CHRISTIANCOUNSELORCOOPERATIVE

Living with Heart Authorization, Consent, and Release

Fees and Payment:

The fee for the 60-minute session is $50.00. Cash, personal checks, debit cards, credit cards, and health savings account cards are all accepted. All card charges will include a $3.00 service fee. It is the policy of *Christian Counselor Cooperative, LLC* that the **Session Fee** is to be paid at the beginning of each session. There will be a $25.00 processing fee for all returned checks. An invoice or receipt will be available if you request one. If you have an upcoming session, but do not have the ability to pay, then you will need to cancel your appointment in advance and reschedule for a more suitable time.

Other contingent fees associated with your work may be: One (1) email counseling exchange, including one follow-up exchange - $60.00; other counseling related services (phone counseling, letters, preparing and sending records, etc.) - $2.00/minute. Also, counselors with the Co-op are not able to participate with insurance or as an out-of-network provider. No Co-op counselor is qualified to be a part of any court-ordered or legal process.

I understand and agree that I will be charged for and required to pay for missed appointments, at the full **Session Fee**, if not cancelled at least 24 hours in advance.

50-minute Session Fee **$** _____

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

Confidentiality Release

I, _____, pledge that I will respect the confidentiality and anonymity of every other participant. I will hold all information and personal experiences that occur as part of the group in strictest confidence. I agree to accept responsibility for honoring my fellow participants' information and experience and will not discuss them among other participants or with people who did not participate in this group. I will share only personal information about myself and my own experiences should I choose to talk with others about the group, be they other participants or not.

I make this pledge in order to contribute to an environment of safety, respect, and trust. I understand this group is designed to assist me in understanding myself and how I relate to others. Even though it provides guidelines for improving my life, I may encounter challenging results. I understand that I am fully and solely responsible for the results I experience and decisions I make regarding my use of the information and processes. I release the leaders of this group and all related institutions from any and all responsibility or promise and accept full responsibility for any change or decision now or ever made regarding my participation in the group.

Printed Name:_____

Signed: _____ Date:_____

Communication Security:

Your confidentiality is of the utmost important to us. Outside of the counseling room, our communications can include telephone, video chatting, texting, email, snail mail, and online scheduling. When communications are "secure", it indicates that there are means in place, such as encryption, to keep things private. Front to back end encryption means that the sender and receiver are both operating on a secure & private channel. Ask your particular counselor about opportunities we have for you to participate in secure video chatting, email and texting. Telephone conversations and online scheduling are not able to be secured at this time, so keep this in mind when choosing to utilize these means of communication. It is the Co- op's policy, in compliance with HIPAA, to not send a client's PHI (protected health information) over unsecured channels. PHI would include any "personally identifiable" health data. If you, as a client, send your PHI to us, it will be unsecured unless we have pre-established a secure channel together.

I accept and affirm the Christian Counselor Cooperative's policies regarding secured communications pertaining to my PHI. My initials indicate that I accept, understand, and assume the risk of telephone calls, video chatting, texting, emailing and online scheduling that is not sender-receiver-sender encrypted. _____ (initials)

Emergencies and After-Hours Communication:

After office hours, if your situation is a medical emergency, please call 911 immediately or your local emergency services for assistance. Should you call or email me between appointments, please provide a clear message and include your return contact information. Your call or email will be responded to as promptly as possible, generally between 24-48 hours. Any in-between session communication will be subject to a reasonable fee, as stated above. In order for me to return your call and, if necessary, to leave you a voice-mail, please be sure your mailbox is set up, that it clearly identifies that it is yours by name, and that there is adequate space available to lodge a message in it. Unless your mailbox is identified as yours, I cannot leave you a message.

Supervision:

I, *first name last name*, hold a master's degree in _____ _____ _____ and am actively seeing clients as a Candidate for Licensure in the State of Tennessee. I am employed by the Christian Counselor Cooperative, which provides me with an appropriate clinical setting, further professional development and weekly supervision as I accumulate direct client hours and supervision required for me to eventually be licensed in Tennessee. Once licensed, I will be able to practice on my own as an independent practitioner. My supervisor is Kirstee Williams, PhD, TN LMFT #935, COAMFTE certified supervisor for the past 6 years. Kirstee has 9 years of clinical experience and teaches as a professor in Lee University's marriage and family therapy program. Her contact number is: 423-503-9002.

Privileged Communications:

Mental Health Providers, like myself, have a strong privileged communication law in Tennessee, which carries virtually the same legal status as that of attorney-client. As the client, your disclosures and communications are considered privileged and confidential, and your records are protected under federal and state regulations governing confidentiality and cannot be disclosed or released without your written consent unless the following circumstances are believed to or do exist; *(1) where the abuse or endangering neglect of children, the elderly, or the disabled or of incompetent individuals is known or reasonably suspected; (2) where the validity of a will of a former client is contested; (3) where such information is necessary for the counselor to defend him or herself against a malpractice action brought by a client; (4) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor; (5) in the context of civil commitment proceedings, (6) where an immediate lethal threat of self-inflicted harm is disclosed to the counselor; (7) where the client, by alleging mental or emotional*

damages in litigation, puts his or her mental state at issue and the clinical record is required by the court, (8) where the client is examined pursuant to a court order, and (9) within the process of supervision and/or peer consultation, where I will need to review "non-identifying details" of your case with other counseling professionals. With the foregoing exceptions in mind, all aspects of your record are kept private, confidential, and privileged unless you specifically sign and authorize a release of information divulging information from your clinical record.

Your Informed Consent to Receive Care:

INTAKE INTERVIEW: The intake interview is an opportunity for you and I to begin the work of identifying and evaluating the situation you are presenting. A main goal of this initial interview is to match your identified needs with the most helpful resources available. Occasionally, this will mean a referral to another therapist at Elbow Tree, the Cooperative, or an outside professional or agency. If an outside referral is deemed appropriate, the Cooperative will make every effort to connect you with the therapeutic resources best suited to meet the needs with which you initially present.

LIMITATIONS OF SERVICES: I understand that Christian Counselor Cooperative services are limited to psychological and spiritual evaluation, assessment, consultation, and intervention. I understand that interventions may include consultation, counseling, and psychotherapy oriented toward helping you face life's challenges from a Biblical perspective. I understand that Christian Counselor Cooperative is not promising a cure or offering any guarantee of results or improvement of any condition or situation. I understand that while Tennessee law may permit minors sixteen years and older to consent to mental health care without parental consent, Elbow Tree does not treat minors without parental permission or authorization.

ASSUMPTION OF RISKS: I understand that the potential risks of undergoing psychological and/or counseling services may include limited precision of psychological assessment procedures, possible disagreement with the opinions offered to me, and possible increased emotional distress concerning my situation. I also understand that any court order requiring me to obtain psychological services is an obligation solely between myself and the courts and NOT the provider. I accept full responsibility for payment of all charges rendered under such obligations.

COMPLAINT PROCEDURES: If you are dissatisfied with any aspect of our work, please inform Greg Seymour, owner of CCC, immediately. This will make our work together more efficient and effective. If a problem arises requiring a legal remedy to solve, the client agrees to solve all problems through the means above or independent mediation and not in the pursuit of formal litigation.

Complaints should also be registered with the Tennessee Department of Health, Attn: Office of Investigations, 665 Mainstream Drive, 2nd Floor, Suite 201, Nashville, TN 37243, (1.800.852.2187).

You have been provided with the preceding information fully informing you about the policies of our office and some of the parameters of the care you will receive. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered to a client. Since such limitations are always a function of the particular situation in question, an individualized treatment plan will be constructed and discussed with you. Please discuss any questions you have regarding these policies and/or procedures with me.

By signing below, you are acknowledging that you have read, understood, and are fully consenting to the policies and procedures of Christian Counselor Cooperative, LLC. Your signature acknowledges your complete authorization for treatment and informed consent for care.

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

_____ _____

Witness Date

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. The Patient Notification of Privacy Rights document, provided to you, is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please ask for your therapist to provide you with further clarification.

By law, Christian Counselor Cooperative, LLC is required to secure your signature indicating you have reviewed this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Greg Seymour, M.A., LPC-MHSP HIPAA Compliance Officer

I, _____, have personally reviewed and, as needed, achieved a satisfactory understanding with my counselor of the Patient Notification of Privacy Rights document which provided me with a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I am satisfied with my understanding of this document and am signing this "acknowledgment form" as evidence of my satisfaction.

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age Date

_____ _____

Witness Date

■ Copy of *Patient Notification of Privacy Rights* made available to client/parent/guardian

■ Copy of *Patient Notification of Privacy Rights* declined by patient/parent/guardian