# Welcome to the
# Branch of Life, Inc.
# Ministries
# Counseling, Life Coaching and Alternative Dispute Resolution

The Packet:

You will find enclosed an admissions packet with the following forms to be completed. The completion and signing of these forms will be a "Memorandum of Understanding" of services to be provided. These forms include:

- 1 Welcome Page
- 2 Welcome Page – Signature Page
- 3 Client Consent to Treat
- 4 Client Fee Accountability
- 5 Client Insurance Intake
- 6 Client Personal Information
- 7 Client Medical Information
- 8 Client Consent to Know
- 9 Memorandum of Understanding
- 10 Clients Notice Rights to Records
- 11 Client Notice How to File a Complaint
- 12 Client Notice No Surprise Act
- 13 Location and Contact Information

The Provider:

Your counselor/therapist will be the Rev. Billy W. Corn. Rev. Corn is the founder of the *Branch of Life Ministries* and holds multiple advanced educational degrees. In addition, Rev. Corn holds various board-certified specialty certifications & professional licenses to include;

- License Professional Counselor (LPC)

Disclaimer: *Please be advised that any reference to Reverend Corn as Doctor is in reference to his License to Minister and Doctor of Divinity Degrees in Biblical Studies and Pastoral Counseling; not an attempt to represent himself to be a Doctor of psychotherapy or relationship counseling as a Licensed Professional Counselor.*

The Procedure:

First you are asked to consider if a Christian agency and provider meets your unique and individual needs. Please be assured that your faith and belief system is not an issue for this agency or provider. Second please complete the attached admissions forms. Third if you agree to the policies and procedures disclosed in the admissions packet and you feel that we satisfy your needs, you will then meet with your provider to complete the screening and intake process. Fourth, during this initial session with your provider you will be asked to commit to eight (8) weeks of uninterrupted meetings. If you are interested in additional services after those eight (8) weeks have ended you will be asked to commit to uninterrupted scheduled meetings. This procedure will continue until such time as you are discharged. It is very important that your last counseling session be an official "Discharge Session".

Special Note:

Please be advised that Branch of Life, Inc., Billy W. Corn, LPC will **not** complete Social Security Disability, Private Insurance Disability or Family and Medical Leave Act (FMLA) paperwork. We recommend that you ask your Medical Doctor or Psychiatrist to complete this type of paperwork.

Personal Injury, Personal Belongings or Vehicle Damage:

Regarding the property located at 8554 County Road 4023 Kemp, Texas 75143 and/ or: Branch of Life, Inc., Billy W. Corn and / or Tamberly Corn are not responsible for any Personal Injury, Loss of Life, Lost or Stolen Belongings, Property or Vehicle Damage of Clients or their Friends, Family members or anyone else on said property.

Please sign on the space below to indicate that you have read, understand and accept the content of *Welcome Pages.*

| ______________________________ | ______________________________ | __________ |
|---|---|---|
| Parent/guardian if under 18 | Print Name | Date |
| ______________________________ | ______________________________ | __________ |
| Client Signature | Print Name | Date |

# Branch of Life, Inc.

## CONSENT TO TREAT

Please read and initial the following:

_______ I consent to take part in treatment with a provider associated with the Branch of Life, Inc. I further understand that the development of intervention goals with my provider, and working toward those goals, are in my best interest.

_______ I understand that no promises have been made to me (us) as to the results and/or outcome of individual or family counseling by my provider. I have been made aware of and understand that individual counseling is not the best model to resolve marital disputes. I have been made aware of and understand that there is a risk to successfully resolving martial disputes to mutual satisfaction without all parties being present and participating in the family counseling session.

_______ I understand that treatment sessions last for 45 to 50 minutes. I understand and accept that I am finically responsible for the agreed number of sessions per week (whether I am present or not) for the duration of my treatment agreement. I understand that if a crisis occurs with another client and causes my provider to run behind, that my provider will do everything in their power to give me my full time. I also understand that if I am late to my appointment they will not run over into another client's time in that session. I understand that I may stop treatment at any time. Yet, I am also aware that many times clients may feel like stopping therapy due to the pain or discomfort of addressing issues that are important to their well-being. Therefore, I agree to talk with my provider if I feel like quitting therapy before all my treatment goals are met.

_______ I understand that confidentiality and privileged communications are the ethical rights of all clients. However, if a client demonstrates the intention to harm themself or another person, my provider has a DUTY TO REPORT…; (a) the person(s) who may suffer harm inflicted by the client, (b) the family of the person who may suffer the harm inflicted by the client, (c) the emergency contacts of the client who intends to harm themselves, and/or (d) the appropriate state and local agencies. My provider will inform me of the intent to notify relatives and/or authorities in all instances that involves the above exceptions to confidentially.

_______ I understand that all providers are legally bound to immediately report to the proper authorities any case of suspected sexual or physical abuse/neglect/endangerment of minors and of the elderly. This includes instances from the past as well as the present. I understand that my provider is bound by law to report such cases and will do their best to discuss their intent to report with me before doing so.

_______ I understand that in some cases a court of law may require my provider to testify and/or release client files in certain circumstances. I have been made aware of and understand that my family, spouse or other significant member of my marriage or family system may attempt to contact my provider or contact my provider to provide or solicit information, therefor I agree to make all members aware that if they are not on my "right to know list" no information will be provided. I understand that my provider will make every attempt to notify me if this situation should occur.

_______ I understand that for professional reasons my confidential individual, martial or family case file may be discussed with full consideration of client confidentially (example Dr. to provider, provider to provider, attorney to provider, supervisor to provider and/or unit staffing, to mention a few).

_______ I understand that if the client is under the age of eighteen (18), I testify with my signature that I have legal custody and authority and give my consent for _______________________________________ to receive counseling from a provider with the Branch of Life, Inc. Ministries of Counseling, Life Coaching and Alternative Dispute Resolution.

_______ I agree not to harm myself or anyone else as long as I am in treatment with this therapist.

_______ I acknowledge that I have read and understand this "Consent to Treat" contract and agree them.

____________________________________ ______________________________________ _______________

Parent/guardian if under 18 Signature Date

__________________________________ ______________________________________ _______________

Client Signature Date

# Branch of Life, Inc.

## FEE ACCOUNTABILITY

Please read and initial that you understand each of the Good Faith policies below:

_______ Fees; I understand and accept that I am personally finically responsible for all fees for services; to include fees I agree to pay, my insurance co-pay and any fees that my insurance denies paying until such time that I am discharged from treatment. I understand and accept that if a check is returned, I agree to pay the bank service fee plus an additional $25.00 handling fee in addition to the amount of the check. This is to be paid at the next session or to be automatically drafted from my bank. I understand and accept that there will be a $5.00 fee charged to me for any form of credit card or debit card payment for every transaction.

_______ Payment; I understand and accept that I am responsible for payment for all scheduled counseling sessions that I attend or am unable to attend and phone conversations until such time as I am discharged from counseling. I understand and accept that payment is due at the beginning of each session. All payments by check should be made out to the Branch of Life. It is suggested that the date of counseling, life coaching or mediation is noted on the check for your record. I understand and accept that if a balance is due my provider may not be able to meet with me for our regularly scheduled session or make further appointments for me until my account is paid in full.

_______ Rescheduling; I understand and accept that I must call, text or email my provider at (972) 296-2676 or bwcorn@yahoo.com to cancel an appointment within 24 hours of that appointment to reschedule a new appointment during the same work week (depending on the availability of my provider). I understand that I may text my provider anytime to reschedule or cancel my appointment.

_______ ***Cancelation/No Show; I understand and accept that if I fail to attend any scheduled session (for any reason) or am unable to reschedule a time with my provider (within that same week) that I am financially responsible to pay a cancelation fee in the amount of $50.00 for each missed session; this is to be paid at the next session.

_______ Discharge; I understand and accept that I am not discharged until I have met my counseling goals, or I notify my provider (by letter or by email) of the date of counseling termination. I understand and accept that I am financially responsible for amount due for all counseling sessions up to the date of termination.

_______ Collections; I understand and accept that any unpaid balance may be reported to my collection agency and/or a credit score rating agency.

_______ Consent to Bill Insurance Company; I the undersigned, authorize Branch of Life, Inc. and / or Billy W. Corn's office to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my therapist may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his doing so is a necessity in his effort to secure ongoing care. I also authorize payment of medical benefits to Branch of Life, Inc. and / or Billy W. Corn LPC, for services provided.

_______ All fees for services are due on the day of your appointment. This includes but not limited to office sessions, video sessions, phone sessions or cancelation/no show. Types of payment that are excepted include, Cash, Check, Money Order, Debit Card, Master Card or Visa. For Debit and Credit Cards there is a $5.00 fee per charge. Please enter the credit or debit card information below you wish for us to keep on file.

Name as it appears on the Card: ____________________________________________________

Type of Card: [ ] MASTER CARD or [ ] VISA [ ] DEBIT or [ ] CREDIT

Number on Card: ______________________________________________________________

EXP. DATE: ____________________________ Security Code on back of Card: ________________

_______ I acknowledge that I have read and understand this Good Faith "Fee Accountability" contract and agree to all the above conditions as stated.

______________________________________ ______________________________________ ____________

Parent/guardian if under 18 Signature Date

______________________________________ ______________________________________ ___________

Client Signature Date

# CLIENT INSURANCE INTAKE FORM

(Please print neatly)

Date: ___________________________________

Client Name: __________________________________________________ DOB: _______________________

Name on Insurance Card: _______________________________________ DOB: _______________________

Relationship to Client: _________________________________________

Insurance Company: _________________________________________________________________________

Insurance ID#: ______________________________________________________________

Insurance Group #: _________________________________________________________

Types of Counseling: [ ] Individual [ ] Family [ ] Group

_____________________________________ __________________________________ _________
Parent/guardian if under 18 Signature Date

_____________________________________ ____________________________________ _______
Client Signature Date

**Branch of Life, Inc.**

## PERSONAL INFORMATION

*(Please print neatly)*

| *Name:* | | | *Date:* |
|---|---|---|---|
| *SSN:* | *Date of Birth:* | *Age:* | *Gender:* M **F** |

| *Address:* | *City:* | *St:* | *Zip:* |
|---|---|---|---|

| *How is the best way to contact you:* | *Phone:* | *Text:* | *Email:* | *All:* |
|---|---|---|---|---|

| | | | |
|---|---|---|---|
| *Home Phone:* ( ) - | *May we leave a message?* | Yes | No |
| *Work Phone:* ( ) - | *May we leave a message?* | Yes | No |
| *Cell Phone:* ( ) - | *May we leave a message?* | Yes | No |
| *Text:* ( ) - | *May we leave a message?* | Yes | No |
| *Email:* | *May we leave a message?* | Yes | No |

| *Marital Status:* | Single | Engaged | Married | Separated | Divorced | Widowed |
|---|---|---|---|---|---|---|

| *Spouses Name (If Married):* | *DOB:* |
|---|---|

| | | | |
|---|---|---|---|
| *Children Name:* | *DOB:* | *Children Name:* | *DOB:* |
| *Children Name:* | *DOB:* | *Children Name:* | *DOB:* |

| | | | |
|---|---|---|---|
| *Your Employer:* | | *Spouse Employer:* | |
| *Address*: | | *Address:* | |
| *Phone:* | *# of yrs. there:* | *Phone:* | *# of yrs. there:* |
| *Email:* | | *Email:* | |
| *Duties:* | | *Duties:* | |

| *Is your spiritual faith important to you?* | *Y N* | *If so what is your Faith?* |
|---|---|---|

*How did you learn of this Counseling Provider (circle one):*

| | | | | | |
|---|---|---|---|---|---|
| Webb Sight: | Former Client: | Professional Referral: | Family: | Church: | Adds: |
| Internet: | Current Client: | Insurance/EAP: | Friend: | Phone Book: | Other: |

| Parent/guardian if under 18 | Signature | Date |
|---|---|---|
| Client | Signature | Date |

# Branch of Life, Inc.

## MEDICAL INFORMATION

*(Please print neatly)*

| | | | |
|---|---|---|---|
| *Are you under the care of a Psychiatrist?* Y N | *Name:* | | *Phone:* ( ) - |
| *What is your diagnosis?* | | | |
| *Have you been in residential treatment?* Y N | *Reason:* | | *Date:* |
| *Have you been in counseling?* Y N | *Reason:* | | *Date:* |
| *List Medications & Dosages:* | *Are any of the medications causing a concern for you?* Y N | | *Circle the ones that do:* |
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

## CURRENT INFORMATION

*(Please print neatly)*

*Do you drink alcohol?* Y N *Is it a concern to you or someone else?* Y N *Whom:*

*Do you do illegal drugs?* Y N *Is it a concern to you or someone else?* Y N *Whom:*

*I'm seeking counseling for:* Myself My marriage My family My children

*Presenting problems:*

*Rate your current emotional health:* Very Good Good Average Declining Other

*Initial beside the words that best describe you now:*

| | | | | |
|---|---|---|---|---|
| Active | Serious | Stressed | Sad | Fearful |
| Ambitious | Patient | Impulsive | Bitter | Frustrated |
| Confident | Imaginative | Shy | Hopeless | Confused |
| Hard Working | Hopeful | Empty | Lonely | Jealous |
| Good natured | Calm | Unmotivated | Angry | Helpless |
| Sensitive | Focused | Moody | Numb | Intimidated |

*Please provide two people that you give "your permission" for us to contact in case of emergency:*

| | |
|---|---|
| *Name:* | *Name:* |
| Phone: | *Phone:* |
| Relationship: | *Relationship:* |

Parent/guardian if under 18 ______ Signature ______ Date ______

Client ______ Signature ______ Date ______

# Branch of Life, Inc.

## CONSENT TO KNOW LIST

My provider Branch of Life, Inc. and / or Billy W. Corn LPC, has/have my permission to discuss my/our personal, martial, family case with the following individuals or other providers.

| NAME | RELATIONSHIP | PHONE NUMBER |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

__

_________________________________ ___________________________________ __________
Parent/Guardian if Under 18 Signature Date

____________________________________ _________________________________ ___________
Client Signature Date

**Branch of Life, Inc.**

# Memorandum of Understanding

A. ***B.O.L.I. Ministries***

1. I understand that Branch of Life, Inc. is a Ministry of Professional Counseling, Life Coaching, Alternative Dispute Resolution (Mediation and Negotiation) and Pastoral Care.
2. I understand that Branch of Life, Inc. is based on Christian values but *does not* discriminate against those of other faith values.

B. ***Provider (Billy Winford Corn) Credentials***

***I have been informed and understand*** that the Provider Billy W. Corn holds a:

1. *Doctor of Divinity Degree* from Evangelical Theological Seminary and Bible College.
2. Graduate *Specialist Degree* from Southwestern Theological has multiple educational degrees, professional licenses and professional certifications.
3. Rev. (Reverend/Ordained Minister)
4. LPC (Licensed Professional Counselor),

C. Provider Billy W. Corn's "*Doctor of Divinity Degree*" ***"is NOT"*** recognized by the *Texas State Board* of Examiners of Professional Counselors as a *psychotherapist*:

1. LPC - Licensed Professional Counselor

D. I understand and accept that any reference to Provider Billy W. Corn as "Doctor" is in reference to his License to Minister Pastoral Care, Counseling, Life Coaching and Alternative Dispute Resolution (Mediation and Negotiation) by the by the Baptist General Convention of Texas and Texas Senate Bills (SB)

E. I understand and accept that any reference to Provider Billy W. Corn as "Doctor" ***"IS NOT"*** in reference to him as a Professional Counselor (LPC), licensed by the *Texas State Board* of Examiners of Professional Counselors.

________________________________ ________________________________ __________

Parent/Guardian if Under 18 Signature Date

________________________________ ________________________________ __________

Client Signature Date

# CLIENTS RIGHTS TO RECORDS
# Client Copy

Although your records are the physical property of Branch of Life, Inc., the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to your provider. You have the right to:

- Request restrictions on certain use and disclosure of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example: a request that we not identify the agency when we contact you. (i.e. "this is the Branch of Life Ministries)
- Inspect and copy the information that we maintain about you. However, we may deny any individual access, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
  - A health care provider has determined, in the exercise of professional judgment,
  - The access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
  - The information makes reference to another person (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
  - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representatives is reasonably likely to cause substantial harm to the individual or other person.
  - If you wish to inspect or copy your information, you must submit your request in writing to your provider. If the information that we maintain is on sight your provider will have 30 days to respond to your request for information. If the information is stored off sight, your provider will be allowed up to 60 days to resound but must inform you of this delay.
- Other

1. Revoke your consent to release information except to the extent that the agency has taken action in reliance on the previous signed consent form.
2. Reasonable request to receive confidential communications of protected health information from your provider by alternative means or at alternative locations. For example: at your regularly scheduled appointment at a church satellite office, or by email or fax.
3. Amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your provider stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request within sixty (60) days.

Branch of Life, Inc.

# NOTICE
# Client How to File a Complaint
# **Client Copy**

File a complaint if you believe your provider has violated your medical privacy rights. You have the right to file a written complaint to your provider, *OR* CEO, *OR* directly to "The U.S Department of Health and Human Services" *OR* directly to "Texas Behavioral Executive Council".

To file a complaint with the Branch of Life, Inc. you must make it in writing within *180 days* of the suspected violation. Provide as much detail as you can about the suspected violation and send it to: Chairman of the Board, Branch of Life Ministries, Inc. at 8554 County Road 4023, Kemp, Texas 75143. Please be aware there will be no retaliation for filling a legitimate complaint.

For more information about HIPAA or to file a complaint:

The U.S Department of Health and Human Services
Office of Civil Rights
200 Independency Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: (800) 368-1019
TDD toll-free: (800) 537-7697

Email: OCRPrivacy@hhs.gov

U.S. Department of Health and Human Services
Office of Civil Rights
*Regional Office*
1301 Young Street, Suite 106
Dallas, TX 75202
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

OR:

Texas Behavioral Health
Executive Council
333 Guadalupe St., Ste. 3-900
Austin, Texas 78701
Tel.: (512) 305-7700

*NOTE:* Please be advised that we reserve the right to change the terms of our notice to make the new notice provisions effective for all protected health information we maintain. If and when one is available, you may request a written copy of our revised notice from this office.

# NOTICE

## NO SURPRISE ACT

**As of January 1, 2022**

## Client Copy

**Notice to clients and prospective clients:**

Under the law, health care providers need to give clients who *don't* have insurance or who are *not* using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service, or at any time during treatment.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, see your Estimate, or visit www.cms.gov/nosurprises.

## LOCATIONS

**MAIN OFFICE / MAILING ADDRESS:**

BRANCH OF LIFE, Inc.

BILLY W. CORN, LPC

8554 County Road 4023

Kemp, Texas 75143

(Located in Office behind our Home)

There is *no* waiting room at this office, so if you see another client's car parked in front of the office, please wait for that client to exit before entering. If you are not sure please always, knock first. Thank you

## CONTACT INFORMATION:

BILLY CORN: call or text 972-296-2676 or e-mail: bwcorn@yahoo.com

FAX: 1-972-421-1816

Website: thebranchoflife.org