CHANGING HOPE COUNSELING

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Adolescent Informed Consent/ Intake for Counseling Services

Privacy of Information Shared in Counseling/Your Rights and Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, therapists will keep the information shared in sessions confidential, unless there is written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with a therapist in a therapy session. In some situations, therapists are required by law or by the guidelines of my profession to disclose information whether or not permission has been established or given.

Here are listed some of these situations below.

SERVICES OFFERED:

I am trained and experienced in counseling adult individuals and children. I provide counseling for a range of issues. I do not prescribe medications; however, I believe in integrative medicine and will help communicate any information to your doctor or medical staff.

I primarily assist women and children on an individual basis. I counsel minors in play therapy, sand therapy, and EMDR techniques. The Association for Play Therapy (APT), www.a4pt.org, defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Play relieves feelings of stress and boredom, connects us to people in a positive way, stimulates creative thinking and exploration, regulates our emotions, and boosts our ego (Landreth, 2002). In addition, play allows us to practice skills and roles needed for survival. Learning and development are best fostered through play (Russ, 2004).

In the initial session(s), I will gather information about you by taking a personal family history. I will also learn more about the reason you have pursued services with me. After this evaluation session(s), I will be able to offer you some first impressions of what type of work will be necessary for us to work well together. We will come up with a treatment plan for our future sessions. We will work together to devise a counseling plan that offers reasonable promise of success to meet your abilities and goals. We will regularly review these goals in our process and change them is necessary. At any time, the client has the right to terminate counseling.

CONFIDENTIALITY

Confidentiality is essential to the therapeutic relationship. In the law in Georgia your parents have a right to know the patient's records. I am requesting the parent(s) or guardian(s) to respect our privacy and we will all engage to

safeguard your privacy. A Protected Health Information (PHI) is defined as: The communication between you and your therapist is part of your clinical record of treatment. This data will be stored in a file in a secure location. This includes written records and verbal conversations.

Confidentiality cannot be maintained when:

1. You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself. Initials ____

2. You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm. Initials __

3. You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed. Initials ____

4. You tell me you are being abused physically, sexually or emotionally or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Georgia Department of Social Services. Initials ____

5. You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening. Initials ____

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example 1: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential.

Example 2: If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential. Initials: _

Example 3: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing_____, would you tell their parents?" Initials: _

Even if I have agreed to keep the information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Communicating with other adults:

School: I will not share any information with your school unless I have permission from you and your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission, but both your parent or guardian and I believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information. Initials ___

Doctors: Sometimes your doctor and I may need to work together. For example, if you need to take medication in addition to seeing a counselor or therapist, I will get your written permission and permission from your parent/guardian in advance before sharing information with your doctor. Initials: _

The only time I will share information with your doctor (even if I don't have your permission) is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Duty to Warn:
Anytime a person discloses intentions, thoughts, and plans to harm another person, the therapist is required to warn the anticipated victim and report this information immediately to the police. In addition, if a client discloses or implies a plan for self-harm or suicide, the therapist is required to make any reasonable attempt to notify the family, psychiatrist, or authorities for safe housing.

State Mandated Reporter:
If a client suggests that he or she is being abused or is abusing another or they are in danger of abuse, the therapist must and is required to report this information to social services, DFCS, or/and the police.

Client's Death:
In the unlikely event of a client's death, the spouse or parent of the deceased client has a right to the child's or spouse's records.

Court Orders:
Therapists are required to release records of clients when a court order has been placed.

Technology Understanding:
In our ever-changing world it is important that the client understands that cell phones, texting, and email are not completely secure or confidential. Your therapist may use a cell phone or email to attempt to contact you for appointments and scheduling changes only. **While email is an effective source of communication, I cannot provide counseling through the means of email.**

If this is a problem, please discuss this matter with your therapist.

HIPPA Understanding:
I have read and understand the policies for The Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy.

Adolescent Consent Form & Parent Agreement to Respect Privacy

Fees:

- Christine will bill at a rate of $95.00 per 50 minutes with a sliding scale to $65.00 (unemployed, Gwinnett marriage license discount).
- Payment is expected on the day of service by cash, check or major credit card: MC/Visa/Amex
- There is a fee associated with returned checks and late fees when payment is not rendered at time of services. Please let your therapist know if there are any hardships.

CONSENT TO EXCHANGE INFORMATION WITH DR. AHMAD, DR SHIH (and any staff nurse practitioners) to safeguard better medical treatment. Also, permission to speak with other therapists who you have seen in the past to ensure high quality treatment and communication.

Patient Name _____
Minor Parents _____
Name of Other Therapists _____
Date _____

In Case of Emergency and Cancellations:
Outpatient facilities are not set up to accommodate individuals who are reasonably safe and resourceful. Therapists do NOT carry a beeper or emergency phone. Therefore, if there is an emergency please call 911. In the event you are unable to come for your scheduled appointment for any reason, a 24-hour notice to the office is required. If there is a mental health emergency, please refer to the below numbers. A fee of $35.00 will be assessed if we are not contacted.

- 911
- Ridgeview 770.434.4567
- Peachford 770.454.5589
- Behavioral Health Link 800.715.4225

TERMINATION: If the therapist has not seen you in the office for more than 90 – 120 days, you will be contacted for continued care or we will close your file.

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Signature of Minor_____

Date_____

Parent/Guardian:

Check below boxes and sign indicating your agreement to respect your adolescent's privacy:

__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

__/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

__/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature_____Date
Parent Signature_____Date
Therapist Signature_____Date_____

CONSENT TO THERAPY or EMDR:

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature of Patient or Personal Representative_____Date _____

Printed Name of Patient or Personal Representative _____

Description of Personal Representative's Authority: _____

PERMISSION TO RECEIVE EMDR TREATMENT:

Client_____Date _____

Therapist_____Date _____

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below:

I,_____(client), hereby authorize_____(therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

(1) _____

(2) _____

(3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

_____

Additionally, the above named parties, therapist, person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has acted in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist to become effective.

Client's Signature:_____Date: _____

Parent's/Legal Guardian's Signature:_____Date: _____

Therapist's Signature:_____Date: _____

CLIENT INFORMATION FORM FOR ADOLESCENT

(this form is confidential)

Date: _____

Child name: _____
Last First Middle Initial

Parent or Legal Guardian Name: _____
Last First Middle Initial

Date of birth of child: _____ **Age:** _____ **Gender:** _____

Parent or Legal Guardian Social Security #: _____

Home street address: _____

City:_____ **State:**_____ **Zip:**_____

Name of Employer for Parent or Legal Guardian: _____

Address of Employer: _____

City:_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:** _____

Cell Phone:_____ **Email:** _____

*Calls will be discreet, but please indicate any restrictions:*_____

Referred by: _____

May I have your permission to thank this person for the referral? **I Yes I No**

If referred by another clinician, would you like for us to communicate with one another? **I Yes I No**

Person(s) to notify in case of any emergency: _____ _____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (**your signature**): _____

Please briefly describe your child's presenting concern(s):_____

_____

_____

What are your/your child's goals for therapy? _____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or feel you will have the tools to achieve them on your own) ? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has experienced:

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (approximate dates and reasons):_____

_____

Previous psychiatric hospitalizations (approximate dates and reasons): _____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional?
If yes, please list approximate dates and reasons**:** _____

_____

_____

Sexual & Gender Identity: __Heterosexual _Lesbian _Gay __Bisexual
__Transgender _Asexual _In Question __Other: _____

Racial/Ethnic Identity:

__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
_Latino/Latino-American
_Middle Eastern/Middle Eastern-American
_White/European-American
_Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____

_____

_____

How would you describe your child's relationship with his or her father?_____

_____

_____

Are the child's parents still married?_____If they are divorced, or a parent passed away, how old was the child when the parent(s) separated, divorced, or passed away? _____
How do you think this impacted the child? _____

Please describe your child's relationship with his or her grandparents:

_____

_____

Were there other primary caregivers who had a significant relationship with your child? _____
If yes, please describe how these people may have impacted your child's life: _____

_____

_____

How many sisters does your child have? ____ **Ages?** _____

How many brothers does your child have?____ **Ages?** _____

How would you describe your child's relationships with his or her siblings?_____

_____

_____

_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Current level of satisfaction child has with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____

Please briefly describe any history of abuse, neglect and/or trauma:

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What kind of diet, weight, and exercise/activity patterns does your child demonstrate?

_____

_____

Please briefly describe your child's grade, school performance, and extra school activities.

_____

_____

What are your child's hobbies, talents, and strengths? _____

Current Relationships: _____

Support System: _____

Self-Care: _____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & CIRCLE THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues such as Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting for Their Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Falling Asleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY (check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression		
Legal Trouble		Sexual Abuse		Anxiety		
Domestic Violence		Hyperactivity		Psychiatric Hospitalization		
Suicide		Learning Disabilities		"Nervous Breakdown"		

Any additional information you would like to include: (e.g., sleep habits, romantic relationships)

_____

INITIAL INTAKE REPORT

Client Name(s):_____ Date:_____

Therapist(s) Name: _____

A. Presenting Problem

B. General History

1. Abuse/Neglect:

2. Traumas:

3. Medical History:

4. Substance Dependence/Addictions:

C. Family, Friends, Relationships

1. Mother:

2. Father**:**

3. Siblings**:**

4. Other Family:

D. Romantic Relationships

E. Sexual Functioning/Issues

F. Social Support

G. Self-Care/Coping Mechanisms

H. Diet/Exercise

I. Spirituality/Religion

J. Career

1. Education**:**

2. Current Position:

3. Past Positions:

K. Recommendations / Future Plans / Referral

L. Client Strengths/Prognosis

M. Diagnosis/Diagnoses

MENTAL STATUS EXAM

Appearance: Neat__Disheveled__Appropriate Attire__Other_____
Physiological Signs: Restless_Tearful_Tense Posture_Agitated_Decreased Motor Activity_Relaxed
Manner and Attitude: Accessible_Evasive_Defensive_Euphoric_Suspicious__Irritable__Guarded Frightened Aggressive__Optimistic__Passive__Resentful__Other_____
Orientation: Time_Place_Person_Situation_
Eye Contact: Direct_Intermittent_Intense_Poor_
Verbal: Answers Appropriate_Rambling_Detailed_Circumstantial_Repetitive_Slow_Rapid_
Thought Content: Normal_Hallucinations_Delusions_Obsessions_Ruminating_Flight of Ideas_

Therapist(s) Signature: _____

DIVORCED AND GUARDIANSHIP OF ADOLESCENTS

Due to the sensitive nature of counseling and the stage of development that your teen is currently experiencing, the therapeutic relationship is a critical bond between your teen and myself. It is important that your teen feel safe and comfortable discussing personal and private topics with me. In an effort to respect the privacy and sensitive needs of your teen, I will not be discussing the content of therapy sessions with you. It is my hope that through the therapeutic process that new skills and insights will be gained, and your teen can discuss these sensitive topics with you in time. However, if at any time I assess that your son or daughter is in danger or might be dangerous to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of your teen, you will be notified immediately so that the necessary actions and precautions can be taken.

It is important not to pressure your child about what was discussed in a session. I do encourage that you always maintain an "open-mind/open-door" attitude and approach. For example: "If you want to tell me about your session, I'm interested in hearing what you have to say, but I understand if you don't want to talk about it." If at any time you have questions about your teen's progress, please feel free to contact me so we can schedule a time to meet.

Your signature below indicates that you have read and agreed with this form designated for Divorced and Guardianship persons of Adolescents.

_____

Parent's or Legal Guardian's Name (please print) Date

_____

Parent's or Legal Guardian's Signature Date

_____

Parent's or Legal Guardian's Name (please print) Date

_____

Parent's or Legal Guardian's Signature Date

_____

Client's Name (please print) Date

_____

Client's Signature Date

The signature of the Therapist indicates this form was discussed and has addressed questions you may have had relating to this information.

_____

Therapist's Signature Date

Face-to-Face Requirement

If you and your therapist agree that TeleMental Health services are the primary way that you and your therapist choose to conduct sessions, we require one face-to-face meeting at the onset of treatment. We prefer for this initial meeting to take place in our office. If that is not possible, we can utilize video conferencing as described above. During this initial session, your therapist will require you to show a valid picture ID and another form of identity verification (such as a credit card in your name). At this time, you will also choose a password, phrase, or number which will be used 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 your therapist to utilize for your treatment or administrative purposes. You and your therapist 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 us 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 our practice, and we will be utilizing that technology unless otherwise negotiated by you.

- □ Texting
- □ Email

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.

Communication Response 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 beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and additional resources can be discussed or possibly transferring your case to a therapist or clinic with 24-hour availability. We will return phone calls by texts and email within 24 hours. However, we do not return calls, in any form, 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 a return call, but to do one (or more) of the following:

- Call Behavioral Health Link/GCAL: 800.715.4225
- 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

TeleMental Health

If you and your therapist decide to include TeleMental Health as part of your treatment, there are additional procedures required specifically related 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 will not be appropriate.
- We require an Emergency Contact Person (ECP) who can be contacted on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you/we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, the ECP agrees to take you to a hospital if either you, your ECP, or we determine it's necessary. Your signature indicates that you understand we will only contact this person in any extreme circumstances as stated above.

  Please list your ECP:
  Name:_____Phone: _____

- You agree to inform your therapist of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform your therapist of the nearest mental health hospital (of your preference) to your primary location, in the event of a mental health emergency (*usually located where you will typically be during a TeleMental Health session).*

  Please list hospital name and contact number below:
  Hospital:_____Phone: _____

Structure and Cost of TeleMental Health Sessions

We primarily offer face-to-face therapy sessions. However, based on your treatment needs, your therapist may provide phone, text, email, or video conferencing (TeleMental Health). The structure and cost of TeleMental Health is the same fee as for in-person sessions. The fee for each therapy session is due at the conclusion of the meeting. Cash, personal checks, Visa, and MasterCard are accepted. We will provide you with a detailed receipt of payment. If applicable, receipt of payment may also be used as a statement for submitting to insurance. Please note that there is a $30 fee for any returned checks.

Phone calls, texting, and emails (other than for setting up routine appointments) are billed at your therapist's hourly rate for the time spent reading and responding. For ease of billing for TeleMental Health therapy, we require a credit card ahead of time. 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. Again, this includes any additional therapeutic interaction (besides setting up routine appointments).

Insurance companies have many rules and requirements specific to certain plans. For example, most will not cover therapy conducted over the telephone, or via a text/email format. Unless otherwise negotiated, it is your responsibility to learn about your insurance company's policies and to file for insurance reimbursement. As mentioned 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.

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 your therapist 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.

Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this form as well as the **Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** (which was provided to you separately). Your signature also indicates that you agree to the policies of your relationship with your therapist and/or group leader, and you are authorizing your therapist and/or group leader to begin treatment with you. Please note that this document replaces any previously signed informed consents.

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions, please ask your therapist.

_____ _____

Client Name (please print**)** Date

_____

Client Signature

If Applicable:

_____ _____

Parent or Legal Guardians Name (please print**)** Date

_____

Parent or Legal Guardian Signature

_____ _____

Parent or Legal Guardian Name (please print**)** Date

_____

Parent or Legal Guardian Signature

The signature of the Therapist indicates this form was discussed and has addressed questions you may have had relating to this information.

_____ _____

Therapist's Signature Date

FINANCIAL AGREEMENT

I _____, promise to pay my account in good faith at the time of service or for missed appointments that I did not properly cancel. I understand that I must cancel 24 hours in advance to be respectful for others that may be on a waitlist. If I do not show up for my appointment or call 24 hours in advance, I am responsible for paying a $45.00 fee. I will be unable to return for future therapy sessions until the fee is paid by phone or in person, prior to my next appointment.

Failure to show up or call 24 hours in advance, I will be responsible for paying a $45.00 fee and agree to leave my credit card information below to facilitate payment. Initials ___

I understand that if I need Christine Cantilena Barnes for court appearances or to prepare letters/documentation (in response to subpoenas, court orders, phone conversations with DFCS or lawyers, etc.), that I will pay 125.00 an hour and $500.00 in advance. Initials ___

Date: _____

Name on credit card: _____

Card number: _____

Expiration (month/year): _____

CVC: _____

Billing address: _____

Billing state/zip code: _____

Signature: _____

SELF-CARE PLAN

1. People that participate in therapy sometimes experience one or more of the following conditions:

   - Self-Harm (thoughts/feelings/behaviors to hurt, cut, hit, burn, etc.)
   - Aggression (thoughts/feelings/behaviors to hurt, break things, threaten, cut, hit, burn, etc.)

2. If you ever experience such thoughts, feelings, or behaviors, this document is a Self-Care Plan intended to help you facilitate seeking out help and assistance.

3. By signing this document, you are agreeing to the following statements and actions:
   - I understand that there are people available to help me.
   - I also understand that getting the help and assistance I need might take some time.
   - I agree not to do anything to harm myself or others in any way while I am seeking help and assistance. This includes any kind of overt or passive acts of danger to me or to others.
   - Overt acts are intentional acts to harm myself or others. Passive acts involve putting myself or others in possible danger, such as not looking when crossing a street or engaging in unprotected sexual activities.

4. If, at any time, I should feel unable to resist impulses to self-harm, to act out aggressively, or to engage in harmful behaviors, I agree to do several of the following options:

Self-care activities: _____

Call a relative, friend, or sponsor:
Name:_____Phone:_____
Name:_____Phone:_____
Name:_____Phone:_____
Name:_____Phone: _____

- Call Behavioral Health Link/GCAL: 800.715.4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.455.3200
- Visit a local Emergency Room
- Call 911

SELF-CARE PLAN (please keep in your wallet)

Self-care activities:
_____

- Call a relative, friend or sponsor:
  Name:_____Phone:_____
  Name:_____Phone:_____
  Name:_____Phone:_____
  Name:_____Phone: _____
- Call Behavioral Health Link/GCAL: 800.715.4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.455.3200
- Visit a local Emergency Room
- Call 911
- Call your therapist at 770.765.3039

I also agree to call my therapist at Changing Hope Counseling. I understand that my therapist will return my call within 48 hours unless otherwise negotiated.

5. This Self-Care Plan begins immediately and will remain in effect for the duration of your therapy with Changing Hope Counseling. Your agreement to this plan illustrates your commitment to work through any thoughts, feelings, and behaviors at this time as well as in the future.

6. Your signature below indicates that you have read and understand what is being requested of you, and you agree to uphold this Self-Care Plan without exception.

Recipient of Services (signature/date)_____

Parent/Guardian (signature/date) _____

Therapist (signature/date) _____

INFORMATION, AUTHORIZATION, AND CONSENT TO TELEMENTAL HEALTH

Thank you for choosing the services that I provide. This document is designed to inform you about what you can expect 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, smartphone, tablet, PC desktop 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, I have completed specialized training in TeleMental Health and I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

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 the call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I 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 me know. Telephone conversations (other than setting up appointments) are billed at my 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 who you have talked to, who initiated the call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. However, I 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 I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy. Even though we will utilize texting primarily for appointments, I am willing to text for DBT concerns.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I 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 for appointment confirmations and quick DBT questions or check-ins.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Blog, etc.:
It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc., because it may compromise your confidentiality and blur the boundaries of our relationship.

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. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA).

Website Portal:
I have a client portal that is accessible through my website at changinghopecounseling.com, which is powered by Weebly. Changing Hope Counseling provides forms that can be printed prior to appointments.

Recommendations For Other Websites or Applications:
During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I 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 provided as an adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Billing Purposes:
If I am credentialed with and a provider for your insurance, please know that I utilize a billing service who has access to your PHI.

Electronic Transfer of PHI for Certain Credit Card Transactions:
I utilize the company ROAMPAY for processing credit card information. This company may send the cardholder 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 or at the time the card is processed. Please be aware that it is your responsibility to know if you or the cardholder has an automatic receipt notification set up in order to maintain your confidentiality, if you choose not to receive receipts via text or email.

Your Responsibilities for Confidentiality and Tele-Mental 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:
I am required to make sure that you are aware that I am located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return texts and emails within 24 hours. However, I do not return calls 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, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800.715.4225
- 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 need to be 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, I may determine that you need a higher level of care and TeleMental Health services will not be appropriate.
- I require an Emergency Contact Person (ECP) who I 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 conducting every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go 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 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:
I offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, I may provide phone, text, or email. If your treatment needs determine that TeleMental Health services are appropriate for you, then you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

Payment is due at the time of your session — we accept Visa, MasterCard, Discover, American Express, cash, or check. A receipt of payment and the services provided will be given to you. The receipt of payment and 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. Unless otherwise negotiated, it is your responsibility to find out if your insurance company processes insurance reimbursement for TeleMental Health services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist 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/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, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone disconnection, video drops) . This can be frustrating and interrupt the normal flow of personal interaction. Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I have done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Requirement:
If we agree that TeleMental Health services are the primary way to conduct sessions, I require one face-to-face meeting at the onset of treatment and 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 (such as 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 simply 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.

Please check one or more:

Email: _____
Texting: _____
Video Conferencing: _____
Website Portal: _____
Electronic Chat Forum:_____
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 I am open to any thoughts or feelings 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:

_____ **Date:** _____

Parent or Legal Guardian's Name (Please Print)

_____

Parent or Legal Guardian's Signature

Office Use:

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

Therapist's Signature: _____
Date: _____

COURT FEES AGREEMENT

I _____, promise to pay my account in good faith at the time when I enter into a court situation. I understand that I must in advance of my court date.

I understand that if I need Christine Cantilena Barnes for court appearances or to prepare letters/documentation (in response to subpoenas, court orders, phone conversations with DFCS or lawyers, etc.), that I will pay 125.00 an hour to prepare and $800.00 for a day in court. Initials ___

I agree to pay on my credit card that I have supplied on Credit Card Agreement form.

Client's Signature: _____

Parent's Signature if Client is Minor: _____

Date: _____

Release of Information Consent

Client's name: _____

I authorize _____ to send / receive

The following information: (Please check that applies)

___ Medical history and evaluation(s)
___ Mental health evaluations
___ Developmental and/or social history
___ Educational records
___ Progress notes, and treatment or closing summary
___ Other _____

To: _____
From: _____
Your Relationship to Client:
Self _____
Parent/ Legal Guardian _____
Personal Representative _____
Other _____

The above information will be used for the following purposes:
___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review
___ Updating files
___ Other (Specify): _____
_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____

Date: _____

Witness Signature (if client is unable to sign): _____

Witness Date: _____

NO SHOW AGREEMENT

I _____, promise to pay my account in good faith at the time when **NO SHOW** for my appointment. I understand that I must cancel **24 hours** in advance to be respectful for others that may be on a waitlist. If I do not show up for my appointment or call 24 hours in advance, I am responsible for paying a $75.00 fee. Changing Hope Counseling has right to charge to my credit card the fee of $75.00. If they are unable to charge, I will be unable to return for future therapy sessions until the fee is paid by phone or in person, prior to my next appointment.

Failure to show up or call 24 hours in advance, I will be responsible for paying a $50.00 fee and agree to leave my credit card information below to facilitate payment. Initials ___

I understand that if I need Christine Cantilena Barnes for court appearances or to prepare letters/documentation (in response to subpoenas, court orders, phone conversations with DFCS or lawyers, etc.), that I will pay 125.00 an hour and $500.00 in advance. Initials ___

I agree to pay on my credit card that I have supplied on Credit Card Agreement form.

Client's Signature: _____

Parent's Signature if Client is Minor: _____

Date: _____

INSURANCE VERIFICATION FORM

Name of Patient: _____

Patient Address: _____

Patient Date of Birth: _____

Phone Number: _____

Insurance Company Name: _____

Insurance ID Number: _____

Group Number: _____

If Patient is Minor

Name of Primary Insured: _____

Insured Relationship to Patient: _____

Insured Employee Name: _____

Insured Phone Number: _____

Insured address: _____

Credit Card Agreement

Authorization use Master Card, Visa, American Express, Discover or any other card.

Client Name: _____

I hereby authorized Christine Cantilena Barnes MS, NCC, LPC (Changing Hope Counseling) to charge any unpaid balance for professional services render, to my credit card, as follow.

__MasterCard __Visa __American Express __Discover __ other

Card Number: _____

Expiration Date: _____

CVV code (3 numbers on back or 4 numbers on front of AMEX): _____

Name as appears on my card: _____

Billing Address: _____
City: _____
State & Zip Code: _____

Client Signature (Guardian signature if patient is a minor): _____
Date: _____