact listed in times of medical emergency.

_____ _____
(Client Signature and Date) (Guardian Signature and Date)

Medical Information

Primary Care Physician: _____ Phone Number: _____

Address: _____
(Street) (City) (State) (Zip Code)

Medical Information (list any illnesses, injuries, conditions): _____

_____

Medications (name and dosage): _____

Insurance Information

This section must be filled out by the insured

Primary: _____ Secondary: _____

Primary Policy Holder: _____ Primary Policy Holder: _____

PPH's DOB: _____ PPH's DOB: _____

PPH's PH/ADD: _____ PPH's PH/ADD: _____

Employer: _____ Employer: _____

Pol. #: _____ Pol. #: _____

Group/Plan Type: _____ Group or Plan Type: _____

Deductible: _____ Amt. Met: _____ Deductible: _____ Amt. Met: _____

Copay: _____ CoIns.: _____ Copay: _____ CoIns: _____

PLEASE VERIFY BY SIGNATURE THAT I HAVE READ, UNDERSTAND, AND AGREE WITH INFORMATION INCLUDED IN EACH OF THE FOLLOWING DOCUMENTS. MY SIGNATURE VERIFYS THAT I HAVE BEEN GIVEN OPPORTUNITY TO THESE DOCUMENTS BY THE FORMS PAGE OF WWW.ONELIFEHOLISTICHEALTH.COM, DOCUMENT BOOK IN OFFICE, OR HARD COPIES FOR MYSELF AT MY REQUEST.

1. I have been informed and/or have read the following documents FINANCIAL POLICY and ELECTRONIC COMMUNICATION POLICY of One Life Holistic Health and am aware that I may have a copy of this policy to take with me at my request.
   SIGNATURE_____
2. I have been given and/or have read the POLICIES AND PROCEDURES regarding my treatment/sessions with One Life Holistic Health, and consent to my treatment. I am aware that I may have a copy of this contract to take with me at my request.
   SIGNATURE_____
3. If I am a parent or legal guardian of the above minor child, I have been given and/or read the MINOR POLICY and consent to their treatment with One Life Holistic Health. I am aware that I may have a copy of this to take with me at my request.
   SIGNATURE_____

CONSENT TO TREATMENT

It is with full consent that I am entering into a professional relationship with One Life Holistic Health, Nina Wilson, PLMHP, CHLC, CFLE, RYT 200.

I am aware that Nina Wilson is a Provisionally Licensed Mental Health Practitioner, licensed through the Department of Health and Human Services of Nebraska; Certified Holistic Life Coach accredited by the National Exercise Sports Trainer Association; Certified Family Life Educator accredited by the National Council on Family Relations; and Yoga Alliance Certified 200 hr. She has told me about the scope of her practice and the educational experiences that support her skill base. She has noted that in her work, she may address brain health and overall wellbeing with psychotherapy combined (when indicated) with dietary and lifestyle recommendations. She informed me that she is not a Medical Nutrition Therapist, Nutritionist, or Medical Doctor in the State of Nebraska. She may also utilize yoga during any sessions as decided upon by the client and in such a way that does not exceed her scope of practice as a Certified Yoga Instructor.

She has informed me that the dietary education she may provide is not intended to "treat" or "cure" any disease, nor is it seen as a replacement for the care of a physician, psychiatrist, or other health care provider. She has advised me to speak to my physician before making any dietary changes including the introduction of any dietary supplements.

Please sign and print your name below to indicate that you have read the above statements and willingly agree to enter into a professional relationship with One Life Holistic Health, Nina Wilson, PLMHP, CHLC, CFLE, RYT 200.

Signature of Client(s) (or Legal Guardian):_____Date:_____

RELEASE AND WAIVER OF LIABILITY

In consideration of being able to participate in the services offered by [One Life Holistic Health] (the "Company") pursuant to the Service Agreement between me and the Company; executed as of the date hereof, I, for myself, my spouse, my personal representatives, assigns, heirs, and next of kin, hereby:

1. REPRESENT that I understand the nature of Counseling/Therapy (defined by the treatment of mental or psychological disorders by psychological means), Coaching (defined as guided planning for living differently in the future), Yoga (defined as guided body movements and breathing exercises), Ayurveda (defined as an ancient Indian way of healing through dieting and yogic breathing), and Weight Management (defined as personalized dieting and life planning) (the "Services"), represent that I am in good health and in proper physical condition to participate in one or more of the Services, and agree and warrant that if, at any time, I believe the conditions to be unsafe, I will immediately discontinue participation in all the Services;

2. ACKNOWLEDGE and UNDERSTAND that: (a) the Services involve inherent risks such as physical injury, allergic reactions, and such other reasonably foreseeable consequences of participating in such activities ("Risks"); (b) these Risks may be caused by factors including, but not limited to: my own actions or inactions, the condition in which the Services take place, or the negligence of the Company; and (c) there may be other risks and social and economic losses either not known to me or not readily foreseeable to me at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND RESPONSIBILITY FOR ANY LOSSES, COSTS, AND DAMAGES I incur as a result of my participation in the Services;

3. HEREBY WAIVE and RELEASE my ability to sue the Company, its agents, or its employees from any and all liability, claims, demands, action and causes of actions related to any loss, damage, or injury that may be sustained by me, or to any property belonging to me, while being a client of the Company, on the premises owned by the Company, or at any location where the Company's services are being provided, except to the extent caused by gross negligence or willful misconduct by the Company.

4. All parties ACKNOWLEDGE that the goal of COUNSELING/THERAPY is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions. Therefore it is understood by all parties that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind. Therefore, no party shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for ANY reason.

I HAVE READ THIS RELEASE AND FULLY UNDERSTAND ITS TERMS, FULLY UNDERSTAND THAT I AM GIVING UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HEREBY SIGN IT FREELY WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE AND WAIVER TO THE GREATEST EXTENT ALLOWED BY NEBRAKSKA LAW.

Signature of Client(s) (or Legal Guardian):_____Date:_____

Financial Policy

This statement is to inform you of One Life Holistic Health's financial policy. We are committed to providing you with the highest quality service. Our financial policy is intended to facilitate excellent service to you, while minimizing administrative costs.

All charges incurred are your responsibility regardless of your insurance coverage. I must emphasize that as your provider, our relationship is with you, the client, not with your insurance company. As a courtesy to you, we will help you process all your insurance claims. In order to do so, you must provide current and accurate insurance information.

Financial Agreement

I understand and agree:

- Nina Wilson, MS, PLMHP, CFLE, CHLC, RYT 200 performs services necessary for the well -being of clients regardless of insurance benefits.
- Co-pay, deductible, or self-pay fee is due at the time of service. It is ultimately my responsibility to know the copay and deductible prior to services. If help is needed in finding what these copays and deductibles are, Nina will help to try to find this information but cannot guarantee amounts.
- If there is a remaining balance upon payment by the insurance company, I will pay it in full at that time.
- I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay, I will be responsible for the full amount.
- A fee of **$2** is added to all credit/debit card transactions to cover fees.
- A late fee of **$10** will be added to overdue accounts each month.
- A **$35** fee will be added for any return or insufficient fund checks.
- Accounts over 90 days will be sent to a collection agency and will have additional fees.
- **One Life Holistic Health requires a 24-hour notice for cancellations.** When scheduling your appointment with the counselor, keep in mind that this is your agreement that the counselor will hold this time exclusively for you. Because this time is reserved by you, One Life Holistic Health will bill you **$55** for any appointments that is not kept and **$45** for appointments canceled or rescheduled less than 24 hours advance notice. I understand that insurance companies DO NOT get billed and will NOT pay for these fees. These will be paid by me, the client. Payment for late cancellation, fail to arrive, and return checks are due at the time of your next session.

If you have questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience.

Signature _____ Date: _____