Changing Perceptions

Janae Combs, M.A., LPC, NCC

CLIENT REGISTRATION INFORMATION

Today's Date: _____

Client Name: _____
Last First MI

DOB: _____/_____/_____ Sex:_____ Age:_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Telephone: Home (_____)_____ Work (_____)_____Cell (____)_____

Email:_____ May I leave messages for you at home?_____ work?_____

Social Security #:_____-_____-_____ Marital Status: _____

Employer:_____ Employer Address:_____

Student: Full-time_____ Part-time_____ School:_____

Permanent Address, if student: _____

City:_____ State:_____ Zip:_____

Telephone: Home (_____)_____

Person Responsible for Bill :(if patient is a minor)_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact: _____ Relationship:_____

Telephone: Home (_____)_____ Work (_____)_____ Cell (____)_____

Primary Insurance Company:_____

Company Address:_____Telephone: (_____)_____

Under what name is the insurance policy?_____

Insured's Social Security #:_____-_____-_____ Insured's DOB:_____/_____/_____

Insured's Address:_____

Insured's Telephone: Home (_____)_____ Work (_____)_____

Insured's Employer:_____

Policy / group number:_____ Member number:_____

Insured's co-payment percentage / amount: _____

Has deductible been met for this client? Yes No

Limits on insurance for this type of benefit:_____

Secondary Insurance Company:_____

Company Address:_____Telephone: (_____)_____

Under what name is the insurance policy?_____

Insured's Social Security #:_____-_____-_____ Insured's DOB:_____/_____/_____

Telephone: (_____)_____ ID #: _____ Group policy? Yes No

Insured's Address:_____

Insured's Telephone: Home (_____)_____ Work (_____)_____

Insured's Employer:_____

Policy / group number:_____ Member number:_____

Changing Perceptions

Guiding you through life's transitions.

Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information

We have a duty to protect the confidentiality of information about you. We are required to provide you with a Notice of Privacy Practices explaining the ways we may use and disclose your information. ***Changing Perceptions*** will follow the Notice. It will be followed by any professionals and staff affiliated with ***Changing Perceptions***.

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

I may use or disclose your protected health information (PHI) for treatment, payment, and healthcare operations purposes with your consent. To help clarify what this means, explanations are provided.

Specific Examples Include:

- Emergency treatment
- Appointment reminders
- Auditing
- Worker's Compensation
- Lawsuits and disputes
- Managed Care Networks
- Payment/Reimbursement
- Protection against serious threat
- As required by law

Uses and Disclosures Requiring Authorization

I may use or disclose PHI when your appropriate authorization is obtained. For instances outside of treatment, payment, and healthcare operation, your authorization will be requested. Your "authorization" is your written permission for specific contact or transfer of information to occur with a specified individual/agency. I will request your authorization before releasing information including psychotherapy notes or evaluations. Psychotherapy notes are notes that I have made from our sessions or conversations that are not a part of your medical record. These notes have a greater degree of protection than your PHI.

You are able to give your authorization and you are able to revoke all authorizations at any given time. Revocation for each authorization must be given in writing. You cannot revoke authorization if the authorization has been relied upon for treatment or if was necessary as a condition to obtain insurance coverage.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following situations:

- **Child Abuse:** Reasonable cause to suspect a child is being abused will lead to a mandatory report to the appropriate authorities.

- **Adult and Domestic Abuse:** Reasonable cause to suspect a disabled adult or elderly person is being abused, has been neglected, or exploited will lead to a mandatory report to the appropriate authorities.
- **Judicial and Administrative Proceeding:** If you are involved in a court proceeding and a request is made about your professional services received, such information is privileged under state law, and will not be released without written consent or a court order. However, this privilege does not apply if you are being evaluated by a third party or where an evaluation is court ordered. You will be informed in advance if this is to be the case.
- **Serious Threat to Health or Safety:** If I determine that you present a serious danger of violence to yourself or another person, I may disclose information in order to provide protection against such danger to yourself or the intended victim.
- **Worker's Compensation:** I 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 illness without regard to fault.

<u>Patient's Rights and Therapist's Duties</u>

Patient Rights:

- The right to request confidential communication by alternative means and at alternative locations.
- The right to request restrictions on certain uses of your information. However, I am not required to agree to a restriction that you request.
- The right to inspect and to copy certain information of PHI in my medical or billing records. I may deny your access under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- The right to request an amendment of your information for as long as it is maintained in your record. I may deny your request. Upon your request, I will discuss with you the amendment process.
- The right to an accounting of certain disclosures of your PHI. On your request, I will discuss with you the details of the accounting process.
- The right to paper copy of the notice from me upon request even if you agreed to receive a notice electronically.
- The right to have a copy of this notice, and to choose someone to act for you.

Therapists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will make this information available either by mail or by request for a review of this information.

Breach:

- Should a Breach occur (a breach is the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI) I will contact 911/the police to make notification of such a breach as well as notify you of such a breach.

Complaints

If you believe your rights have been violated, or you disagree with a decision I made about access to your records you may contact either of the partners in this practice. We encourage you to speak to us about your healthcare concerns. You may file a written complaint to the Secretary of the US Department of Health and Human Services. This address can be provided to you upon request.

I, the undersigned, acknowledge that I have received, read, and understand the ***"Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information"*** from ***Changing Perceptions Counseling***. This policy is required by law under Health Insurance Portability and Accountability Act (HIPAA).

_____

Signature of Client or Parent/Guardian Date

_____

Name of Client or Parent/Guardian (Please Print) Date

_____

Signature of Other Adult Party/ or co-client in couples therapy Date

_____

Name of Other Adult Party/co-client in couples therapy(Please Print) Date

_____

Name of Client if under 18 years of age Date

_____

Signature of Treating Therapist Date

Changing Perceptions
Janae Combs M.A., LPC, NCC
265 West Pike Street, Suite 4, Lawrenceville, GA 30045
(678-431-4861 Fax (678) 407-4444

CONSENT FORM FOR EXCHANGE/RELEASE OF INFORMATION

PATIENT NAME:
_____

DATE OF BIRTH:
_____SSN:_____

LEGAL GUARDIAN IF PATIENT IS A MINOR:
_____

I, _____, give my permission to Janae Combs M.A**.,** LPC, NCC, her staff and the person (s) listed below to exchange information and/or records regarding myself or my dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be subject to revoke by the individual signing this consent by providing a written, signed and dated request to withdrawn the authorization except to the extent that action has already been taken.

1._____

2._____

3._____

4._____

_____
Signature of Client Date signed

_____ _____
Witness Signature of parent/ guardian

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Laura Cochling, M.Ed., LPC, NCC , Janae Combs, M.A., LPC, NCC

Contract for Counseling Services

Welcome to our private practice. We appreciate the opportunity to work with you. Before getting started, we would like to familiarize you with the policies of our practice. Please read this information carefully and feel free to discuss any questions or concerns with your therapist at any time. When you sign this document, it will represent a contract between you and your therapist.

The first few sessions will focus on information gathering and getting acquainted. This time allows your therapist to learn more about you and your concerns, goals, hopes, and expectations, while allowing you to learn more about their way of working within the psychotherapy relationship. At the end of this initial evaluation, you and your therapist will jointly plan a course of therapy to meet your needs.

Services Offered: individual, couples and family psychotherapy. Specialties include depression, anxiety, grief/loss, abuse, stress management, relationship/ family issues, (including divorce, co-parenting ,blended and step families, personal growth. I provide treatment for children, adolescents and adults as well as parenting classes.

Appointments and Cancellations

Initial evaluations usually last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Therapy sessions last 45-50 minutes (one appointment hour of 45-50 minutes duration) and are typically scheduled on a weekly basis, although some sessions may be longer or more frequent. If you cancel or reschedule an appointment, please give 24 hours notice in order to avoid being charged for that hour.

Fees and Payment

For the first evaluation appointment, the fee is $140.00. The hourly fee is $125 for each 45-50 minute session, $140 for family sessions. Fees are payable in full at the time of each session. Sliding scale rates are available for those in need of financial assistance. You may pay in cash, check, or by credit card. There is a returned check fee of $ 50.00 per check. Collection services are utilized for delinquent accounts and related charges will be applied to the balance due. There is a charge for documentation requests. See below for additional information.

Emergency/Crisis Contact

Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry a beeper nor are we available at all times. If at any time this does not feel like sufficient support, please

inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other crisis hotline
- Call SummittRidge Hospital at 678.442.5800 or local hospital
- Call Peachford Hospital at 770.454.5589 or local hospital
- Call 911.
- Go to your nearest emergency room.

Use of Insurance

We currently accept insurance panels. Insurance co-payments are due at the time of service. If we are an out-of-network provider and you wish to seek reimbursement from your insurance company, documentation will be provided to assist you with this process.

Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate. We can provide an Insurance and Benefits Information form to help you obtain this information.

We will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the client's/guardian's) responsibility to work with the insurance company to obtain appropriate reimbursement.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes your therapist will have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, your therapist has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. A copy of any report submitted is available upon request.

If you or your child is covered by a secondary insurance plan, we will be happy to provide you with appropriate billing forms which you can submit to your secondary insurance company. We will ask that you be responsible for payment of the portion of services not covered by your primary plan and that you seek reimbursement from the secondary plan for yourself.

Occasionally, services other than psychotherapy time are needed or requested (e.g., treatment reports, letters, extended telephone conversations, etc.). Such services, as well as associated out-of-pocket expenses, will be charged to your account. The hourly fee will apply, and will be pro-rated for portions of an hour if appropriate. If you enter into legal proceedings that require your therapist's participation, they will bill for all professional time (including preparation time and travel time) even if required to testify by another party. **Because of the complexity involved in legal matters the fee for those services are $200 per hour.**

Contacting Your Therapist

Your therapist may not be immediately available by telephone. When he/she is unavailable, their telephone is answered by a voice mail that they monitor frequently. They will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. Please inform her of times when you will be available. If you are unable to reach your therapist and are experiencing a life threatening emergency, contact 911 or the nearest emergency room. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary.

Confidentiality

In general, the privacy of all communications between a patient and a therapist is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a few exceptions. If your therapist has reason to believe that a child, elderly person, or disabled person is being abused, they must file a report with the appropriate state agency. If your therapist becomes aware of an immediate threat of harm to a particular individual, they would be required to take protective actions that might include notifying the potential victim, contacting the police, contacting family members, or seeking hospitalization. If a patient threatens to harm himself/herself, your therapist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, your therapist will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some proceedings, such as those involving child custody and those in which your emotional condition is an important issue, a judge may order your therapist to testify if he/she determines that the issues demand it. Alternatively, if you asserted that you had suffered mental or emotional damage in a lawsuit, such records might be necessary to prove your claim. Under any of these circumstances, your therapist would discuss the situation with you prior to providing any information about you and would protect your privacy to the greatest extent possible under the law.

FOR COUPLES:

Conceivably, one of you might someday think that your therapist's testimony would be helpful to you in a legal proceeding, such as a divorce. Please remember, that the therapist's testimony would require written releases from both of you.

Your therapist may also occasionally find it helpful or even necessary to consult other professionals about a case. During a consultation, every effort will be made to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations unless your therapist feels it is important to your work together.

The laws and standards of the psychological profession require that treatment records be kept. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you. However, since these are professional records, they can be misinterpreted to untrained readers. If you wish to see your records (or your child's records), we recommend that you review them in your therapist's presence so that they

can discuss the contents with you. Patients will be charged our hourly fee for any professional time spent in responding to information requests.

Finally, records can be released to a third party with your written consent. This might include, for example, release of information to another treatment provider or to an insurance carrier per your request. Please note, however, that your therapist cannot be responsible for the confidentiality or disposition of records released to a third party once in the hands of that third party.

Professional Records

The laws and standards of our profession require that we keep treatment records regarding your work with your therapist. You are entitled to receive a copy of the records unless your therapist believes that seeing them would be emotionally damaging, in which case your therapist will be happy to send them to another mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. As such, if access to the records is determined to be non-harmful, records will be reviewed with your therapist so that you can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests. A request to review records must be received in writing.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, your therapist will provide them only with general information about your work together, unless he/she feels there is a high risk that you will seriously harm yourself or someone else. In this case, your therapist will notify them of his/her concern. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what they are prepared to discuss.

INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my 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 I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I 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 I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

Proceed to the signature page

Informed Consent

I _____ (name of client) agree and consent to participate in behavioral health care services offered and provided at/by **Janae Combs, M.A, LPC, NCC** , a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client. If the client is under the age of eighteen or unable to consent to treatment. I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Consent

Your signature below indicates that you have read the information in **The Contract for Counseling Services** and agree to abide by its terms during your professional relationship.

_____

Signature of Client or Parent/Guardian Date

_____

Name of Client or Parent/Guardian (Please Print) Date

_____

Signature of Other Adult Party/co-client in couples' therapy Date

_____

Name of Other Adult Party/co-client in couples' therapy (Please Print) Date

_____

Name of Client if under 18 years of age Date

_____

Signature of Therapist Date

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Guiding you through life's transitions.

Laura Cochling, M.Ed., LPC, NCC Janae Combs, M.A., LPC, NCC

CREDIT CARD AUTHORIZATION

I authorize **Janae Combs (A Good Life Counseling, LLC)** to charge my credit card for services rendered, no show fees, and late cancellation fees. This information is stored in a locked file cabinet and will be shredded upon termination of counseling and balance is paid in full.

Client's Name: _____

Cardholder's Name: _____
(print name)

Cardholder's Address: _____

_____

Credit Card: _____ Visa _____ Master Card _____ Discover _____ Am-Ex.

Credit Card #: _____

Expiration Date: _____ Security Code (3-digit # on back of card):_____

Cardholder's Signature: _____

Date: _____

HSA/FSA Card Information

We are happy to attempt to use your HSA/FSA Card for your co-pays. However a regular credit card must also provided in the event that your HSA does not allow us to run the charge or you have a no-show /late cancellation fee.

HAS/FSA Card: _____ Visa _____ Master Card _____ Discover _____ Am-Ex.

Credit Card #: _____

Expiration Date: _____

Security Code (3-digit # on back of card): _____

Cardholder's Signature: _____

Date: _____

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LATE CANCELLATION, MISSED APPOINTMENT AND FINANCIAL POLICY

Once you schedule an appointment with a Changing Perceptions therapist, that time is reserved exclusively for you. In order to successfully operate our clinical practice, we rely on these therapy appointments. Therefore, we have established the following terms of agreement for missed\late-cancellation appointments and other services:

A. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes direct with the counselor or professional. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

B. Services including phone calls, emails, record reviews, and professional consults at times other than the scheduled therapy session are the patient's responsibility. These services will be billed per quarter of an hour. **The rate for these services is $35 per half hour. This includes form requests for disability. A minimum payment must be received prior to beginning any documentation work.**

C. If you require us to become involved in legal proceedings, **we require at least 5 days notice and you will be charged $375 per hour.** You must pay for the first ½ day (4 hours) prior to the court proceedings. We will be required to clear our client calendar in order to attend court.

C. I authorize my health insurance to provide payment of benefits to LAC Therapy, LLC, or A Good Life Counseling, LLC.

D. I understand records of my treatment may be shared with _____(name of insurance company) when necessary to process claims.

E. I understand I am responsible for payment if my insurance company declines payment.

F. **For any appointment that is missed or canceled with less than the required 24 hour notice, clients will be charged the missed appointment/late cancellation fee.**

G. The missed appointment fee is **$70.00.**

H. A credit card information form must be provided and will be kept in a locked file cabinet. At the time of the missed appointment/late cancellation, your card will be charged the missed appointment fee stated above.

I. Missed appointment fees are not covered by insurance, and the **fees are not the same as your copay.** Insurance can not be billed when you do not come for your appointment.

(continued next page)

J. The only exceptions are: situations that require immediate medical attention, funerals, and deaths in the family. There is no charge in these circumstances. However, there are other circumstances that do result in a charge, even though you had no control over them. These include last-minute business meetings, car breakdowns, minor illnesses, babysitters who don't show up, airplanes that don't fly on time, and similar difficulties.

I have read the above information and have been informed of the policies and procedures above.

Signature:_____ Date:_____

Proceed to the next page

Changing Perceptions Therapy
Laura Cochling M.Ed., LPC, NCC, Janae Combs, M.A., LPC, NCC
2090A. Hwy 317 #276
Suwanee, GA 30024
www.changingperceptionstherapy.com

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

Thank you so much for choosing the services that we provide. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, we have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, we may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let us know. Telephone conversations (other than just setting up appointments) are billed at our hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see

Please initial here

who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at our hourly rate. Additionally, we do not keep your phone number our cell phones, but if we need to, it is listed by your initials only and our phones are password protected. If this is a problem, please let us know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Even though we will only utilize email for appointments and brief topics, I utilize a secure email platform that is hosted by **G Suites/Google Apps for work** for your added protection. I have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. **We encourage you to also utilize this software for protection on your end. Otherwise, when you reply to one of our emails, everything you write in addition to what we have written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.**

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is our policy not to accept "friend" or "connection" requests from any current or former client on our **personal** social networking sites such as Facebook, Twitter, Instagram,

Please initial here

Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

However, Changing Perceptions has **professional** Facebook page You are welcome to "follow" me on any of these **professional** pages where we post therapeutic content. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Changing Perceptions Therapy. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. We utilize DOXY.ME. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that DOXY.ME is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, we will give you detailed directions regarding how to log-in securely. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps):

During the course of our treatment, we may recommend that you visit certain websites for pertinent information or self-help. We may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that we do not make these recommendations. Please let us know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:

Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be may be stored electronically with Therapy Notes , a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption**. Or y**our PHI will be kept on our password protected computer in an encrypted file format.

Please initial here

Electronic Transfer of PHI for Billing Purposes:

If we are credentialed with and a provider for your insurance, please know that we utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to **Net Claims Medical Management**. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions: We utilize **BB&T Swipe Simple and Chase Paymentech** as the companies that processes your credit card information. These company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as A Good Life Counseling LLC, Changing Perceptions Therapy, or LAC Therapy LLC.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time

We're required to make sure that you're aware that we're located in the Southeast and we abide by Eastern Standard Time. Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry a beeper nor are we available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We will return phone calls , texts, email," within 24 hours. However, we do not return calls (or any form of communication) on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from us, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Summit Ridge 678-442-5858

Please initial here

- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- We require an Emergency Contact Person (ECP) who We may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____
  Phone: _____
- You agree to inform me of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:
  Hospital: _____
  Phone: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number.

If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Structure and Cost of Sessions

We offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, we may provide phone, text, email, or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If

Please initial here

appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in our general "Information, Authorization, and Consent to Treatment" form. Texting and emails (other than just setting up appointments) are billed at our hourly rate for the time we spend reading and responding. We require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card Payment Form, which was sent to you separately and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. **This includes any therapeutic interaction other than setting up appointments.** We will provide you with a receipt of payment and the services that I provided. The receipt of payment & services completed may also be used as a statement for insurance if applicable to you (see below).

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. (Note: If they cover it, it's generally only for video conferencing only) Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services. As stated above, we will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, we might not see a tear in your eye. Or, if audio quality is lacking, we might not hear the crack in your voice that we could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let us know if something we've done or said has upset you. We invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Requirement

Please initial here

If we agree that TeleMental Health services are the **primary** way we choose to conduct sessions, **I require one face-to-face meeting at the onset of treatment.** We prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

- ☐ Texting
- ☐ Email
- ☐ Video Conferencing
- ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name or co-client in couples therapy (Please Print) **Date**

_____

Parent's or Legal Guardian's or co-client in couples' therapy Signature

My signature below indicates that I have discussed this telemental health form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Changing Perceptions

Guiding you through life's transitions.

Counseling Intake Form

Name_____ Date_____

Please answer the following questions honestly and to the best of your ability. ALL SECTIONS MUST BE COMPLETED.

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT FOR COUNSELOR TO REVIEW

BACKGROUND INFORMATION

Employer:		Profession/Job Title:	
Length of time with current job:		Job Satisfaction Level: (Circle)	Very Low-Low-Medium- High
Employment Status: (Circle)	FT PT SELF EMP. STUDENT UNEMP. HOMEMAKER	Highest Education Level:	

PSYCHOSOCIAL QUESTIONAIRE

1. Relationship History (Circle):

Presently Living with: Spouse Parents Roommate Alone Fiancée Partner Other: _____

Marital Status: Single Engaged Married Separated Divorced Widowed Domestic Partnership

If engaged, when is the wedding? ____/_____/_____

If married, how many years? _____ Anniversary _____/_____/_____

If divorced, provide date divorced was finalized _____/_____/_____

If widowed, how long since your spouse passed away? _____

If in a domestic partnership, how long? _____

2. Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:

_____

_____

_____

_____

_____

Has anything happened that may have brought on/intensified the problems you are experiencing?

__ Yes __ No If yes, please explain:

_____

_____

_____

When (month/year) did you first begin experiencing these problems?

_____

How many days, weeks, months or years have you been experiencing these problems?

_____

How often do you experience these problems? (check the one that best describes your current experience).

___ Most of the day, every day
___ Some part of the day, every day
___ Most of the day on most days
___ Some part of the day on most days
___ More than one a week
___ More than one a month
___ Other _____

How much is/are the problems affecting you? __ Mildly __ Moderately __ Severely

In what areas do your problems impact your life? (check all that apply)

___ Lifestyle (the way you live your life)
___ Activities (things you normally do or would like to do)
___ Relationships (your ability to form and maintain relationships with others)
___ Eating
___ Sleeping
___ Mood

Have you ever attempted suicide? ___ Yes ___ No

Have you been thinking about suicide? ___ Yes ___ No

Have you ever self harmed (ie. Cutting)? ____ Yes ____No

If so, when and do you still? _____

Have you **ever** thought about harming or killing someone else? ___ Yes ___ No

If yes, when? _____

Have you **been** thinking about harming or killing someone else? ___ Yes ___ No

3. History

Have you ever served in the Military? ___ Yes ___ No

If yes, what branch_____When: _____

Have you ever been convicted of a crime? ____No ___ Yes- Explain: _____

Are you on ___Probation ___Parole? Probation/Parole Officer: _____

In the **past year** how often have you used the following:

	Never	Once or Twice	Monthly	Weekly	Daily/Almost Daily
Caffeine	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Prescription Drugs (for non medical reasons)	_____	_____	_____	_____	_____
Illegal Drugs	_____	_____	_____	_____	_____

Exercise: ___ Never ___ 1-2 times/week ___3-4 times/week ___5-7 times/week

Overall Diet: ___Very Healthy ____Moderately Healthy ____Unhealthy ____Very Unhealthy

Hobbies/ Interests/ Talents:

_____

_____

Have you ever been diagnosed with a mental health disorder? ____ Yes ____No

If yes, what was the diagnosis(es)? _____

Please list your **previous** psychiatric/mental health providers and treatment dates:

Provider: _____ Treatment Dates: _____to_____

Provider: _____ Treatment Dates: _____to_____

Provider: _____ Treatment Dates: _____to_____

Provider: _____ Treatment Dates: _____to_____

Are you **currently** under the care of any doctor for psychiatric/mental health reasons? ____Yes ____No

If yes, what doctor and what meds are you prescribed?

Provider: _____ Treatment Dates: _____to__PRESENT__

Medication: _____ Dosage Amt and Frequency_____

Medication: _____ Dosage Amt and Frequency_____

Medication: _____ Dosage Amt and Frequency_____

Medication: _____ Dosage Amt and Frequency_____

Medication: _____ Dosage Amt and Frequency_____

Are you compliant with your meds? ___Yes ___No

Have you ever been hospitalized in a psychiatric facility? ____Yes ____No

If yes when and what was the reason? _____

Have you ever suffered form an eating disorder, such as bulimia, anorexia or obesity ___Yes ___No

If yes, which kind and when? _____

Any recent major illnesses or surgeries? If so please list:

_____

All confidential information listed on this form is essential in your therapist being able to best assess your needs.

Client Signature _____

Comments: Please feel free to include below anything else that you think is important for me to know as your therapist.