



Consent for Evaluation and Treatment

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 Haven's 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. It's 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 a client 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 client 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. Clients may participate in short, medium or long-term therapy. Some clients 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 Haven's goal is to help clients gain the necessary tools and insight so that they may leave stronger, more confident and able to move forward with their lives.

For adult clients, the first appointment is for assessing and understanding the problems for which the client is seeking assistance. For minors, the evaluation process is a two-step process with initial separate appointments with the parent(s)/guardian(s) and the other with the child or teenager. These initial evaluation appointments are important to planning appropriate care and treatment. After the initial evaluation, the therapist will make treatment recommendations and work with the client and/or family 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 client or family with suitable information for seeking the needed services. Session appointments are 45-50 minutes.

Ultimately, it is Bethel Haven's desire to be an extension of Christ's 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 client's belief and value systems sharing our own faith as a function of legitimate self-disclosure according to client need. Bethel Haven's approach is "to 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." (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 Haven's 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.

Bethel Haven's Consent for Treatment and Evaluation Continued

Confidentiality

Trust is an essential part of the therapeutic relationship for both adult and minor clients. However, Bethel Haven's counselors understand that it is necessary to establish an agreement between parents/guardians and youth which clearly defines agreed upon limits of confidentiality. 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 Haven's 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 Haven's counselors utilize evidence-based therapeutic approaches, they recognize each client's 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 Therapists' rules and Code of Ethics. Currently, Fletcher McClelland, LPC serves at Bethel Haven as Clinical Supervisor 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.

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 and their parent(s)/guardian(s), 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 24-hour cancellation** notice via phone call. After the first 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 clients' family size and income, and clients' 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 Haven's 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.

Bethel Haven's Consent for Treatment and Evaluation Continued

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. We realize there may be times when information may need to be shared prior to a regularly scheduled appointment; therefore we offer clients and/or guardians the options of setting up an appointment or sending a note to be read prior to the session. You are welcomed and encouraged to call the office if there is a major change with you or your child between sessions. We check messages and return phone calls around lunchtime and late afternoon.

Clients or guardians 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 (706) 612-8083, and the on-call therapist will return your call as soon as possible. However, for life-threatening emergencies day or night, 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

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

Print name of client: _____

Print name & relationship if signing for a minor: _____

Signature of client or guardian: _____ Date: _____

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

Print name & relationship if signing for a minor: _____

Signature of client or guardian: _____ Date: _____

Bethel Haven
Client Information for Minors

Client's 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*)

Mother/Guardian's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Phone #: _____ Work #: _____

Father/Guardian's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Phone #: _____ Work #: _____

Emergency contact information:

Name: _____ Relationship to client: _____

Phone #: _____ Work #: _____

If client's 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:** _____

Print name and relationship if signing for a minor: _____

Bethel Haven
New Client Questionnaire
 (Children & adolescents under 18 yrs. of age)

Date: _____

Personal Data:

Client Name:		Prefers to be Called:	
Age:	Date of Birth:	Client's Birthplace:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> African-American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> 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

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

Are you concerned about the client's 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 client's eating habits? No Yes

Client Childhood Development:

Please describe the pregnancy (include any complications such as illness, injury, prolonged emotional stress, early onset of labor, etc. Also, please include parents' feelings about the pregnancy): _____

Was the client exposed to any substances such as medications, alcohol, tobacco, environmental toxins, etc during the pregnancy? No Yes (*If yes, please list*): _____

Birth Weight _____ Type of Delivery _____ Weeks Gestation at Delivery _____

Development Milestones (*answer as best you can recall*)

Motor Development (sitting, crawling, walking)	<input type="checkbox"/> Normal	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow
Speech & Language	<input type="checkbox"/> Normal	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow
Self-help skills (dressing, brushing, toileting, hygiene)	<input type="checkbox"/> Normal	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow

Has the client ever receive speech therapy, occupational therapy, etc.? No Yes (*If yes, specify*)

Client is disciplined at home: frequently occasionally rarely

Discipline is administered by (*Check all that apply*) mother father others

What type of discipline is used? (*Check all that apply*)
 spankings loss of privileges restrictions isolation/time out talking rewards

Effectiveness of discipline: behavior improves remains same behavior changes behavior worsens

Bedtime hour and time of getting up in the morning: _____

What are the client's responsibilities at home? _____

Client's Family Relationships:

Marital status of parents: *(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

Client's primary residence: Single-parent home Two-parent home Other _____

Currently living with:

- Both bio parents Bio Father Bio Mother Other significant relatives Other *(explain)*

If parents are separated or divorced, what age was the client when the separation occurred? _____

If one or both parents are remarried, what age(s) was the client when the remarriage(s) occurred? _____

Siblings/Step-Siblings:

Name	Age	Lives with	Relationship with client

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

Name	Age	Relationship with client

Please describe visitation and custody arrangements if parents are divorced or separated:

If adopted, please describe the circumstances and age of the client at the time of the adoption:

If adopted, is the client aware that he/she is adopted: Yes No *(If not, reason?)* _____

Please describe any bonding or attachment concerns: _____

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

Social History:

Interaction with peers:

- no friends few friends loses friends many friends
 trouble making friends bossy, controlling too shy or timid mean, aggressive

When the client chooses friends, they are:

All ages Younger Older Own age Females Males Both males and females

Does the client have a best friend? No Yes What is the age of the friend? _____

Is this a supportive friendship or destructive friendship? _____

In groups, the client is usually a: leader _____ follower _____ loner _____

What special interests, hobbies, sports and games does the client enjoy? _____

If the client is no longer participating in the above activities, what prohibits participation? _____

Please list the client's strengths and positive qualities: _____

Please list the client's weaknesses or problematic characteristics: _____

How would you describe the client as a person, not just as a son or daughter? _____

How does the client describe him/herself? _____

Have family members, friends, teachers or others ever characterized the client as being:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Humorous | <input type="checkbox"/> Fun to be around | <input type="checkbox"/> Cheerful | <input type="checkbox"/> Restless | <input type="checkbox"/> Inattentive |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Abusive | <input type="checkbox"/> Sneaky | <input type="checkbox"/> Creative | <input type="checkbox"/> Quick to anger |
| <input type="checkbox"/> Daydreamer | <input type="checkbox"/> Untruthful | <input type="checkbox"/> Nervous/Tense | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Hard Worker |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Friendly | <input type="checkbox"/> Talented | <input type="checkbox"/> Disruptive | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Mature for age | <input type="checkbox"/> Fearful | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Imaginative |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Mean to others | <input type="checkbox"/> Sad | <input type="checkbox"/> Messy | <input type="checkbox"/> Worrier |
| <input type="checkbox"/> Cruel | <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Loud | <input type="checkbox"/> Careless | <input type="checkbox"/> Helpful |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Gives up easily | <input type="checkbox"/> Motivated | <input type="checkbox"/> Sweet | <input type="checkbox"/> Quiet |
| <input type="checkbox"/> A complainer | <input type="checkbox"/> A leader | <input type="checkbox"/> Lacks Confidence | <input type="checkbox"/> Rambunctious | <input type="checkbox"/> Kind |
| <input type="checkbox"/> Conscientious | <input type="checkbox"/> Considerate | <input type="checkbox"/> Insecure | <input type="checkbox"/> Criticizes others | <input type="checkbox"/> Uncaring |
| <input type="checkbox"/> Can be trusted | <input type="checkbox"/> Doesn't complete work | | <input type="checkbox"/> Jealous of brother(s)/sister(s) | |

Has the client experienced or witnessed physical abuse, sexual abuse, or neglect?

No Yes (*If yes, please briefly describe*): _____

Is the client sexually active? No Yes

Is the client currently using or had a history of using tobacco, alcohol, or illicit drugs?

No Not sure Suspect Yes (*If yes, frequency, drug name, amount, etc*): _____

Client history of legal charges or probation: No Yes (*If yes, please explain*): _____

School/Work History:

Name of school: _____	Grade: _____
Grades Repeated, if any: _____ Any learning problems/disabilities? _____	
Please check the box for all that apply and explain the grades related to each.	
<input type="checkbox"/> Had extended or frequent illness(es): _____	
<input type="checkbox"/> Had to repeat a year: _____	
<input type="checkbox"/> Skipping school: _____	
<input type="checkbox"/> Changed schools mid-year: _____	
<input type="checkbox"/> Began school year at a new school: _____	
<input type="checkbox"/> Had conduct problems: _____	
<input type="checkbox"/> Other _____	
How does the client feel about school, teachers and peers? _____ _____	

Spiritual History:

Is spirituality, religion or faith important in the client's life? <input type="checkbox"/> No <input type="checkbox"/> Yes
Spiritual affiliation: <input type="checkbox"/> None <input type="checkbox"/> Christian <input type="checkbox"/> Other (<i>please specify</i>): _____
Please describe the client's participation in spiritual activities (<i>i.e. prayer, church attendance, youth group, etc.</i>): _____
If applicable, please specify which church, temple, synagogue you attend: _____
Does the client believe in God? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>If yes, please describe his/her relationship with God</i>): _____
Was the client raised in a spiritual or religious tradition? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>If yes, please describe</i>): _____
Does the client practice in the tradition in which he/she was raised? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>If yes, please describe</i>): _____
When the client has religious/spiritual concerns and problems, who does he/she talk to? _____
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:

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: ___ 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
Sliding Fee Scale for 45-Minute Counseling Session

Please circle the income range corresponding to the size of the family unit.

Income reported should include alimony, child support and/or SSI. For young adult clients, who are still dependents of a parent/guardian, (s)he should report the family income of the parent/guardian claiming them. If you do not wish to report this information, Bethel Haven's standard counseling rates will apply.

Family Size	Annual Gross Household Income					
	A	B	C	D	E	F
1	< / = \$14,000	\$14,001 – \$19,000	\$19,001 – \$30,000	\$30,001 – \$43,000	\$43,001 – \$54,000	> / = \$54,001
2	< / = \$20,000	\$20,001 – \$26,000	\$26,001 – \$40,000	\$40,001 – \$59,000	\$59,001 – \$73,000	> / = \$73,001
3	< / = \$25,000	\$25,001 – \$32,000	\$32,001 – \$51,000	\$51,001 – \$74,000	\$74,001 – \$92,000	> / = \$92,001
4	< / = \$30,000	\$30,001 – \$39,000	\$39,001 – \$61,000	\$61,001 – \$89,000	\$89,001 – \$112,000	> / = \$112,001
5	< / = \$35,000	\$35,001 – \$45,000	\$45,001 – \$72,000	\$72,001 – \$105,000	\$105,001 – \$131,000	> / = \$131,001
6+	< / = \$40,000	\$40,001 – \$52,000	\$52,001 – \$82,000	\$82,001 – \$120,000	\$120,001 – \$150,000	> / = \$150,001

1st Time New Client Evaluation = Regular sliding fee amount + \$25.00 new client fee

I verify that the above information I have provided is correct, and understand fees are due at the time services are rendered. I also may be asked to verify evidence of income by paystub or W2 form. (Clients will be asked to update this information annually at the beginning of each calendar year.)

Client Name _____ Signature _____ Date _____

Print name and relationship if signing for a minor _____

<p>Office Use Only</p> <p>Individual Counseling Fee: _____</p> <p>Couples/Family Counseling Fee: _____</p>

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 “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 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/Counselors’ 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:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations” 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.
- “Payment” 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.
- “Health Care Operations” 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.
- “Use” applies only to activities in our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- “Disclosure” 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 “authorization” 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. “Psychotherapy Notes” 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 notes 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 nor Authorization

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

- **Serious Threat to Health or Safety** – 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** – 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** – 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** – If we are the subject of 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** – 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** – We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s 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** – 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** – 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** – 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** – 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** – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, we will discuss with you the details of the accounting process.
- **Right to Paper Copy** – 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 “Psychotherapy Notes” under any circumstance with the following exceptions:
 - If you file a lawsuit or ethics complaint against us, we may release “Psychotherapy Notes” for use in our defense.
 - When the following “Uses and Disclosures with Neither Consent nor Authorization” apply:
 - Child Abuse
 - Adult and Domestic Abuse
 - Health Oversight
 - Judicial or Administrative Proceedings
 - Serious Threat to Health or Safety

Important Notice for All Clients

Missed Appointment Policy

We value our clients and the time reserved for each person. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments:

First Missed Appointment

Due to unforeseen circumstances or human forgetfulness, Bethel Haven will **not** charge for the first missed appointment. At which point, Bethel Haven's policy will be reviewed with you.

Missed Appointments After First:	
Notice given within a four hour window of appointment HALF OF SESSION FEE CHARGED	No Advance notice (No call, no show) FULL SESSION FEE CHARGED

**Missed appointments without a given notice lowers the quality of care we can provide to clients. Each therapy session is specifically reserved and cannot be offered to anyone else. Because of this fact and Bethel Haven's commitment to quality and timely services, we have implemented this policy to ensure availability for all. Clients will not be billed or invoiced late fees. The card information below will be used to charge the client's account. A receipt may be generated at the client's request. Please fill out the information below. Your signature only authorizes Bethel Haven to charge your account strictly under the listed circumstances alone.*

First Name:	Last Name:	E-mail:
Card #:	Expiration Date:	CVV code on back:
Zip Code associated with card:	Card Type:	
Date:	Signature:	