FREE TO FLOURISH COUNSELING
CONSENT FOR TREATMENT

PLEASE READ THOROUGHLY BEFORE SIGNING

CONFIDENTIALITY

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is provided in the patient information packet. Communications between you (as the client) and I (as the therapist) are confidential and will not be revealed ***unless required by law***, such as in the case of child or elder abuse, or threats of physical harm to yourself or others.

Initials: ______________

COUNSELING FEE/INSURANCE

Our agreed upon fee for a standard 50 minutes session is $100.00. Insurance is not accepted at this time, however sliding fees are available for financial hardships. You may choose to submit insurance claims on your own; receipts for this purpose are available to you. Please keep your account current. If there is a financial hardship that impacts payment, let me know at once so I can work with you. Should your fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. We only accept credit or debit cards. Your payment will appear on your statement as **Compassion Cove Counseling.**

Initials: ______________

CANCELLATION OF APPOINTMENTS

If you need to cancel your appointment, please call **at least 24 hours in advance**. A fee at the rate of the regular appointment will be charged for cancellations within 24 hours or no shows for appointments, except in the event of emergency. Be advised that insurance cannot be billed for missed or late canceled appointments.

Initials: ______________

TELEPHONE CALLS

You may contact me by phone during waking hours, or email 24 hours a day. Please leave a message (including your name, number, and concern) if I am unavailable and your message will be returned as soon as possible.

Initials: ______________

ELECTRONIC COMMUNICATION

While your therapist takes reasonable precautions to protect your confidential information, e-mail, texting & social networking is not a completely secure method of communication. I acknowledge that if I use electronic mail to initiate contact with my therapist, that he/she and/or his/her representative has my permission to correspond via the originally initiate communication (i.e. text, email. etc.). I also acknowledge that records may be kept in an electronic format. The purpose of e-mail and other forms of electronic communication is to ease communication with the client regarding scheduling or reminding of appointments, homework assignments, follow-up care, or information regarding the clients' payment status. Electronic communication is not a way of communicating therapeutic information regarding care or of communicating emergency treatment.

Initials: ______________

PUBLIC CONTACT

In order to maintain your confidentiality, in the event that we encounter each other in public, my policy is not to acknowledge you. This way you will never be put on the spot to figure out how to respond to me. However, if you would like to acknowledge me (by eye contact, smiling, speaking, etc.) I would be happy to respond. I will not be offended if you decide not to acknowledge me. While I don't view therapy as shameful and necessary to be concealed, I do completely understand that there are times when discretion is important. I will let you handle that, as you are comfortable. As stated above information about our session will always be kept confidential, even if we engage in a social conversation in public.

Initials: ______________

EMERGENCIES

While I strive to be available when needed, please note that I am not "on call" for emergencies. If you have an emergency, you will need to contact: the closest hospital emergency room, 911, or the police. Ridgeview Hospital is available for psychiatric emergencies: 770/434.4567

Initials: ______________

SUPERVISION

I will be consulting with my supervisor/director on all cases. Please let me know if you have a concern or a previous relationship with him.

Clinical Supervisor: Clinical Director:
David Lane, PhD Melanie Gulley

Initials: ______________

I have read the above information and voluntarily request counseling services from Jason Haynes, MA, NCC, and I agree with the terms and conditions.

Signature of Client____Date ____________

As undersigned, I am acknowledging that I am seeking services for my child (named above) to engage in a professional relationship with Jason Haynes, MA, NCC and agree to the terms and conditions.

Signature of Parent/Guardian____Date ______________

PATIENT NOTI ICATION OF PRIVACY RIGHTS

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION. (EFFECTIVE 4-14-03)

LEGAL DUTIES

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

PUBLIC SAFETY

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source. Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed.

Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures. In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1 per page, plus postage. You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing. Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Georgia Board of Psychology. If you file a complaint we will not retaliate in any way.

PATIENT NOTI ICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protection surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and the storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords to all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Free to Flourish, LLC is required to secure your signature indicating you have received a copy of the Patient Notification or Privacy Rights document.

Free to Flourish, LLC/ Jason Haynes, MA, NCC HIPAA Compliant Officer

Patient Name (print) ____

I have received a copy of the Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

____ ______________________

Patient Signature Date

____ ______________________

Parent or Guardian Signature Date

CLIENT INFORMATION

THIS SHEET MUST BE FILLED IN COMPLETELY

GENERAL INFORMATION

Date_______________

Client's First Name____Last Name__________________________MI__________

Address____ City______________________State__________Zip___________

Telephone (Home)_____________________ (Cell)____________________Is it okay to leave a message? _______________

Email____Is it ok to contact you by email? _________________________

Birth Date_____/______/_______ Age_______ Gender F M____Other (specify:________)

Race______________________________________

Marital Status____Single____Married (if yes, number of years____)_____Divorced/Separated_____Widowed_____Partnered

Living With____Parents____Alone_____Roommates____Spouse_Partner_______Other (Specify_______________________)

Religious Affiliation____Active In Your Faith? ________________________

Name of Spouse/Guardian____Phone_____________________________

Address____ City______________________ State_______Zip__________

Person Responsible for Payment____ Soc. Sec. #_______________

Signature of Person Responsible for Payment____(Must be signed for services to begin)

EMERGENCY CONTACT INFORMATION

Name_________________________________Relationship_______________Phone__________________Work______________

Address____City_________________________State__________Zip___________

EMPLOYMENT INFORMATION (If client is a child, use parent's employment)

Client/Guardian: Place____ Phone_____________________Hrs__________

Spouse: Place____ Phone_____________________Hrs___________

REFERRAL SOURCE

How did you hear of our clinic (or from whom)?____

May we thank them? Yes_______No_________

Physician Information

Health_______Excellent_______Good________Fair_______Poor   Do you have a disability? ___________________________

Do you have any health concerns? ____

Are you presently taking any medications?_______Yes______No

If yes, please list name and dosage ____

____

Have you had counseling before?_____Yes______No

If yes, when____

Physician____   Phone____________________

Psychiatrist____   Phone____________________

Other Physicians____Phone___________________

Family Information

Relationship	Name	Age	Grade Last Completed in School	Occupation
Spouse				
Father				
Mother				
Brothers				
Sisters				
Children				

Parents are______Married_______Separated______Divorced________Widowed

Any history of drug or alcohol abuse in your family? If yes, briefly describe ____

____

____

Any history of physical, emotional, verbal, or sexual abuse in your family? Circle one: Yes   No   Not sure

Concerns

Using the following scale, mark the appropriate number next to the concerns you have. **You only need to mark your concerns, you may leave the other items blank**.

0	1	2	3	4	5	6	7	8	9	10
Not Concerned					Moderate Concern					Very Concerned

_______ Assertiveness
_______ Friends
_______ Anxiety
_______ Nervousness
_______ Motivation
_______ Time Management
_______ Career
_______ Leadership
_______ Eating Patterns
_______ End of Relationship
_______ Anger
_______ Parenting
_______ Decision Making
_______ Loneliness
_______ Social Relationships

_______ Financial Problems
_______ Perfectionism
_______ Racial Issues
_______ Work
_______ Thoughts
_______ Guilt
_______ Physical Problems
_______ Identity
_______ Depression
_______ Sexual Concerns
_______ Spouse/Partner
_______ Alcohol/Drug Use
_______ Self Control
_______ Children
_______ Parents

_______ Stress
_______ Traumatic Experience
_______ Feeling Helpless
_______ Gender Issues
_______ Sexual Assault
_______ Trust
_______ Moodiness
_______ Grief
_______ Self-Esteem
_______ Procrastination
_______ Fear
_______ Thoughts of Suicide
_______ Unhappiness
_______ Other:
_______ Other:

HARM TO SELF

Please circle your responses and sign at the bottom

Yes No I am thinking about killing or physically harming myself

Yes No I have recently harmed myself.

Yes No I am thinking about harming or killing someone else.

Yes No I have recently physically harmed someone else.

Yes No I am in immediate danger of being physically harmed by someone.

Yes No I am very concerned about someone else who may be in immediate danger of physical harm.

Yes No I have been raped or sexually assaulted within the last year or am concerned about a previous rape or sexual assault.

Yes No I believe that I am about to be forced into having sex, about to be raped or about to be sexually assaulted.

Yes No I am being harassed sexually or in another way.

Signature____Date __________

Credit/Debit Card Authorization

Please write legibly – accurate information is required for correct processing.

Client Name: ____
(Person receiving treatment. Cardholder name is entered below)

Card Holder Name: ____
(Exactly as it appears on the card)

Street Address: ____
(Address where credit card statements are mailed.)

City:______________________________________State:______Zip:______________

Phone:____

Card Type: MasterCard Visa (for Amex see below)

Card Number -- _________

Security Code: (3 digits on BACK of card)______ Expiration Date:____/____

Card Type:__

Card Number: __ -__ __ __________- ____________

Security Code: (4 digits on FRONT of card) _________

Expiration Date: __________
(Mo/Yr)

I authorize Compassion Cove Counseling, LLC to charge the above referenced card for therapy services and materials for the above referenced client until such date as I inform them otherwise. I understand that Association Counseling Center reserves the right to charge this card for appointments that are not cancelled according the policy contained in the Free to Flourish Counseling Information and Agreement document.

____ Date: ___________
Card Holder Signature (or Parent/Guardian if Card Holder is under 18)

Credit/Debit Card Information for Third Party Payer

IMPORTANT: This form is provided solely for the use of a third party who is paying for therapy services but who will not be personally in attendance. Third party payers must also complete and sign a Credit/Debit Card Authorization form.

Client Name: ____
(Person receiving THERAPY. NOT the cardholder.)

Card Holder Name: ____
(Exactly as it appears on the card)

Street Address: ____
(Address where credit card statements are mailed.)

City:______________________________________State:______Zip: _____________

Card Type:___MasterCard___Visa (for Amex see below)

Card Number -- _________

Security Code: (3 digits on BACK of card)______ Expiration Date:____/____

Card Type:___ Amex

Card Number: __ __ __ __ -______________- ____________

Security Code: (4 digits on FRONT of card) _________

Expiration Date:_________(Mo/Yr)

THE CARD INFORMATION ON THIS FORM WILL BE ELECTRONICALLY TRANSFERRED TO A THIRD-PARTY CARD PROCESSING COMPANY.

I authorize Compassion Cove Counseling, LLC to charge the above referenced card for therapy services and materials for the above referenced client until such date as I inform them otherwise. I understand that Association Counseling Center reserves the right to charge this card for appointments that are not cancelled according the policy contained in the Free to Flourish Counseling Information and Agreement document.

____Date: ___________
Third-Party Card Holder Signature (or Parent/Guardian if Card Holder is under 18)