Sheltered Cove Counseling Center
6488 Spring St., Suite 102, Douglasville, GA 30134
Ph: 770-949-1595 Fax: 770-489-7521

Informed Consent Form for Psychotherapy Assessment & Treatment

****Please read the following carefully and initial on the line at the bottom of each page indicating that you have read and understand the information provided.*

Welcome to Sheltered Cove Counseling Center ("SCCC"). We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at SCCC. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background, Theoretical Views and Services

SCCC offers professional psychotherapy (i.e. counseling) services to individuals, couples, and families. SCCC counselors are independent contractors. Each counselor offers services in a variety of treatment areas based on their education, training and experience. SCCC's counselors' practice within their specific scope of training and experience. If SCCC does not have a counselor that is a good fit for your treatment needs, or if additional needs arise during your treatment, you may be referred to other treatment providers. All SCCC counselors will have, at minimum: (1) a master's degree in their chosen field; and (2) a current license from the Georgia Board of Professional Counselors, Social Workers, & Marriage and Family Therapists. Please feel free to discuss with your counselor any further questions you may have regarding individual credentials, certifications, theoretical views, background and experience.

Treatment Process & Rights

Your counseling process will begin with one or more sessions devoted to an initial assessment so that your counselor can develop an appropriate understanding of your issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, you and your counselor will discuss the goals and objectives of treatment and develop a treatment plan. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment, or to withdraw your consent for treatment. You have the right to accept or reject any information presented by your counselor.

Length of Treatment

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.

Purpose, Limitations, and Risks of Treatment

The purpose of counseling is to: (1) identify issues that are causing you distress; (2) help you create therapeutic goals and objectives (a "treatment plan") that will help you resolve those issues; and (3) achieve positive results through a process of personal change. Counseling has both benefits and risks. Because the counseling process often requires discussing unpleasant aspects of your life, risks often include uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Additionally, attempts to address issues can sometimes result in changes that are unexpected or unintended. Counseling has also been shown to have benefits in many cases. Counseling can often lead to a significant reduction in feelings of distress; increased satisfaction in interpersonal relationships; greater personal awareness and insight; increased skills for managing stress; and resolutions to specific problems. While the expectation that clients may benefit from counseling is reasonable, progress can't be guaranteed due to the responsibility of the client to initiate and maintain change. While our therapists certainly hope that participating in counseling will help you resolve issues and achieve your goals, it is important that you understand the limitations and risks of treatment discussed above, and that there are no guarantees that the counseling process will be effective.

Please initial that you have read this page _____

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at SCCC**.** We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

Client Participation & Responsibilities

In order for therapy to be most successful, it is important for you to:

- ✓Maintain your own personal health and safety and to report any Safety Concern immediately.
- ✓Take an active role in the counseling process (i.e. honestly sharing thoughts and feelings and concerns).
- ✓Follow through on assignments both during and in between session that were mutually agreed upon with your counselor. Generally, the more of yourself you are willing to invest, the greater the return.
- ✓Reflect of the themes or issues that may arise during therapy
- ✓Provide accurate information regarding past and present physical and psychological problems (including hospitalizations, medication, and/or previous treatment that may impact your current treatment)
- ✓Avoiding any mind-altering substances like alcohol or non-prescription drugs for at least 8 hours prior to your therapy sessions.
- ✓Keep scheduled appointments and reply to SCCC contact requests.

Client's Rights

- ✓ Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- ✓ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ✓ Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
- ✓ Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- ✓ Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI.
- ✓ Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- ✓ I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- ✓ I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- ✓ If I revise my policies and procedures, I will provide you with a revised notice via U.S. regular mail, email or patient portal.

Client-Counselor Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Please initial that you have read this page _____

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their client's secret. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Cancellation Policy

If you are not able to keep your appointment, you must call **24 HOURS IN ADVANCE** of your appointment to cancel and/or reschedule. If SCCC in NOT contacted 24 hours in advance of your appointment time, it is considered a "NO SHOW." If you call less than 24 hours, it is considered a "LATE CANCELLATION." If the 24-hour advance notice is not received, **you will be financially responsible for the session you missed by paying a $65.00 fee**.
***Please note that insurance companies DO NOT reimburse for missed sessions.

The following are conditions under which a client would no longer be able to be eligible to receive services at the SCCC for a period of 6 months. (Client(s) may receive assistance with a referral):

- No-Shows for two (2) schedule appointments in a 90 day period
- A combination of four (4) No-Show/Late Cancellations in a 90 day period
- A pattern of non-attendance including No-Shows, Late Cancellations, or rescheduling of appointments.

In certain conditions, SCCC may contact you via phone, email, etc. to attempt to schedule an appointment. If you are not reached directly via phone, often a voicemail and/or email will be left that includes a deadline for contacting SCCC via phone or in-person. Because of the large number of people requesting services, if we have not heard from you before the deadline, we will have to give your therapist assignment to another client awaiting SCCC services, and you will have to be re-assigned or placed on a waitlist to be rescheduled.

Emergencies

SCCC hours are Monday through Friday from 8am – 5pm AND by appointment (which may include evening and weekend appointments depending on the therapist schedule).

SCCC is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do NOT have 24-hour availability. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call 911.
- Go to your nearest emergency room.
- Call Ridgeview Institute at 770.434.4567 (Locations: Smyrna, GA & Monroe, GA), All Ages
- Call Peach Ford Hospital at 770.454.5589 (Location: Atlanta, GA), All Ages
- Call Willowbrooke at 770-456-3266 (Location: Villa Rica, GA), All ages
- Call Laurelwood Hospital at 770-531-3808 (Location: Gainsville, GA)
- Call Riverwoods at 770-991-8500 (Location: Riverdale, GA), Adolescents and Adults

Please initial that you have read this page _____

Privacy, Confidentiality and Records

In general, the privacy of all communication between a client and your therapist, including that of minors, is protected by law. As such, your counselor is not at liberty to release information to another professional or interested party without written permission from the client/guardian, except when such disclosure is permitted by law.

Records

Please be aware, pursuant of HIPAA, SCCC therapists and staff keep a written record of your work together. The law states it must be kept for seven years. Any electronic records are encrypted and password protected. All original documents are secured in a locked filing cabinet in our business office. These records may include any correspondence, completed paperwork, session dates, any payments, your reason for pursuing counseling, how it has impacted your life, and any goals established during counseling. You have a right to request a copy of this information, for yourself or someone else. This request must be made in writing at least seven days in advance, along with $25.00 to cover administrative costs. You will not be given notes referred to as Psychotherapy notes, as this could hinder the counseling relationship and process. These notes can only be released upon court order. Also, you will not be given your record until you pay any outstanding charges. Please note, SCCC therapists will not audio or video record interactions, and neither may you.

Electronic Transmissions

Please know that any information transmitted via credit card payment, fax, email, or text cannot be guaranteed as secure. While SCCC does send appointment reminders via email or text, no identifying information will be contained therein. Anything you put in a fax, email, or text is your responsibility. SCCC will respond; however, we will make every effort to not divulge anything pertinent in doing so. Again, any electronic files are encrypted, password protected. Please note, most insurance providers are now online. Authorization, billing, payment, and records necessary to counseling are typically handled in this manner, or via fax. You have the right to refuse to have anything handled electronically. If you wish to refuse, you will be given a receipt, known as a Superbill, to file with your insurance provider yourself. Payment for counseling services will be due upfront.

Consultation

The competent and ethical practice of counseling requires regular case consultation with other licensed professionals. Should SCCC therapists obtain consultation regarding aspects of your case, they will omit identifying information so your confidentiality may be maintained.

Confidentiality Outside of SCCC - Legal & Community

Please let your SCCC therapist know if you are currently involved in legal proceedings, think you may become involved in legal proceedings, or are pursuing counseling at the direction of an attorney and/or judge. SCCC reserves the right to decline services based upon such criteria, and cannot testify in court on behalf of anything that occurred before becoming a client. Subpoenas are highly discouraged to protect the confidentiality of our sessions, as well as the counseling relationship and process as a whole. A Release of Information must be signed prior to any court appearances. The Notice of Privacy Practices, that you have also been given, explains confidentiality in detail. Please let your therapist know if you have any questions. Please note that while this office is in a shared space, every effort is being made to protect your privacy. Please also note that should your therapist see you in public, they may not acknowledge you unless you first acknowledge them, nor will they befriend you on any social media websites. Reviews made on any social media websites cannot be guaranteed as private.

I. Uses and Disclosures of Records for Treatment, Payment, and Health Care Operations

All documented communication becomes part of a clinical record of treatment, and it contains Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
    a. Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    b. Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Please initial that you have read this page _____

c. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures of Records Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures of Records Permitted by Law (Not Requiring Authorization)

Disclosure may be required (i.e. confidentiality may not apply) in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Composite Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

*In the case of Judicial and Administrative Proceedings, your therapist's license DOES provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential. Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Professional Fees
All sessions (Individual, Couples, Family, & TeleHealth) are **billed to your insurance** at a rate of $120/session.

SCCC therapists agrees to provide psychotherapy according to the following **SELF-PAY** fee schedule:

Intake Session/Individual, Couples, Family, TeleHealth – 60 min	$120
Individual, Couples, Family or TeleHealth – 45-50 min	$65-$95
Individual, Couples, Family or TeleHealth – 30 min	$45-$75
Evaluations (Drug & Alcohol, Trauma (for DFCS), etc.)	$300
Non-Therapy Phone Calls longer than 10 minutes	Billed at $2/min
Subpoena/Court Fees	$300 base rate, $150 for each additional hour including travel time. $65/hour when not cancelled 48 hours in advance.
Late Cancellation/No Show Fee	$65
Returned Check Fee	$25
Medical Records Request Fee (Per GA Dept. of Comm. Health – Effective July 1, 2019)	$25 for Search/Retrieval, 1-20 pages (.97/pg), 21-100 pages (.83/page), Over 100 pages (.66/page)

Psychotherapy self-pay fees vary by therapist, however typically range from $65-$120/Session. ***All payments (deductible, co-pay, or self-pay rate) will be made at the time services are rendered***, unless other arrangements have been made with your therapist. Cash (exact change), personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and a receipt will be provided. SCCC reserves the right to change fees with 30 days' notice.

Collections
I am aware that in the event of default of payment on this account, my account may be turned over to an outside collection agency or legal representative for collection. Any additional costs incurred by SCCC to collect the outstanding balance will become my responsibility.

Court/Subpoena Fees
If your therapist is subpoenaed to court on your behalf, the charge will be a minimum of $300.00 (two hours including travel) and $150.00 for each hour thereafter. If court is canceled or postponed or it is decided that your counselor's testimony is not needed without a 48 hour notice you will be charged a $65.00 fee for each hour you have booked.

Refund Policy: All fees for counseling services that are delivered to you are non-refundable. However, if you have pre-paid for multiple sessions, you can request a refund of all unused counseling fees at any time. You are also entitled to a refund on any unused overpayments (i.e., credits) on your account.

Third Party Billing: If your counseling fees are being paid for by a third party (a church, family member or friend, employer, etc), please note that you will be responsible for (a) any late-cancel/no-show fees; and (b) any payments that the third party does not pay.

Insurance and Billing: If you have health insurance, it may provide coverage for behavioral health services. SCCC provides outpatient services. As a courtesy to you, SCCC staff are happy to bill your insurance provider for you. This does not release you from the responsibility of any charges they do not cover. You, the client, are ultimately responsible. SCCC staff will notify you if your insurance company has not paid SCCC within 60 days from the date of service. SCCC will send you a bill if your insurance company has not paid SCCC within 90 days from the date of service.

Proof of insurance will be provided at the time of service, or I will be required to pay the session fee at the time of visit. I will be responsible for paying my full balance should my insurance default on payment for any reason.

- If your therapist is out-of-network, SCCC is happy to provide you with a receipt, known as a Superbill, to submit to your insurance provider within 90 days for reimbursement to you after each session. You will be responsible for payment in full in advance. Please be aware that insurance providers often require an update on how counseling is going, any concerns or stressors you may have, as well as your general level of functioning. They also require a diagnosis for reimbursement of counseling services. A diagnosis is a term used to describe the nature of your problem, and indicates if the problem is considered long-term or short-term. All diagnoses come from the DSM V or ICD-10. Please consult with your therapist to discuss any diagnostic impressions.

Please initial that you have read this page _____

- Paying out-of-pocket helps avoid a diagnosis altogether, thus further ensuring your privacy. There are many benefits to paying out-of-pocket for counseling services. Confidentiality is lessened when protected health information (PHI) must be reported to your insurance provider. When this information is reported, it becomes a part of your mental health record and a national data-bank. Certain diagnoses may hinder your ability to receive disability, health insurance, life insurance, or even certain employment opportunities. Furthermore, insurance providers often dictate who you may see, the number of sessions you may have, and the length sessions may be. Struggling with one of life's many challenges, such as divorce or grief, may not meet your insurance provider's criteria as being medically necessary to receive counseling services. For example, most insurance providers do not recognize couples counseling. Such struggles are common, and do not necessarily mean you are suffering from a mental illness. Additional benefits to paying out-of-pocket, is the ability to keep costs down. Insurance providers contract with Counselors for a percentage of their customary rates, causing Counselors to have higher rates in order to keep their practices open and services flowing. Paying out-of-pocket also means less paperwork for the Counselor, thus allowing more time and energy for the direct care of the client. Overall, care is more personalized, treatment options are more flexible, sudden insurance changes may be avoided, sudden rate increases may be prevented, certain costs may be waived in the face of hardship, labels and their long-term effects may be avoided, any stigma associated with counseling may be removed, and true privacy may be maintained. The costs of this practice are kept below fair market value for the area, as we do not want anyone to be discouraged from pursuing counseling due to financial concerns. If you wish to decline, and thus forego the use of insurance, please let us know. You may make this decision at any time, making you responsible for payment in full at the beginning of each session.

Statement Regarding Ethics, Client Welfare & Safety

SCCC assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact LISA KLINGER at 770-949-1595.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Lisa Klinger, Compliance Officer at 770-949-1595.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the attention of your therapist's name c/o Lisa Klinger, Compliance Officer at Sheltered Cove Counseling Center, Inc. at 6488 Spring St., Suite 102, Douglasville, GA 30134.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 1, 2020. SCCC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that maintained by SCCC. SCCC will provide you with a revised notice by U.S. Regular Mail, email and/or your client portal.

Please initial that you have read this page _____

SCCC Informed Consent/Notice of Privacy Practices
Signature Page

We are sincerely looking forward to working with you on your journey toward healing and growth.
If you have any questions about any part of this document, please ask your therapist.

My signature below indicates that I:

- ✓ Have read and understand all of the information in this document
- ✓ Accept SCCC policies & procedures related to services, privacy, and consultation
- ✓ Accept the risks to confidentiality inherent in the use of electronic mail for communications regarding scheduling, administrative, and other non-clinical matters
- ✓ Authorize by my signature below to Sheltered Cove Counseling Center, Inc. to release to authorized representatives of my insurance company, their agents or third party payers, confidential information including copies of records as these records may be requested or necessary for the completion of claim processing and/or authorizations for future treatment.
- ✓ Release Sheltered Cove Counseling Center, Inc. from all legal responsibility or liability that may arise from the release of such records.
- ✓ Are responsible for notifying SCCC of any changes in my mailing address, telephone numbers, insurance and employment.
- ✓ Authorize my therapist to begin treatment

_____ _____

Child or Teen's Name (Please Print) **Date**

_____ _____

Legal Guardian's Name (Please Print) **Date**

_____

Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

I have saved an electronic copy.

I would like a paper copy.

I decline a copy of this document.

Please initial that you have read this page _____

SHELTERED COVE COUNSELING CENTER
6488 SPRING STREET, SUITE 102
DOUGLASVILLE, GA 30134
PH: 770-949-1595

CONSENT FOR TELE-HEALTH SERVICES

Introduction

Tele-Health is the delivery of Mental Health services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. The interactive electronic systems used in Tele-Health incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits

• Increased accessibility to psychiatric care.

• Patient convenience.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of Tele-Health. These risks include, but may not be limited to:

• Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision-making by your provider.

• Your provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.

• Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

• Security protocols can fail, causing a breach of privacy of confidential health information.

• A lack of access to all the information that might be available in a face to face visit, but not in a Tele-Health session, may result in errors in judgment.

Alternatives to the Use of Tele-Health

• Traditional face-to-face sessions in your provider's office.

Patient's Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-Health.

• I have the right to withhold or withdraw my consent to the use of Tele-Health during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

• I have the right to inspect all medical information that includes the Tele-Health visit. I may obtain copies of this medical record information for a reasonable fee.

Please initial that you have read this page _____

• I understand that my provider has the right to withhold or withdraw consent for the use of Tele-Health during the course of my care at any time.

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-Health.

• I understand that the all rules and regulations that apply to the provision of healthcare services in the State of Georgia also apply to Tele-Health.

Patient's Responsibilities

• I will not record any Tele-Health sessions without written consent from my provider. I understand that my provider will not record any of our Tele-Health sessions without my written consent.

• I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

• I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for Tele-Health. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of Georgia to be eligible for Tele-Health services from my provider.

• I understand that my initial evaluation will not be done by Tele-Health except in special circumstances under which I will be required to verify my identity.

Patient Consent to the Use of Tele-Health

I have read and understand the information provided above regarding Tele-Health. I have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Tele-Health in my health care and authorize my provider to use Tele-Health in the course of my diagnosis and treatment.

_____
Print Name of Client

_____ _____
Signature of Guardian (for clients age 17 or younger) Date

_____
Print Name of Guardian

I accept an electronic copy of this consent form. _____ (Guardian Initials)

Sheltered Cove Counseling Center

6488 Spring Street, Suite 102, Douglasville, GA 30134
Ph: 770-949-1595, Fax: 770-489-7521

Recurring Credit Card Payment Authorization

You agree to authorize scheduled charges to your credit card. You will be charged the amount of your Co-Payment/Deductible according to your insurance OR the Self-Pay rate OR a No Show/Late Cancellation fee ($65). A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the amount changes, in which case you will be notified at the time of your appointment and prior to charging your credit card.

Please complete the information below:

I _____ authorize **Sheltered Cove Counseling Center** to charge my
(Cardholder's Name) (Merchant's Name)

Credit Card indicated below for the purpose of counseling services in the amount of $_____ on the date(s) of my scheduled appointment(s) OR for the purpose of a $65 fee for no show or late cancellation (less than 24 hours' notice in advance of your scheduled appointment).

Billing Address: _____
Street

_____ _____ _____
City State Zip

Phone: _____ Email: _____

Account Type: Visa Mastercard AMEX Discover

Cardholder Name:

Account Number:

Expiration Date: CVV:

SIGNATURE _____ DATE _____

I authorize Sheltered Cove Counseling Center to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the reasons described above, for the amount indicated above only. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Sheltered Cove Counseling Center in writing of any changes in my account information or termination of this authorization prior to the next billing date/counseling session. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.