Consent for Evaluation and Treatment for Couples

About Bethel Haven

Bethel Haven is a Christian non-profit organization with the purpose of providing help, hope and healing to distressed children, teens, young adults and families through professional therapeutic services. At Bethel Haven, we believe that counseling and therapy provide an individual and/or family a unique opportunity for growth and healing. Bethel Havenôs counselors are committed to addressing the needs of the whole person recognizing the biological, social, psychological and spiritual components which make up an individual. A necessary and basic component of counseling and therapy is the collaborative relationship between the therapist and client, and is based upon mutual respect, trust and agreed upon treatment goals. Itôs important to understand that counseling and therapy have both potential risks as well as potential benefits. Risks may include uncomfortable levels of unpleasant emotions for the individual and/or family, individuals receiving counseling and therapy may feel worse, emotionally, before they begin to feel better, etc.

To get the most from counseling, we believe that it is best if couples can meet with the counselor on a weekly to every other week basis so that too much time does not pass in between sessions. This keeps the relationship open and the therapist and clients up-to-date so the focus can remain on the current needs of the client. Depending on the severity of a problem, the counselor may recommend more frequent sessions especially during times of crisis or when dealing with a more complex problem. Couples may participate in short, medium or long-term therapy. Some couples may have a specific, focused problem that is resolved after several months, while others may need counseling and care for longer periods of time. Bethel Havenós goal is to help couples gain the necessary tools and insight so that they may leave stronger, more confident and able to move forward with their lives.

The first appointment is for assessing and understanding the problems for which the couple is seeking assistance. The initial appointment is important to planning appropriate care and treatment. After the initial evaluation, the therapist will make treatment recommendations and work with the couple to set goals and schedule follow-up appointments. At that time, if a different type of treatment is needed other than which Bethel Haven is able to provide, we will make the appropriate referral or provide the couple with suitable information for seeking the needed services. Session appointments are 45-50 minutes.

Ultimately, it is Bethel Havenôs desire to be an extension of Christôs love to those who are facing various difficulties. We do not discriminate and serve individuals regardless of their religious or non-religious affiliation. We work to understand each individualôs belief and value systems sharing our own faith as a function of legitimate self-disclosure according to client need. Bethel Havenôs approach is ñto set apart Christ in our hearts as Lord and always be prepared to give a reason for the hope that is within us, with gentleness and respect, all for the glory of God.ò (1 Peter 3:15, *paraphrased*)

Client's Rights & Responsibilities

Participation

Clients are expected to participate in the planning of their treatment, and they or their guardian(s) have the responsibility to provide accurate information relevant to treatment and/or treatment planning, and follow mutually agreed upon treatment goals. Failure to provide accurate and relevant information as well as follow mutually agreed upon treatment may result in dismissal from treatment. Clients have the right to specify, in advance, the treatment(s) he/she would want/not want in the future should he/she become unable to communicate those wishes. Clients also have the right to refuse treatment and discontinue at any time. However, this is best done in consultation with the provider of care. It is Bethel Havenôs desire to work with clients to resolve any grievances that may arise and build upon the therapeutic relationship. Nonetheless, clients have the right to file complaints with freedom from restraint, interference, coercion, discrimination, or reprisal.

Confidentiality
Trust is an essential part of the therapeutic relationship. Confidentiality is a privilege protected by law and ethics of the counseling profession that allows for strict private discussion of issues that concern clients. Exceptions include:

- Disclosure to appropriate authorities or family members when there is sufficient cause to believe that a client poses a threat of physical harm to his/her self or others.
- We are required by law to report any form of child neglect or abuse.

In order to provide comprehensive care and emergency coverage for our clients, cases may be shared when needed with our Director or other Bethel Haven on-call therapists. Furthermore, please be aware that another Bethel Haven therapist, counselor, employee or volunteer in the office may answer the phone and may make phone calls to notify and/or remind clients of any appointment changes. All therapists, employees, supervisors and volunteers are required to adhere to Bethel Havenôs confidentiality policy.

Informed Consent
Clients have the right to an explanation of his/her condition and treatment that he/she can understand. Clients have the right to receive sufficient information about proposed and alternative interventions and program goals (and possible risks or consequences of not following recommendations) to enable them to participate effectively. Although Bethel Havenôs counselors utilize evidence-based therapeutic approaches, they recognize each clientôs right to self-determination and individuality and, therefore, cannot guarantee results.

Bethel Haven employs associate therapists that are under supervision according to the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapistsô rules and Code of Ethics. Currently, Doug Duke, LPC, Leigh Ellen Watts-Magness, LCSW, RPT-S, and Vance Sims, LSCW serve as Bethel Haven Clinical Supervisors for associate therapists who require such supervision while they are seeking full licensure. Bethel Haven adheres to the Code of Ethics outlined by the American Association of Christian Counselors.

Interaction with the Legal System
Clients will not involve or engage their therapist in any legal issues or litigation in which they are a party to at any time either during counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that clients wish to have a copy of their file, and they execute a proper release, their therapist will provide a copy of their record. If a client believes it necessary to subpoena their therapist, they would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time spent over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. Clients understand that if they subpoena their therapist, he or she may elect not to speak with clientôs attorney, and a subpoena may result in your therapist withdrawing as your counselor.

Respect & Non-Discrimination
Clients have the right to be treated with consideration, respect, and full recognition of dignity and individuality regardless of circumstances. Clients have the right to be protected by licensee from neglect; from physical, verbal, and emotional abuse; and from all forms of exploitation. Clients have the responsibility to treat staff of Bethel Haven appropriately with consideration and respect.

Reviewing Records
Each client has the right to review his/her client record as outlined by state law and according to HIPAA regulations.

Keeping Appointments
We value our clients and the time reserved for each person. Therefore, we require **at least a <u>24-hour</u> cancellation** notice via phone call. After the SECOND late cancellation (**less than 24-hour notice**) or missed appointment, **full session fees** will apply for each late cancellation or missed appointment, as these may prevent another client from being scheduled. Possible termination as a client may also result if behavior is habitual.

Financial Responsibility
Bethel Haven uses a sliding fee scale based on clientsô family size and income, and clientsô fees are discussed during the initial evaluation appointment. Please note there are different sliding fees for an individual session versus couple/family sessions. **Fee payment is due at time of service and collected prior to counseling sessions unless other arrangements have been discussed.** Bethel Havenôs superbills serve as a receipt of services for clients or guardians to keep for their records and include our NPI number, CPT and ICD codes which may be used when filing for consideration of out-of-network benefits. Please be aware that not all codes are recognized the same by different insurance companies, and Bethel Haven cannot be responsible for ensuring reimbursement and will not change codes for such purposes.

In addition to counseling and therapy appointments, Bethel Haven also provides phone consultations, reports and official letters at the request of clients or guardians. Fees for these and other services are outlined below:

- Phone consultation (15-45 min.) Fee equals client session fee
- Report $60
- Official letter $30
- Returned check $25

Therapeutic and support groups are offered from time to time with group session fees dependent on the size and type of group offered.

Contacting your Therapist
We value our time for each client and meeting their needs; therefore, we have to limit out-of-session communication. You are welcomed and encouraged to call the office if there is a major change between sessions. We check messages and return phone calls around lunchtime and late afternoon.

Clients are also responsible for notifying Bethel Haven of any change in address, contact number or other pertinent information important to safe care in a timely manner.

Emergencies
If you have an after-hours emergency, call 911 or go to the nearest emergency room and ask for a mental health assessment.
You can call the following numbers to receive crisis psychological help:

- Advantage Behavioral Health Services 1-800-715-4225
- Suicide hotline 1-800-784-2433 or 1-800-273-8255

Information Regarding Technology

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.
Bethel Haven has strived to ensure your privacy to the best of our ability. Some of these strategies have included encrypted communication through email and phone calls. However, we cannot ensure complete confidentiality in any form of communication through electronic media. You are advised that any email sent to me via a computer has the possibility of information breech if not properly encrypted by both the sending and receiving parties. If you call me, please be aware that unless we are both on encrypted phone lines, the conversation is not confidential. Likewise, text messages are not confidential. I will not respond to a text message. If you send a fax, our fax line is in a secure location. Any computer files referencing our communication are maintained using secure and encrypted measures.

Spouse 1

Email Agreement:
___Yes I consent to communicate through **email**

Email Address_____

___No I do not consent to communicate through **email**

Phone Call Agreement:
___Yes I consent to Bethel Haven **calling** me on the following numbers INCLUDING voicemails.
Phone #_____

___No I do not consent to communicate with Bethel Haven through phone calls or voicemails

Text Message Appointment Reminders
___Yes I consent to Bethel Haven **texting** me regarding appointment reminders Phone #_____

___No I do not consent to communicate with Bethel Haven text message appointment reminders

Client_____

Date_____

My signature below indicates that I have read, been informed of, and understand the above information and that I give consent to receive counseling and therapy services under these conditions

Spouse 1

Print name:_____

Signature of client:_____ Date:_____

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices.

Print name:_____

Signature of client:_____ Date:_____

Spouse 2

Email Agreement:
___Yes I consent to communicate through **email**

Email Address_____

___No I do not consent to communicate through **email**

Phone Call Agreement:
___Yes I consent to Bethel Haven **calling** me on the following numbers INCLUDING voicemails.
Phone #_____

___No I do not consent to communicate with Bethel Haven through phone calls or voicemails

Text Message Appointment Reminders
___Yes I consent to Bethel Haven **texting** me regarding appointment reminders Phone #_____

___No I do not consent to communicate with Bethel Haven text message appointment reminders

Client_____

Date_____

Print name:_____

Signature of client:_____ Date:_____

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices.

Print name:_____

Signature of client:_____ Date:_____

Bethel Haven
Client Information-Spouse 1

Clientôs Name: _____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Phone #:_____Work #: _____

Referred by: _____

Primary Care Physician: _____ Phone #:_____

Does the client currently have health insurance? Yes or No (*please circle*) Name of Insurance Company_____

If yes, co-payment, deductible & co-insurance amounts _____

Does the client plan to use out-of-network benefits? Yes or No (*please circle*)

Emergency contact information:

Name: _____Relationship to client: _____

Phone #:_____Work #: _____

If clientôs parents are separated or divorced, please describe who has primary guardianship and visitation & custody arrangements:

_____

_____

Party responsible for payment of services: _____

I acknowledge that the information I have provided above is correct and accurate. I also acknowledge that I will notify Bethel Haven of any changes to this information.

Signature: _____ Date: _____

Bethel Haven
Client Information-Spouse 2
If information is the same as Spouse 1, please just sign at the bottom

Clientôs Name: _____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Phone #:_____Work #: _____

Referred by: _____

Primary Care Physician: _____ Phone #:_____

Does the client currently have health insurance? Yes or No (*please circle*) Name of Insurance Company_____

If yes, co-payment, deductible & co-insurance amounts _____

Does the client plan to use out-of-network benefits? Yes or No (*please circle*)

Emergency contact information:

Name: _____Relationship to client: _____

Phone #:_____Work #: _____

If clientôs parents are separated or divorced, please describe who has primary guardianship and visitation & custody arrangements:

_____

_____

Party responsible for payment of services: _____

I acknowledge that the information I have provided above is correct and accurate. I also acknowledge that I will notify Bethel Haven of any changes to this information.

Signature: _____ Date: _____

Bethel Haven
New Client Questionnaire-Spouse 1

Date: _____

Personal Data:

Client Name:	Prefers to be Called:	
Age:	Date of Birth:	Clientôs Birthplace:
Sex: ☐Male ☐Female	Race: ☐African-American ☐Caucasian ☐Hispanic ☐Asian ☐Other	
Person Completing this form:	Relation to client :	

Reason for visiting:

Briefly describe your concerns for which you are seeking help at this time:

_____

_____

_____

_____

Approximately when did the problems begin:

Any known stress or event cause or contribute to the problem(s)? ☐No ☐Yes (*please describe*):

_____

_____

Please list your goals/expectations for counseling/therapy: _____

_____

_____

Client Mental Health History:

Has the client ever seen a mental health provider for any reason (counselor, psychologist, psychiatrist, etc.)?

Year	Reason	Name of provider

Results of previous therapy: _____

Has the client ever received inpatient hospitalization for a mental health reason?

Year	Reason	Name of hospital

Has the client ever had any psychological testing?

☐No ☐Yes *If yes, performed by whom:* _____

Has the client ever been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, eating disorders, substance abuse, oppositional defiant or conduct disorder, obsessive compulsive disorder or PTSD?
☐No ☐Yes (*If yes, please describe*): _____

Has the client ever threatened or attempted suicide? ☐No ☐Yes (*If Yes, please describe*):
_____
_____

Family Mental Health History:

Has any family member been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, suicide, obsessive compulsive disorder, substance abuse or other mental health concerns? If yes, please specify:

_____
_____

Please examine the following, and please check any boxes that apply:

Issue	Current Family	Mother's Family	Father's Family	Step-parent's family	Others in the home	Client's previous family
Drug abuse						
Alcohol abuse						
Physical abuse						
Emotional abuse						
Sexual abuse						
Multiple moves						
Financial strain						
Parental absence						
Criminal offenses						
Eating disorder(s)						
Death of a close family member						

Has a close family member ever attempted suicide or ever been hospitalized in a psychiatric facility?
☐No ☐Yes (*If yes, please describe*):_____
_____

Client Medical History:

Client's doctor:

Date of client's last physical examination and results:

Please list all current medications (*including over-the-counter meds, vitamins, herbs, or supplements*):

Medication name	Dosage	How long prescribed

Does the client have any drug allergies? ☐No ☐Yes (*please list*):

_____

Does the client have any current or chronic medical problems? ☐No ☐Yes (*please list*):
_____

If female, age of onset of menses_____ Date of last menstrual period_____ Are cycles regular? ☐No ☐Yes

Have you ever had an abortion? ☐No ☐Yes Date:

Exercise habits:
☐Sedentary (no exercise) ☐ Occasional moderate exercise ☐ Regular moderate exercise
☐Occasional vigorous exercise ☐Regular vigorous exercise

Are you concerned about the clientôs exercise habits? ☐No ☐Yes

Eating habits:
☐Healthy relationship with food ☐ Eat too little ☐ Eat too much ☐Diagnosed with an eating disorder

Are you concerned about the clientôs eating habits? ☐No ☐Yes

Client's Family Relationships:

Marital status: (*Please include dates or number of years for all that apply.*)

☐married_____ ☐separated_____ ☐divorced_____
☐remarried_____ ☐spouse deceased_____ ☐living together, but not married_____
☐never lived together ☐single

Siblings/Step-Siblings:

Name	Age	Lives with	Relationship with client

Other adults/ non-family members living in the home:

Name	Age	Relationship with client

Are there any family problems that may be contributing to your present difficulties? _____
_____
_____
_____
_____

Spiritual History:

Is spirituality, religion or faith important in your life? ☐No ☐Yes

Spiritual affiliation: ☐None ☐Christian ☐Other (*please specify*): _____

Please describe your participation in spiritual activities (*i.e. prayer, church attendance, youth group, etc.*):
_____

If applicable, please specify which church, temple, synagogue you attend: _____
Do you have a specific spiritual concern that is causing any known distress at this time?_____

_____

Does the client have a specific spiritual concern that is causing any known distress at this time?_____

Is there anything else we did not ask that you feel would be helpful for your counselor to know? _____
_____
_____
_____
_____
_____

Please review the following list of symptoms and check all that apply: Spouse 1

Sleep Pattern: Please describe if the client has problems with sleep such as frequent awakenings, nightmares, sleeping too much/not enough, sleep apnea, snoring, etc._____ Average # of hrs/night_____

Appetite changes: No___ Yes ___ Describe:_____

Weight loss or Weight gain: No___ Yes ___ Describe: _____

Fear of weight gain, purging, bingeing, restricting food, misuse of laxatives, etc.: No___ Yes___ Describe _____

Mood Swings: No ___ Yes ___ Describe _____

Loss of pleasure of previously enjoyed activities: No ___ Yes ___ Describe: _____

Fatigue or loss of energy: No ___ Yes ___ Describe: _____

Feelings of worthlessness or inappropriate guilt: No ___ Yes ___ Describe: _____

Depression: No ___ Yes ___ Describe: _____

Recurrent thoughts of death or thoughts of suicide: No ___ Yes ___ Describe: _____

Cutting or other self-harm: No ___ Yes ___ Describe: _____

Hearing voices or seeing things that others do not see: No ___ Yes ___ Describe: _____

Odd beliefs that others do not believe: No ___ Yes ___ Describe: _____

Recent concerning behavioral changes: No ___ Yes ___ Describe: _____

Unrealistic Fears/Worries: No ___ Yes ___ Describe:_____

Panic Attacks: No ___ Yes ___ (*Circle symptoms*) Shortness of breath, chest pain, racing heart, feeling of choking or dying, flushing

Time consuming rituals: No ___ Yes ___ Describe: _____

Distressing obsessive thoughts/compulsions: No ___ Yes ___ Describe: _____

Social concerns: No ___ Yes ___ Describe: _____

Any emotional trauma or recent loss: No ___ Yes ___ Describe: _____

Racing thoughts, inflated self-esteem, decreased need for sleep or participation in activities that have a high potential for painful consequences that are out of normal character (i.e. spending sprees, sexual indiscretions, substance abuse):
No ___ Yes ___ Describe: _____

Aggression/Anger: No ___ Yes ___ Describe: _____

Unexplained Headaches or Stomach Aches: No ___ Yes ___ Describe: _____

Focus/Concentration problems: No ___ Yes ___ Describe: _____

Hyperactivity/Impulsivity: No ___ Yes ___ Describe: _____

Alcohol consumption: No ___ Yes ___ If yes, list frequency and amount: _____

Marijuana use: No ___ Yes ___ If yes, list frequency and amount: _____

Other drug use: No ___ Yes ___ If yes, list substance, frequency and amount: _____

Addictions (pornography, food, internet, substances, etc.): No ___ Yes ___ If yes, Describe: _____

Defiance: No ___ Yes ___ Describe: _____

Bedwetting or daytime wetting: No ___ Yes ___ If yes, how often? _____

Fecal soiling of clothes: No ___ Yes ___ If yes, how often? _____

Lying, stealing, destroying property, initiating fights, cruelty to children/animals, or sexually acting out behaviors towards others:
No ___ Yes ___ Describe:_____

Bethel Haven
New Client Questionnaire-Spouse 2

Date: _____

Personal Data:

Client Name:	Prefers to be Called:	
Age:	Date of Birth:	Clientôs Birthplace:
Sex: ☐Male ☐Female	Race: ☐African-American ☐Caucasian ☐Hispanic ☐Asian ☐Other	
Person Completing this form:	Relation to client :	

Reason for visiting:

Briefly describe your concerns for which you are seeking help at this time:

_____

_____

_____

_____

Approximately when did the problems begin:

Any known stress or event cause or contribute to the problem(s)? ☐No ☐Yes (*please describe*):

_____

_____

Please list your goals/expectations for counseling/therapy: _____

_____

_____

Client Mental Health History:

Has the client ever seen a mental health provider for any reason (counselor, psychologist, psychiatrist, etc.)?

Year	Reason	Name of provider

Results of previous therapy: _____

Has the client ever received inpatient hospitalization for a mental health reason?

Year	Reason	Name of hospital

Has the client ever had any psychological testing?

☐No ☐Yes *If yes, performed by whom:* _____

Has the client ever been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, eating disorders, substance abuse, oppositional defiant or conduct disorder, obsessive compulsive disorder or PTSD?
☐No ☐Yes (*If yes, please describe*): _____

Has the client ever threatened or attempted suicide? ☐No ☐Yes (*If Yes, please describe*):
_____
_____

Family Mental Health History:

Has any family member been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, suicide, obsessive compulsive disorder, substance abuse or other mental health concerns? If yes, please specify:

_____
_____

Please examine the following, and please check any boxes that apply:

Issue	Current Family	Mother's Family	Father's Family	Step-parent's family	Others in the home	Client's previous family
Drug abuse						
Alcohol abuse						
Physical abuse						
Emotional abuse						
Sexual abuse						
Multiple moves						
Financial strain						
Parental absence						
Criminal offenses						
Eating disorder(s)						
Death of a close family member						

Has a close family member ever attempted suicide or ever been hospitalized in a psychiatric facility?
☐No ☐Yes (*If yes, please describe*):_____
_____

Client Medical History:

Client's doctor:

Date of client's last physical examination and results:

Please list all current medications (*including over-the-counter meds, vitamins, herbs, or supplements*):

Medication name	Dosage	How long prescribed

Does the client have any drug allergies? ☐No ☐Yes (*please list*):

_____

Does the client have any current or chronic medical problems? ☐No ☐Yes (*please list*):
_____

If female, age of onset of menses_____ Date of last menstrual period_____ Are cycles regular? ☐No ☐Yes

Have you ever had an abortion? ☐No ☐Yes Date:

Exercise habits:
☐Sedentary (no exercise) ☐ Occasional moderate exercise ☐ Regular moderate exercise
☐Occasional vigorous exercise ☐Regular vigorous exercise

Are you concerned about the clientôs exercise habits? ☐No ☐Yes

Eating habits:
☐Healthy relationship with food ☐ Eat too little ☐ Eat too much ☐Diagnosed with an eating disorder

Are you concerned about the clientôs eating habits? ☐No ☐Yes

Client's Family Relationships:

Marital status: (*Please include dates or number of years for all that apply.*)

☐married_____ ☐separated_____ ☐divorced_____
☐remarried_____ ☐spouse deceased_____ ☐living together, but not married_____
☐never lived together ☐single

Siblings/Step-Siblings:

Name	Age	Lives with	Relationship with client

Other adults/ non-family members living in the home:

Name	Age	Relationship with client

Are there any family problems that may be contributing to your present difficulties? _____
_____
_____
_____
_____

Spiritual History:

Is spirituality, religion or faith important in your life? ☐No ☐Yes

Spiritual affiliation: ☐None ☐Christian ☐Other (*please specify*): _____

Please describe your participation in spiritual activities (*i.e. prayer, church attendance, youth group, etc.*):
_____

If applicable, please specify which church, temple, synagogue you attend: _____
Do you have a specific spiritual concern that is causing any known distress at this time?_____

_____

Does the client have a specific spiritual concern that is causing any known distress at this time?_____

Is there anything else we did not ask that you feel would be helpful for your counselor to know? _____
_____
_____
_____
_____
_____

Please review the following list of symptoms and check all that apply: **Spouse 2**

Sleep Pattern: Please describe if the client has problems with sleep such as frequent awakenings, nightmares, sleeping too much/not enough, sleep apnea, snoring, etc._____ Average # of hrs/night_____

Appetite changes: No___ Yes ___ Describe:_____

Weight loss or Weight gain: No___ Yes ___ Describe: _____

Fear of weight gain, purging, bingeing, restricting food, misuse of laxatives, etc.: No___ Yes___ Describe _____

Mood Swings: No ___ Yes ___ Describe _____

Loss of pleasure of previously enjoyed activities: No ___ Yes ___ Describe: _____

Fatigue or loss of energy: No ___ Yes ___ Describe: _____

Feelings of worthlessness or inappropriate guilt: No ___ Yes ___ Describe: _____

Depression: No ___ Yes ___ Describe: _____

Recurrent thoughts of death or thoughts of suicide: No ___ Yes ___ Describe: _____

Cutting or other self-harm: No ___ Yes ___ Describe: _____

Hearing voices or seeing things that others do not see: No ___ Yes ___ Describe: _____

Odd beliefs that others do not believe: No ___ Yes ___ Describe: _____

Recent concerning behavioral changes: No ___ Yes ___ Describe: _____

Unrealistic Fears/Worries: No ___ Yes ___ Describe:_____

Panic Attacks: No ___ Yes ___ (*Circle symptoms*) Shortness of breath, chest pain, racing heart, feeling of choking or dying, flushing

Time consuming rituals: No ___ Yes ___ Describe: _____

Distressing obsessive thoughts/compulsions: No ___ Yes ___ Describe: _____

Social concerns: No ___ Yes ___ Describe: _____

Any emotional trauma or recent loss: No ___ Yes ___ Describe: _____

Racing thoughts, inflated self-esteem, decreased need for sleep or participation in activities that have a high potential for painful consequences that are out of normal character (i.e. spending sprees, sexual indiscretions, substance abuse):
No ___ Yes ___ Describe: _____

Aggression/Anger: No ___ Yes ___ Describe: _____

Unexplained Headaches or Stomach Aches: No ___ Yes ___ Describe: _____

Focus/Concentration problems: No ___ Yes ___ Describe: _____

Hyperactivity/Impulsivity: No ___ Yes ___ Describe: _____

Alcohol consumption: No ___ Yes ___ If yes, list frequency and amount: _____

Marijuana use: No ___ Yes ___ If yes, list frequency and amount: _____

Other drug use: No ___ Yes ___ If yes, list substance, frequency and amount: _____

Addictions (pornography, food, internet, substances, etc.): No ___ Yes ___ If yes, Describe: _____

Defiance: No ___ Yes ___ Describe: _____

Bedwetting or daytime wetting: No ___ Yes ___ If yes, how often? _____

Fecal soiling of clothes: No ___ Yes ___ If yes, how often? _____

Lying, stealing, destroying property, initiating fights, cruelty to children/animals, or sexually acting out behaviors towards others:
No ___ Yes ___ Describe:_____

BETHEL HAVEN, INC

1030 Village Drive, Suite B * Watkinsville, GA 30677 * Phone (706) 310-9046 Fax (706) 310-9076

Updated September 2013

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information (PHI). Commonly referred to as ñmedical records privacy law,ò HIPAA provides patient protections related to the electronic transmission of data; the keeping and use of patient records; and storage and access to health records. 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 have already received similar notices as this one from your other health care providers.
As you might expect, HIPAA laws and regulations are extremely detailed and confusing if one does not have formal legal training.

Georgia HIPAA Notice

Notice of Therapists/Counselorsô Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPAA LAWS. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- ñPHIò refers to information in your health record that could identify you.
- ñTreatment, Payment and Health Care Operationsò is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist/counselor.
- ñPaymentò is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- ñHealth Care Operationsò are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- ñUseò applies only to activities in our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- ñDisclosureò applies to activities outside of our office such as releasing, transferring or providing access to information about you to other parties.
- A health plan that intends to use or disclose PHI for underwriting purposes is prohibited from using or disclosing genetic information for underwriting purposes.
- The disclosure of PHI is restricted (for payment or health care operations) to a health plan when the patient paid for the service or item in question out of pocket in full.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An ñauthorizationò is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. ñPsychotherapy Notesò are notes that we have made about our conversation during a private, group, joint or family counseling session, which have been kept separate from the rest of your medical record. These note are given a greater degree of protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as the law provides the insurer the right to contest the claim under the policy.

- Most uses and disclosures of psychotherapy notes will require authorization.
- Uses or disclosures of protected health information for marketing purposes will require authorization.
- The sale of protected health information (PHI) requires authorization.

III. Uses and Disclosures with Neither Consent not Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

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Serious Threat to Health or Safety ï If we determine, or pursuant to the standards of our profession should determine, that you present serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- **Child Abuse** ï If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
- **Adult and Domestic Violence** ï If we have reasonable cause to believe that an adult with a disability or elder person has had a physical injury or injuries inflicted upon such adult with a disability or elderly person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authorities.
- **Health Oversight** ï If we are the subject to an inquiry by the Georgia Board of Examiners, we may be required to disclose PHI regarding you in proceedings before the Board.
- **Judicial or Administrative Proceedings** ï If you are involved in a court proceeding and a request is made about the professional services we provide you or the records thereof, such information is privileged under state law, and we will not release information without written consent from involved parties or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Worker's Compensation** ï We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to workerôs compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.
- **Fundraising**- You have the right to opt out of receiving fundraising communications.

IV. Patient's Rights and Therapist/Counselor's Duties

Patient's Rights:

- **Right to Request Restrictions** ï You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction that you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** ï You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in treatment. On your request, we will send your bills to another address to your choosing.)
- **Right to Inspect and Copy** ï You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in our presence so that any issues can be discussed. Normal hourly and/or copying charges will apply. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend** ï You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon your request, we will discuss with you the details of the amendment process.
- **Right to Accounting** ï You generally have the right to receive an accounting of disclosures of PHI. Upon your request, we will discuss with youôre the details of the accounting process.
- **Right to Paper Copy** ï You have the right to obtain a paper copy of the notice from us upon request.
- **Breach Notification**-You have a right to know when a breach of your unsecured PHI has occurred.

Therapist/Counselor's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you at the mailing address you provided.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision that we made about access to your records, you may contact us at (706) 310-9046 or via U.S. mail at 1030 Village Dr. Suite B, Watkinsville, GA 30677. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon your request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Restrictions

We will limit the uses or disclosure that we will make as follows:

- We will not release contents of ñPsychotherapy Notesò under any circumstance with the following exceptions:
  - If you file a lawsuit or ethics complaint against us, we may release ñPsychotherapy Notesò for use in our defense.
  - When the following ñUses and Disclosures with Neither Consent nor Authorizationò apply:
    - Child Abuse
    - Adult and Domestic Abuse
    - Health Oversight
    - Judicial or Administrative Proceedings
      Serious Threat to Health or Safe