PHOENIX RISING
Counseling Services, LLC

LEGALS

Intake Form :**FORM**

TODAY'S DATE: _____

	Emergent		Urgent		Routine

Are you feeling suicidal / homicidal ?	Are you seeing or hearing things others can't?
YES NO	YES NO

CONSUMER INFO

Name	
DOB	
Age	
SS#	
School/Work	
Race	

GUARDIAN/SELF CONTACT INFO

Name(s)	
Address	
City/St/Zip	
Hm Phn	
Cell Phn	
Wrk Phn	
Email	

PAYMENT INFORMATION

Insurance	
Insurance ID	
Group #	
Policyholder	
Policyholder DOB	
Policyholder SocialSecurity	

EMERGENCY CONTACT

Name	Address	Relationship	Phone

ADDITIONAL COMMENTS

As a consumer with Phoenix Rising Counseling Services you have been assured of certain rights. You have the right to:

- Receive accurate and easily understood information in sufficient time to assist you in making informed decisions about your health plans, facilities, and professionals.
- Have a choice of health care providers that is sufficient to assure access to appropriate high-quality health care.
- Be told complete current information concerning your diagnosis, treatment, and prognosis in terms and language you can be reasonably expected to understand. When it is not medically advisable to give such information to you, it will be made available to an appropriate person on your behalf.
- Participate in planning your own program and the right to request choice over the composition of the service delivery team.
- Exercise all civil, political, personal, privacy, and property rights to which you are entitled as a citizen.
- Refuse service, unless a physician or licensed psychologist feels that refusal would be unsafe for you and others.
- Expect confidentiality and privacy of all facility records and communications to the full extent provided by law.
- Request an opportunity to inspect, copy, and correct your records (a copy fee may be charged).
- Refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.
- Informed consent to the extent provided by law.
- Receive services free from abuse, financial or other exploitation, retaliation, humiliation, restraints, and neglect.
- Fully participate in all decisions related to your health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- Receive considerate, respectful care at all times and under all circumstances. Consumers must not be discriminated against in based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.
- Communicate with healthcare providers in confidence and have the confidentiality of your health care information protected.
- The right of referral to legal entities for appropriate representation, and to self-help and advocacy support services.
- File a complaint & obtain a resolution if you think any of these rights have been restricted or denied.

If you feel that your rights have been violated or you have been discriminated against, you have the right to file a Grievance. To file a Grievance, you may contact our Consumer Rights Representative at (678) 404-2577 and they will assist you with the procedure. If you are not satisfied with the outcome of this process, you have the right to contact the CEO, Aundretta Wood for further investigation. If you are still not satisfied with the decision, you may contact the Department of Human Resources, Two Peachtree Street, Atlanta, GA 30303-3142 at (404) 657-5411 or (404) 657-5728.

It is the policy of Phoenix Rising Counseling Services, Inc (PRCS) to ensure that all services are provided to the consumer will be carried out in an environment that is supportive, confidential and respectful to the individual serviced. PRCS provides an immediate and fair method of resolving consumer grievances/ complaints. PRCS will not tolerate any retaliation or barriers to services as a result of a consumer's filing a complaint/grievance.

Procedures

Informal Level

If you believe you have a valid basis for client inquiry or grievance, you may discuss the matter informally and on a verbal basis with the PRCS Consumer Rights Representative, who shall in turn, investigate the complaint and reply with an answer to the complainant within five (5) working days. This communication can occur via telephone call or face to face by contacting the Consumer Rights Representative, Consumer Rights Advocate at the office number: 678-824-2010.

Formal Level

If the consumer is not satisfied with the discussion and/or resolution at the informal level, the consumer may file a grievance and initiate the formal procedures in accordance with the following:

- If the complaint is rejected or not resolved to the consumer's satisfaction, the consumer may request in writing, a review of the complaint/grievance with the CEO. This request must be filed within ten (10) working days after receiving the outcome.
- The consumer may discuss the complaint directly with the CEO/or designee. This review will be completed within ten (10) working days from the date of the request. The consumer will be informed of the outcome in writing within 5 days of the meeting.
- A written statement can be addressed to: 863 Flat Shoals Rd SE, Suite C #149 Conyers, GA 30094. The phone number is 678-824-2010.

Appeal Level

If the consumer is not satisfied with the resolution at the previous level, he/she may appeal the decision to the State of Georgia Department of Human Resources in accordance with their policy and procedures.
The consumer may appeal the decision of the PRCS CEO by filing a written request to the Regional Board Director, within ten (10) working days of receiving the disposition report. The Regional Board Director/designee will issue a decision within ten (10) working days.

Advocacy

The consumer has the right to request an advocate to assist with the grievance process if unable to do so alone.

The consumer has the right to file a complaint with:
Department of Behavioral Health & Developmental Disabilities
Two Peachtree Street, NW
24th Floor
Atlanta, GA 30303
Phone: (404) 657-2252

The contents of a counseling, intake, or assessment session are considered to be confidential under Federal Law and regulations. Both verbal information and written records about a consumer cannot be shared with another party without the written consent of the consumer or the consumer's legal guardian (42CFR). It is the policy of this organization not to release any information about a consumer without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

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

Abuse of Children and Vulnerable Adults

If a consumer states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

In the Event of a Consumer's Death

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

Professional Misconduct

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

Court Orders

Health care professionals are required to release records of consumers when a court order has been placed. Consumer's who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the County Juvenile Court may have waived certain rights to confidentiality when entering Phoenix Rising Counseling Services

Minors/Guardianship

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

Audio/Video Taping

In the event it becomes necessary to audio and/or video tape a consumer for treatment or supervision purposes, a specific consent form for the purpose of audio and/or video will be required. No recordings on any kind will be conducted without the expressed consent of the consumer.

Other Provisions

Phoenix Counseling Counseling Services, Inc. does not conduct research on any of their consumers. Outcome measure, as pertains to the effectiveness or non-effectiveness of therapeutic services, are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any consumer is disclosed, nor can any consumer be identified by any of outcome information collected. Insurance companies and other third-party payers are given information that they request regarding services to consumers. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

GENERAL POLICIES / PROCEDURES

This handout is an outline of the new policies and conditions of our practice. Please read it carefully and feel free to ask for clarification or any other questions you may have.

GENERAL RULES

- No cursing.
- No verbal/physical aggression (no hitting, kicking, biting, scratching, throwing things, etc.).
- No weapons.
- No drug use, drug intoxication, or possession of drugs.
- Contact staff 24 hours before the time of your appointment if you need to cancel or reschedule.
- Consumers are responsible for any items brought with them to PRCS property. PRCS is "held harmless" due to any items lost or stolen on PRCS property.

HOURS AND APPOINTMENTS

- Office hours are by appointment.
- We assume you are here for evaluation and treatment related to specific problem areas in your life. Your provider will work with you to assist you in making positive changes and, like all clinicians, cannot guarantee results. You will benefit the most from treatment if you are committed to the process and attend appointments regularly.
- Please plan to arrive for your appointment on time.
- We make every effort to be on time. If we run over with a previous consumer, it is related to an emergent situation. Please be patient and we will do our best to make up the time to you.
- Initial evaluations last 90 minutes. You will be asked to fill out various questionnaires. These will help your provider learn important information about you without taking up extra treatment time.
- During the initial session, recommendations / suggestions for treatment may be made including psychiatric services, therapy, or both. We may also decide to meet for one or two more 45-minute visits to get a full picture before recommendations can be made. Effective treatment requires a good match between a consumer and a provider. During your sessions, you and your provider together will determine if you are a good fit. If not, we can assist you in finding a provider that might work better for you.
- Psychotherapy appointments are 45-50 minutes. When you feel you have made sufficient progress toward your goals and are ready to end therapy, or if you wish to take a break, it is useful to have 2 or 3 sessions for this ending phase.
- Consumers arriving late will be seen for the remaining time, at the discretion of their provider. Please be aware that individuals arriving more than 15 minutes after the start of their appointment will be rescheduled.
- If you do not attend (no show) 2 or more appointments or have a history of last minute cancellations, your provider may not be able to continue treatment with you. You should receive a letter warning you of potential closure due to non-attendance and should discuss that with your

provider. In the event that you are closed for services, we will be happy to assist you with names of providers in the area.

SESSION FEES

- If acceptable insurance coverage is carried, our office will be happy to bill your insurance as a courtesy to you.
    - Regardless of insurance coverage, full payment for appointments is your responsibility.
    - If you are not covered by insurance the full fee will be required at the beginning of each appointment.
    - If a payment is not made at the time of visit, or you have an unpaid balance on your account, another appointment will not be scheduled until the payment is made.
    - If needed, a payment may be made by responding to the email invoice for your balance. If you need an invoice to be sent to you, please call 678-824-2010 and leave a message about this with your correct email address.
    - If you have special circumstances and need to make payment arrangements, please work this out with our office prior to treatment. Our work together can best proceed when financial issues are worked out ahead of time.
    - Additional policies regarding fees:
        - Please know that there is a $25 charge for any returned checks.
        - Unpaid balances will be charged 5% per month after a bill is past due.
        - Unpaid accounts will be turned over to a collections agency after 6 months if there is no payment plan is in place and no payment is received.

CANCELLATIONS AND SCHEDULING APPOINTMENTS

- Please make every effort to schedule future appointments at the beginning or end of a treatment session.
- If you need to schedule or change an appointment time, please call at 678-824-2010.
- Your appointment time is reserved exclusively for you. It is necessary for you to cancel any appointment you cannot keep. There will be no charge for appointments cancelled **24 hours** or more in advance. If you do not attend a scheduled appointment or fail to cancel prior to the **24-hour** time frame, **you will be charged $100**. Please see the section on Session Fees, above, for further information about scheduling appointments only after paying outstanding balances.

MESSAGES AND EMERGENCIES

If you have a medical emergency please call 911.

Business Week: Our clinic does not currently have regular business hours and all sessions are by appointment only. If you need to communicate with your clinician outside of your scheduled session, please call the clinic at 678-824-2010 or your therapists business phone.

Urgent Issues: For issues that *cannot wait* until the next business day, involve life or death or potential harm to self or others and occur after hours or on holidays and weekends please dial 911 immediately or go to your nearest Emergency Department.

SUPERVISION AND CONSULTATION

For professional growth and monitoring, we obtain professional consultation and supervision from our peers in the mental health field. In that context we may discuss your diagnosis and treatment plan but will not disclose your name or other identifying information.

MEDICAL RECORDS

If you wish to review your medical records we request that you make an appointment to review them with your clinician. Afterwards, you will be charged a $1.00 per page charge for the specific records you wish a copy of.

HOSPITALIZATION

We do not provide in-patient hospital care. Should you need hospitalization we will assist you by providing you information about the nearest emergency room or will provide you with the phone number to GA Crisis and Access services, who will be able to send out a mobile crisis unit to your home or location to assess for need for hospitalization.

GROUP

- Payment for services (if applicable) is due prior to entering the group room.
- Participants must attend all scheduled groups to receive credit; missing 2 or more groups will result in you having to start the group over.
- Contact agency two hours before the start of group if you will not be present for group.
- Be on time for group, if you are over 15 minutes late, you will not be allowed into group.
- You are required to hold confidential all information discussed in groups, as well as, all information concerning other group participants.
- There will be no side conversations or comments; whoever is speaking will be given full attention and respect.
- Persons not enrolled into the group will not be allowed into the group.
- You are expected to fully participate in and to be open and honest during your personal testimony.

Consumer Name: _____ Date of Birth

Guardian (if applicable): _____

I, the above named consumer or guardian acknowledge that I give permission and consent to Phoenix Rising Counseling Services, Inc (the agency) and clinical staff members to provide therapeutic counseling services to me and/or for whom I am the legal guardian. I have had the opportunity to ask questions and have had the program structure and guidelines explained to me. While I expect benefits from this treatment, I fully understand that because of factors beyond this agencies control, such benefits and particular outcomes cannot be guaranteed.

I have been provided with contact information on who to call after hours and for life threatening emergencies. I understand that regular participation will produce maximum benefits; but, my participation is strictly voluntary and I am free to discontinue treatment at any time.

I understand that conversations with clinical staff are confidential, except under certain legally defined situations. Confidentiality may be broken in situations involving threats of self-harm, harm to others, and cases of child or elder abuse. I understand that my clinician will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for this treatment. I give the agency the authorization to file claims with my insurance carrier. I authorize the agency to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical/mental condition and/or treatment to the payor or its legal representative. I also authorize the the agency to appeal any decline of authorization/payment for services.

I have read and understand the conditions stated above and I consent to voluntarily participate in treatment for myself and minor(s) listed on this Consent Form.

_____

Consumer Date

_____

Legal Guardian (if applicable) Date

_____

Staff Member Date

Consumer Name: _____ Date of Birth _____

Guardian (if applicable): _____

In order to effectively and best service each consumer in the therapeutic services programs, consumers and/or guardians may sometimes be assisted to appointments by team members, directly impacting identified treatment plan goals and objectives.

By signing below, you agree not to take any legal actions against the agency or transporting staff for any bodily harm occurred during transport. I also agree if there are any injuries requiring medical attention or any other outside professional attention I will take full financial responsibility. At no time will the agency or transporting staff be responsible for any lost or stolen property. I understand that my completion of this form is voluntary; however failure to sign the form means that I take full responsibility for ensuring that my child has transportation to any/all appointments needed while enrolled in services with this agency.

I authorize Phoenix Rising Counseling Services, staff to transport the client or my child to any scheduled appointments. I also have read and agree to the above stated transportation release statement presented by the agency and transporting staff.

_____

Consumer Date

_____

Legal Guardian (if applicable) Date

_____

Staff Member Date

PHOENIX RISING
Counseling Services, LLC

LEGALS

Release of Information :**FORM**

Consumer Name: _____ Date of Birth

Guardian (if applicable): _____

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this authorization, I authorize the use or disclosure of my protected health information maintained by Phoenix Rising Counseling Services. My health information may be disclosed in a two way or reciprocal manner under this Authorization as follows:

TO/FROM	TO/FROM
Phoenix Rising Counseling Services, Inc 863 Flat Shoals Rd SE, Suite C #149 Conyers, GA 30094	

SECTION B: SCOPE OR USE OF DISCLOSURE

This information / allowance may include, if applicable:

- ❑ Info pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- ❑ Info concerning the testing for Human Immune Virus and/or treatment for Acquired Immune Deficiency Syndrome and any related conditions.
- ❑ Privileged Communications between me and a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family counselor, or licensed professional counselor or between them concerning my communications with any of them.
- ❑ School Records, to include but not limited to: academic/attendance reports, behavioral/discipline reports, Student Team Minutes, Behavioral plans, Special Education (IEP records), Standard Test Scores, Tribunal Records.
- ❑ To provide permission for therapeutic services to occur on school/work grounds during normal hours of operation of same.
- ❑ To record my sessions for supervision / consultation purposes in either an audio and/or video format.

SECTION C: PURPOSE OF USE OR DISCLOSURE

Continuity of Care

SECTION D: AUTHORIZATION EXPIRATION

Expiration Date:

or

Expiration Event:

If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.

SECTION E: OTHER INFORMATION OF IMPORTANCE

1. I understand that this agency cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that, except when I am (1) receiving research-related treatment or (2) receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from this agency.
3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by this agency in reliance on this Authorization before written notice of revocation is received by this agency. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at this agency.

_____

Consumer Date

_____

Legal Guardian (if applicable) Date

_____

Staff Member Date

Consumer Name: _____ Date of Birth _____

Guardian (if applicable): _____

Acknowledgment of Consumer Rights

I acknowledge that I have received a copy of my Consumer Rights and understand these rights. My rights have been explained to me in a plain language, and all my questions have been answered.

Acknowledgment of General Policies / Procedures

I acknowledge that I have received a copy of the General Policies and Procedures and understand these policies. Procedures have been explained to me in a plain language, and all my questions have been answered.

Acknowledgment of Consumer Grievance

I acknowledge that I have received a copy of the Consumer Grievance and Appeals Policy and Procedure. The form has been explained to me in a plain language, and all my questions have been answered.

Acknowledgment of Confidentiality Agreement

I acknowledge that I have received a copy and fully understand the Confidentiality Agreement/Guidelines of this agency. The form has been explained to me in a plain language, and all my questions have been answered.

Acknowledgment of HIPAA

I acknowledge that I have received HIPAA –Notice of Privacy Practices for my Health Care information. This Information has been explained to me in a plain language, and all my questions have been answered.

My signature below verifies that I have received, reviewed and signed all documents listed above. Each document has been explained to me in plain language.

_____

Consumer Date

_____

Legal Guardian (if applicable) Date

_____

Staff Member Date

Consumer Name: _____ Date of Birth

Guardian (if applicable): _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective September 1, 2011. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA). If you have questions about this Notice please contact your Treatment Provider or Services Provider, or the Department's Privacy Officer at the address below.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is an agency of the State of Georgia responsible for certain programs which deal with medical and other confidential information. Both federal and state laws establish strict requirements regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. **Protected health information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to provide you this Notice of Privacy Practices, and to abide by its terms, and may change the terms of this notice at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. The Department will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services from the Department.

1. **Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by the Department, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. **Treatment:** Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. **Payment:** Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. **Health Care Operations:** The Department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. **Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object:**

a. **Confidentiality of Alcohol and Drug Abuse Patient Records:** The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or the Department, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by

you either at a facility or program or against any person who works at a facility or program or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time to the extent that the Department has not acted upon your authorization, **except** as permitted or required by law as described below. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, the Department may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.

b. **AIDS confidential information**: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, the Department will not disclose AIDS confidential information without your authorization. The Department may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. The Department may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.

3. **Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object:** The Department may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.
4. **Required Uses and Disclosures:** Under the law, the Department must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine the Department's compliance with the requirements of HIPAA regulations beginning at 45 CFR Section 164.500.
5. **Your Rights:** The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. **You have the right to inspect and copy your protected health information:** You may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the Department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it would be harmful to your physical or mental health.

b. **You have the right to request restriction of your protected health information:** You may ask the Department not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location:** Upon written request to a person listed in section 6 below, the Department will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact. The Department will not request an explanation from you as to the basis for the request.

d. **You may have the right to request amendment of your protected health information:** If the Department created your protected health information, you may request an amendment of that information for as long as it is maintained by the Department. The

Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your protected health information.

e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures the Department made to you, to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from the Department upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with the Department facility providing your treatment or services, or your treatment provider or services provider under contract or agreement with the Department which maintains your protected health information at telephone 678-824-2010, facsimile 888-705-0482, or by mail to Privacy Officer, Phoenix Rising Counseling Services, 1775 Parker Rd SE Building C, Suite 210 Conyers, Georgia, 30094.You must state the basis for your complaint. Neither the facility, the provider, nor the Department will retaliate against you for filing a complaint. You may also contact the **Department's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142,** for further information about the complaint process or this notice.

Please sign a copy of this Notice of Privacy Practices for your provider's and the Department's records.

I have received a copy of this Notice on the date indicated below.

Consumer Date

Legal Guardian (if applicable) Date

Staff Member Date

Telemental Health Informed Consent

The following information is provided to clients who are seeking telemental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully and note any questions you would like to discuss.

Client's Rights

- You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with the names of other qualified therapists.
- You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.
- You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
- You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together.
- Telemental health services are not appropriate for all clients. Generally, those who are experiencing suicidal ideation or altered mental status are not appropriate. Should telemental health services not be a good fit for you, I will assist you in finding alternative options.

Benefits and Risks

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). You will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with your therapist. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- Engage in sessions in a private location where you cannot be heard by others
- Use a private phone
- Do not record any sessions
- Password protect any technology you will be interacting with your therapist on
- Always log out or hang up once sessions are complete
- To avoid others knowing we have connected, your therapist will be contacting you from a blocked number.

Emergency Management Plan

Phoenix Rising Counseling does not provide emergency services. In the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency

hospitals below. In addition, you will need to provide information for an emergency contact person. These all need to be filled out to participate in telemental health services.

Hospital 1	
Name	
Address	
Phone	
Hospital 2	
Name	
Address	
Phone	
Emergency Contact 1	
Emergency Contact 2	

Consumer Date

Legal Guardian (if applicable) Date

Staff Member Date

Recording therapy sessions is sometimes necessary for training and supervision purposes. Your permission to allow a recording to be made of your or your child's therapy sessions is being sought in order to train counselors in training or to provide continuing education to other licensed professionals. In addition to this, small parts of the recordings may be transcribed/written down and used for work towards my training. If this were the case, all names and any factors which may identify you would not be included, so confidentiality would be maintained. All tape recordings would be destroyed after the work was completed.

Your signature below indicates that you give _____(name of your counselor) permission to audiotape / videotape (circle one or both) your sessions and that you understand the following:

1. I can request that the tape recorder or video recorder be turned off at any time and may request that the tape or any portion thereof be erased. I may terminate this permission to tape at any time.
2. The purpose of taping is for use in training and supervision. This will allow the above referenced counselor to consult with his or her assigned supervisor(s) in an individual or group supervision format, who may listen to the tape alone or in the presence of other counselors-in-training involved in direct supervision. This may also allow the counselor listed above to train other counselors.
3. The contents of these taped sessions are confidential, and the information will not be shared outside the context of individual and group supervision.
4. The tapes will be stored in a secure location and will not be used for any other purpose without my explicit written permission.
5. The tapes will be erased after they have served their purpose.

_____
Consumer Date

_____
Legal Guardian (if applicable) Date

_____
Staff Member Date

I, _____ acknowledge that I have had the opportunity to help develop and to review my/my child's Individualized Treatment Plan, which contains my goal(s) for services. The Treatment Plan has been explained to me in a plain language, as well as my questions have been answered.

_____

Consumer Date

_____

Legal Guardian (if applicable) Date

_____

Staff Member Date