Adult Intake Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City/State/Zip: _____

Main Phone: _____ Other Phone: _____

E-mail: _____

Do we have permission to e-mail you (please initial if yes): _____ Leave a message on main phone (please initial if yes)? _____

Employer/phone #: _____

Profession: _____ Highest level of education: _____

Are you currently enrolled in school? If yes, where: _____

How did you hear about us? _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship: _____ Phone: _____

Alt. Phone: _____ Address: _____

Do you authorize KCounseling LLC to discuss care or treatment with this individual in the event of an emergency? (Please initial yes or no) Yes _____ No _____

WELLNESS INFORMATION

How can we help you at this time? What would you like to address?

_____

_____

_____

_____

Have you received any prior mental health treatment? ___ Yes ___ No
If yes, please describe: _____
_____

Drug/alcohol treatment: ___ Yes ___ No
Suicidal thoughts/attempts: ___ Yes ___ No
Psychiatric hospitalizations: ___ Yes ___ No
Involvement with self-helpgroups (e.g., AA, Al-Anon,
NA, Overeaters Anonymous): ___ Yes ___ No

Are you currently receiving psychiatric/psychological services from anyone else (please list name and type of service):

_____
_____

Are you currently taking any psychotropics medications (please list medication, dosage, and name of prescribing physician):

_____
_____
_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression	___ Elevated mood	_____	Phobias/fears
___ Alcohol use	___ Fatigue	_____	Recurring thoughts
___ Anger	___ Gambling	_____	Sexual addiction
___ Antisocial behavior	___ Hallucinations		
__ Anxiety	___ Hopelessness	_____	Sick often
___ Avoiding people	___ Impulsivity	_____	Sleeping problems
___ Chest pain	___Irritability	_____	Speech problems
___ Cyber addiction	___Judgment errors	___	Suicidal thoughts
___ Depression	___Loneliness	_____	Thoughts disorganized
___ Disorientation	___Memory impairment	___	Trembling
___ Distractibility	___Mood shifts	_____	Withdrawing
___ Drug dependence	___Panic attacks	_____	Worrying
___ Eating disorder	__Other: _____		

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ____ Yes ____ No
If Yes, explain: _____

MENTAL HEALTH HISTORY

Have you ever been hospitalized for psychiatric reasons? _____ Yes _____ No

If yes, when and where: _____

Are you currently seeing a psychiatrist? Yes _____ No _____

Have you seen a psychiatrist in the past? Yes _____ No _____

If yes, name, location, dates: _____

Have you seen a counselor in the past? Yes _____ No _____

If yes, name, location, dates: _____

Marital Status

____ Married ____ Single ____ Divorced ____ Separated
Length of time: __ _____ Number of marriages: _____
Assessment of current relationship: ____ Good ____ Fair ____ Poor

Development

Are there special, unusual, or traumatic circumstances that affected your development? _____

Has there been history of child abuse? ____ Yes ____ No
If Yes: ____ Physical ____ Verbal ____ Emotional ____ Sexual

The abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: _____

_____

Comments regarding: childhood development: _____

_____

__

Social Relationships

Check how you generally get along with other people:

___ Affectionate ___ Aggressive ____ Avoidant ___ Fight/argue often ___ Follower
__ Friendly

___ Leader ____ Outgoing _____ Shy/withdrawn

___ Other (specify): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes _____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters?

____Not Much ____Little ____Moderate ____Much

Are you affiliated with a spiritual or religious group? _____

_____

Were you raised within a spiritual or religious group?

_____

Legal

Are you involved in any active cases? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

Have you previously been incarcerated or on probation/parole?

____ Yes ____ No If yes, please describe: _____

_____

Education

Fill in all that apply: Years of education: ___

Currently enrolled in school? ____ Yes ____ No

Highest degree obtained: _____

Special circumstances (e.g., learning disabilities, gifted): _____

_____

Employment

Begin with most recent job, list job history: _____

Employer	Dates	Title
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Currently: ____FT ____PT ____Disabled ____Retired ____Unemployed ____Student ____**Other** _____

Military

Military experience? ____ Yes ____ No

Combat experience? ____ Yes ____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___ AIDS	___ Dizziness	___ Nose bleeds
___ Alcoholism	___ Drug abuse	___ Pneumonia
___ Abdominal pain	___ Epilepsy	___ Rheumatic Fever
___ Abortion	___ Ear infections	_____ STD
___ Allergies	___ Eating problems	___ Sleeping disorders
___ Anemia	___ Fainting	_____ Sore throat
___ Appendicitis	___ Fatigue	___ Scarlet Fever
___ Arthritis	___ Freq urination	_____ Sinusitis
___ Asthma	___ Headaches	___ Smallpox
___ Bronchitis	___ Hearing problems	___ Stroke
___ Bed wetting	___ Hepatitis	___ Sexual problems
___ Cancer	___ Hypertension	___ Tonsillitis
___ Chest pain	___ Kidney problems	___ Tuberculosis
___ Chronic pain	___ Measles	___ Toothache
___ Colds/Coughs	___ Mononucleosis	___ Thyroid problems
___ Constipation	___ Mumps	___ Vision problems
___ Chicken Pox	___ Menstrual pain	___ Vomiting
___ Dental	___ Miscarriages	___ Whooping cough
___ Diabetes	___ Neurological	___ Other (describe): _____
___ Diarrhea	___ Nausea	_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Current medications	Dose	Dates	Purpose
_____	_____	_____	__
_____	_____	_____	__
_____	_____	_____	__
_____	_____	_____	__

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: _____

_____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

___ Sleeping ___ Eating _____ Energy Level

___ Nerves/Tension ___ Weight _____ Physical Activity

Describe changes in areas in which you checked above: _____

_____

GENERAL HEALTH INFORMATION

Primary Physician: _____ Phone#: _____

Name/Address/Zip: _____

Current Medical Conditions: _____

_____

Historical Medical Issues:

_____

_____

SOCIAL/EMOTIONAL HISTORY:

Describe your use of alcohol, tobacco, recreational drugs, and/or prescription drugs: _____

_____

Are you concerned about your alcohol, tobacco or substance use, including prescription drugs? _____

_____

If yes, how can we assist you? _____

Legal involvement: _____

Child custody and/or divorce case: _____

Who do you consider your support system? _____

Other household members:

Name:	Age:	Relationship:	Is this a positive (+) or negative (-) relationship?

Are you currently in a romantic relationship? Yes _____ No _____

Spiritual and/or religious beliefs: _____

Sexual preference: _____ Gender preference: _____

What are your hobbies? _____

_____

What are your best attributes? _____

What else would you like us to know: _____

_____

Clinician-Patient Agreement and Financial Responsibility

KCounseling LLC is a business facility where several mental health professionals and therapists' practice. **Your contract for service is with your current counselor/therapist and may also include collaborative services of multiple providers/therapist(s) affiliated with and/or in collaboration with KCounseling LLC.**

PAYMENT CONTRACT

Fees for Professional Services

Initial Intake Assessment Self-Pay	$100
1 hour Therapy Sessions Self-Pay	$80
No Show Fee	$65
Late Cancellation Fee	$45
Nontherapeutic Paperwork	$ 100 Per Hour (session cost)

Rights and Risks:

You may ask questions about any aspect of the counseling process.
If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
Therapy is most effective when you are open, engaged, and can speak honestly about your emotions and experiences.
Therapy may include talking about emotionally providing subjects and scenarios.

Confidentiality:

Information share by you in session will be kept confidential.
Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
Medical provider(s) are required by law to disclose information pertaining to suspected and/or disclosed child abuse, elder abuse, and/or threatened harm to oneself or others.
The court may subpoena medical and /or counseling records.
It is understood that information regarding treatment, diagnosis, and/or billing concerns may be provided to an insurance company and/or appropriate billing agency/person in relation to filing insurance, billing for services, and financial transactions related to services.
You may want to discuss further limits or exceptions of confidentiality.

Non-Therapeutic Documentation:
If client is seeking services for the purposes of having nontherapeutic documentation (I.E., disability paperwork, Short term/ Long term disability, or custody paperwork) completed, they

are to notify therapist prior to start of treatment. There is an additional fee associated to these services as therapist will need additional time to complete paperwork being requested or to put together case summaries. Please see payment contract for additional fee. _____ Initials

Appointments:

All office visits are by appointment and may be scheduled through the office administrator and/or your counselor directly.
You will have the option to elect if you want to be reminded of your appointment(s) via telephone, text messaging, and/or email. Please let the office administrator know which means of communication you elect.
Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment with the therapist is 45-55 minutes (depending on specific insurance requirements/regulations and clinical treatment plan).
Late cancellation (less than 24 hours before) and/or no-show appointments are billed to the client in the amount of **$50.00 per session for no she and $40 for late cancelation**. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voicemail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges, late cancellation charges, or for telephone consultations.

Fees:

The client portion (co-pay) of fees is expected at the time of service.
Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies over outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit. Please contact our office administrator if you have any questions or concerns regarding your benefits and/or costs.
Insured clients are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. Failure to pay your part may jeopardize your benefits. Copays are not negotiable.
Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of services unless a payment plan has been previously arranged.
Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
Accounts become delinquent after thirty (30) days. Accounts 120 days in arrears will turned over to a collection agency.
It is understood than any change in my financial situation will be discussed with the office administrator and/or provider. In the event you find it necessary to change mental health providers and require records to be sent from **KCounseling LLC**, your account will need to be paid in full.

Emergencies:

During business hours, please contact **KCounseling LLC** at 229-234-1161. If you receive the office voice mail, please leave a message for your personal counselor/therapist providing specific details the potential crisis. Your counselor/therapist may be on the phone, in therapy with someone else, or out of the office. In a crisis and/or if your provider/therapist cannot be reached and/or it is after business hours, please contact **911, the 24-hour Georgian Crisis and Access Line (GCAL) at 1-800-715-425 or go immediately to your local hospital emergency room.**

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize **KCounseling LLC** and my counselor(s)/therapist(s) to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that re-billing fee/financial charge complying with Georgia State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or costs and reasonable legal fees should this be required. I agree to pay all co-payments and/or balances prior to services rendered. I have read and/or received a copy of **KCounseling LLC** Privacy Policy.

CONSENT TO TREATMENT

First name: _____ Last name: _____

You are about to take a very important step for your mental health and overall wellness. We are humbled you are allowing KCounseling LLC to be a part of your journey in obtaining optimal wellness. Please be advised you are seeking services from a mental health professional.

AS your mental health provider, we are entering a protected relationship. Treatment may involve a multidimensional approach, including collaboration with family members or other professionals. As a result, consent is needed for all individuals attending sessions.

We are treating you and will do our best provide you with an accurate diagnosis and develop a comprehensive treatment plan that will address you as a whole person. As a result, we may recommend alternate therapies and other wellness practices. This is part of the service provided by a mental health professional.

With your consent, we can collaborate with your primary care physician and/or other professionals to ensure coordination of care. Please understand therapy is most effective when you can speak honestly and openly with your therapist.

I understand that a release of information will be required for any individual with whom I incorporate into my sessions or with whom my therapist speaks on my behalf. _____ (Initials)

As a client of KCounseling LLC, you have the right for your confidentiality to be respected. We will not share any information about you or services you receive. The exceptions to confidentiality are:

1.) Suspicion or knowledge of child abuse or elder abuse including sexual, physical, mental abuse or neglect.
2.) We have a duty to protect anyone we suspect is in danger of killing themselves.
3.) Threats made to hurt someone else.
4.) When records are summoned by subpoena.

I understand the limitations of confidentiality and the reasons for which it may be violated. ____(Initials)

In the event of treatment for child/adolescent, I acknowledge that pertinent therapeutic information may be shared with the parent/guardian in order to provide the best services. If there is any concern of harm, suicide, or other dangerous behavior parents/guardians will be notified immediately.

Minor's initials: _____ Guardian's initials: _____

I understand to maximize therapeutic effect; frequent appointments may be required. Clients who are inactive and/or not seen for 12 months (or a significant period) may be required to complete a new evaluation and assessment prior to renewing services. _____(Initials)

I, _____(client), understand I am seeking treatment with KCounseling LLC and consent to take an active role in my treatment.

I understand that if I attend group services at KCounseling LLC, the boundaries of confidentiality remain, and I agree to respect the confidentiality for all other group members. I also agree KCounseling LLC is not liable in the event a group member breaks confidentiality. _____(Initials)

In order to provide me with the best possible services, I understand my counselor/therapist may request that I consent to a drug screen. This may be done in the office via urine screen or through hair follicle testing. _____(Initials)

I understand no promises or guarantees are made to me regarding the results of treatment or any services provided by KCounseling LLC. I acknowledge the counseling process can be painful and involve difficulties and risks. Therapy may include talking about emotionally provoking subjects and scenarios. I hold KCounseling LLC free from any liability. (Initials)

I am aware I am entering into a voluntary treatment agreement with KCounseling LLC and understand I may stop services at any time. _____(Initials)

I understand if I am seeking treatment as a result of an order or recommendation of a court order, child protective custody, etc. and discontinue services prior to completion, my referring source will be notified. I also acknowledge if I have been mandated for services by a court or other state agency, I have the option to disclose only what I am comfortable being documented in the report. _____(Initials)

I am aware if I attempt to contact my provider through phone, e-mail, text, or other form of communication over the Internet, there is a risk that the information is not completely secure. In the event my information is intercepted, KCounseling LLC is not responsible for the breach of patient privacy. Please check approved methods to contact you: Phone: _____Email: _____

No Show, Late Cancellation and Co-payment Policy

1. I understand I will be charged a LATE CANCELLATION fee of $40 if I fail to give at least 24-hour notice prior to cancelling my appointment. (Exceptions may be made with proof of emergency, at the discretion of your provider).

2. I understand I will be charged a NO-SHOW fee of $50 if I fail to show for my appointment. If this occurs more than three times, I may be discharged from the practice.

3. I understand I am responsible for knowing my co-payment and deductible amount. I am aware of my co-payment per session for services rendered. Have you met your deductible for this year? _____YES _____NO _____N/A.

4. I understand the above charges are an out of pocket expense and my insurance carrier (if applicable) will not cover these charges.

5. I understand most therapy sessions last between 45-55 minutes. I understand if I am late to the appointment, the session will still end at the allotted time. BY signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Payment Consent Form

Client Name: _____

Name on Card (if different than client): _____

I authorize KCounseling LLC to charge my credit/debit/health account card for professional services cancelled with less than 24 hours before my scheduled appointment. If I do not cancel before 24 hours, I recognize that KCounseling LLC will charge my card as a late cancel or no show if I do not show up for the appointment. The no show or late cancellation charges are **$50.00 per session for no she and $40 for late cancelation**. Initials _____

I understand I have the option of keeping a credit card/debit card/health account card on file to be charged for appointments for (client name)_____up to a total of $ _____. I may cancel this consent at any time by contacting the office administrator. I understand the office will provide me with an itemized receipt upon request for all charges.

I verify the credit card information, provided above, is accurate to the best of my knowledge, and agree to notify the office in the event this information changes. If this information is incorrect, fraudulent or if my payment is declined. I understand I am responsible for the entire amount owed and any interest or additional cost incurred if denied. I also understand by signing and initialing this form all delinquent balances will be sent to collections.

KCounseling LLC stores all financial information electronically and no physical information will be kept in office.

Signature of cardholder: _____ Date: _____

SOCIAL MEDICA POLICY

This document outlines our office policy related to the use of Social Media. Please read it carefully to understand how our professionals conduct themselves on the Internet and the interaction you can expect between you and your provider. If you have any questions about anything in this policy, please discuss it with your provider or the office administrator. You will be notified in writing of any changes made to this policy. Out primary concern is your privacy and maintaining a professional therapeutic relationship with our patients.

Emails, Cell Phones, Faxes, Mobile Devices

Secure and private communications cannot be guaranteed fully with the use of no-secure technology such as cell/smart phones, mobile devices, tablets, regular emails, or via our website. It is your right to decide whether you choose to use this type of non-secure technology and under what circumstances. Should you choose to contact any of our clinical staff using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner, and you agree to take the risk that such communication may be intercepted.

Please be advised that e-mails, the internet, and cell phones include risks of being accessed by unauthorized individuals. Risks include others overhearing your conversation, e-mails being sent to the wrong recipient, messages may be viewed by others on your cell phone, and notification services may indicate your location.

KCounseling LLC maintains all e-mails, and although confidential, they can be read by system administers of the internet service provider. KCounseling LLC does not use encryption in our email system, therefore, should you choose to contact us via email, we ask that you limit your communication to administrative issues only. Our fax is secure, and if you need to communicate clinical information, we ask you to do so by faxing us at 229-234.1161.

IF you communicate confidential or private information via text or email, we assume you have made an informed decision and will view this as an agreement to take the risk and will honor your desire to communicate on such matters. We will no initiate contact via text or email without your consent or as stated above.

NEVER USE EMAIL, TEXT OR FAX FOR EMERGENCIES. Emails and faxes may not be checked daily. Due to computer network problems, emails may not be delivered or there may be disruption in connection, In the event of an emergency, please call 911.

Social Media Networking Sites

Networking sites such as Facebook, Twitter, or LinkedIn are NOT secure. It could compromise your confidentiality to use wall posts, replies, or other means of engaging in conversation on these sites. Exchanges on social networking sites can become part of your legal medical report. This policy serves to notify you that being linked as friends or contacts on theses sties can compromise your confidentiality, privacy, and the therapeutic relationship. As in any other public context, you have control over your own description regarding the nature of your acquaintances. If you choose to disclose information regarding your relationship with one of our clinical professionals, you acknowledge that you understand and accept the risk associated with using social networking. Please note that your provider will not accept “friend” requests from clients in order to protect the professional and therapeutic nature of our relationship.

Location Based Services

If you use location-based services on your cell mobile device, you may compromise your privacy while attending sessions in the office. Please ask your services provider if you are unaware of how to disable this setting.

Website

Our website www.Kcounselingllc.com is for general information purposes only and should not be used as a substitute for your mental health care and/or crisis intervention. Please note that the webpage is not a secure means of communicating clinical information and should be used for general and resource information only.

Search Engines

It is not a regular part of our practice to search for patients on Google, Facebook, and other search engines. Extremely rare exceptions may be made during times of crisis (in the event the counselor or therapist feel you are a danger to yourself or others) and all other means to contact you have been exhausted, a search engine may be used to ensure your welfare. If this occurs, this will be fully documented in the clinical record and discussed with you at your next visit.

Business Review Sites

You may find our services on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their provider and add reviews or comments. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our practice on any of these sites, please understand this is not a request for a testimonial, rating, or endorsement from you as a patient. You have the right to express yourself on any site, but due to confidentiality, we will not respond to any review on any of these sties whether it is positive or negative. You are urged to take your privacy as seriously as we take our commitment to confidentiality. If you choose to write something on a business review site, keep in mind that you may be sharing personally revealing information in public forum, and your provider may or may not see it.

Acknowledgement of Review of Social Media Policy

By signing below, you are indicating that you have read this document, understand your rights as a client and accept the responsibility as stated. You understand you may request a printed copy of Social Media Policy and acknowledge that you understand this policy.

HIPPA DISCLOSURE & ACKNOWLEDGEMENT POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

KCounseling LLC at 411 Cowart Ave., Suite C, Valdosta, Ga 31602, or call 229-234.1161 if you have questions about this notice.

Introduction

This notice of Privacy Practices ("Notice") describes how we may use and disclose medical information about you, referred to in this Notice as protected health information ("PHI"). This notice also describes your rights and certain obligations we have regarding the use and disclosure of PHI and a brief description of how you may exercise these rights.

I. **We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We are also required to comply with the terms described in the Notice currently in effect. We posted a copy of the current Notice in our office, KCounseling LLC, 411 Cowart Ave Suite C, Valdosta, Ga 31602.**

II. **How We May Use and Disclose Medical Information About You:** We may use and disclose your PHI as described in each category listed below without obtaining written authorization from you. For each category, we will explain what we mean in general, but not describe all specific uses or disclosures of PHI.

For treatment: If you give us consent, we will use and disclose your PHI to provide and coordinate your health care and any related services, including the disclosure of PHI for treatment activities of another health care provider. For example, we may need to disclose information to a case manager who is responsible for coordinating your care. We may also disclose your PHI without authorization to another health care provider (i.e. emergency medical workers, your primary care physician or a laboratory) working outside of KCounseling LLC, such as family members, or others who provide services that are part of your care.

For Payment: if you give us consent, we will use and disclose your PHI in order to bill and collect payments for treatment and services provided to you. By way of example, we may disclose your PHI to permit your health plan to take certain actions before your health plan approves or pays for your services. These actions may include: making a determination of eligibility or coverage for health insurance; reviewing your services to you determine if they were appropriately authorized or certified in advance of your care; reviewing your services to ensure the necessity and appropriateness of your care; reviewing your services to ensure the necessity and appropriateness of your care; justifying the charges for your care; or approving additional visits to your therapist. We may also disclose PHI to its business associates, such as billing companies and others that assist in processing health claims. We may also disclose PHI to other health care providers and health plans for payment activities of such providers or health plans.

For Health Care Operations: If you give us consent, we may use and disclose PHI about you for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers/patients receive quality care. These activities may include, by way of example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, patient surveys, underwriting activities, compliance and risk management activities, licensing, accreditation, business planning and development, and general administrative activities. We may combine HPI of many of our consumers/patients to decide what additional services we should offer, what services are no longer needed, and whether certain new treatments are effective. We may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure we are complying with all applicable laws, and to help KCounseling LLC continue to provide quality health care to its patients. We may also disclose PHI to other health care providers and health plans for such entities' quality assessment and improvement activities, credentialing and peer review activities, and health

care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information. Individuals may request no disclosure to insurer if paid out of pocket. Therefore, insurers must comply.

Research. We may disclose your health information to researchers when their research has been approved by an institutional Review Board or a similar privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

As required by Law and Law Enforcement: We will disclose the PHI about you when required to do so by applicable law or when ordered to do so in a judicial or administrative proceeding.

Incidental Disclosures: Some treatments occur in an open setting. For example, you may be offered group counseling or group education sessions. Other consumers/patients without individual authorization. To Avert a Serious Threat to health or safety: We may use and disclose PHI about you to law enforcement personnel or other appropriate persons when necessary to prevent serious imminent threat to your health or safety or to the health or safety of the public or another person.

Public Health Activities: We may disclose PHI about you as necessary for public health activities including, by way of example, disclosures to repot to public health authorities for the purpose of : preventing or controlling disease, injury or disability; reporting abuse and neglect as required by law; reactions to medications or product defects or problems; or notifying a person who have been exposed communicable disease or who may be at risk of contracting or spreading a disease or condition.

Health Overnight Activities: We may disclose PHI about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, other government programs regulating health care and civil rights laws.

Coroners, Medical Examiners or Funeral Directors: We may provide Phi about a deceased consumer to coroners, medical examiners and funeral directors for the purpose of identifying deceased persons, to determine the cause of death in certain circumstances or as otherwise necessary for these parties to carry out their duties consistent with applicable law.

Military and Veterans: If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI as required by military command authorities. We may also disclose for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs. Finally, if you are a member of a foreign military service, we may disclose your PHI to that foreign military authority.

National Security and Protective Services for the President and Others: We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

Inmates: If you are an inmate of correctional institution or under the custody of a law enforcement official, we may disclose PHI about you to the correctional institutional or law enforcement official for treatment, payment , or for the protection of the health and safety of you or others or for the safety and security of correctional institution.

Workers' Compensation: We may disclose PHI about you to comply with the state Worker's Compensation Law or similar laws.

Appointment reminders, Health related Benefits and Services, Marketing: We may use and disclose your PHI to contact you and remind you of an appointment at KCounseling LLC or to

inform you of treatment alternatives or other health related benefits and services that may be of interest to you. If you do not want us to provide you with information about health-related benefits and services, you must notify the **Privacy Officer (Office Administrator) in writing at KCounseling LLC, 411 Cowart Ave, Suite C, Valdosta, GA 31602.**
Please state clearly that you do not want to receive materials about health-related benefit services. We may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift or nominal value.

Disclosure to you for HIPPA Compliance Investigation: We may disclose your PHI to you or to your personal representative and are required to do so in certain circumstances described below in connection with your rights of access to you PHI and to an accounting of certain disclosures of your PHI. We must disclose you PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate KCounseling LLC's compliance with federal privacy regulations.
Disclosures to Individual Involved in your Healthcare or payment for you Healthcare: Unless you object, we may disclose your PHI to a family member, other relative, friends, or other person you identify as involved in your health care or payment for your health care. We may also notify these people about your location or condition. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

III. **Uses and Disclosures of Your Health Information with Your Permission:**

Uses and disclosure not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization in writing at any time. If you revoke your authorization, unless we have already taken an action relying upon the uses of disclosures you have previously authorized. You understand that we are unable to take back any disclosure already made with your permission, and that we are required to retain records of the treatment and services provide to you.

IV. Your Rights Regarding Your Health Information:

Right to Inspect and Copy: You have the right to request an opportunity to inspect or copy your PHI that we retain and use to make decisions about your care. Usually, this would include clinical and billing records. You must submit your request in writing to our **Privacy Officer (Office Administrator) at KCounseling LLC at 411 Cowart Ave., Suite C, Valdosta, GA 31602**. If you request a copy of the information, we may charge a fee for the cost of copying and mailing associated with your request. WE may deny your request to inspect or copy your PHI if the treating physician determines that disclosure would be detrimental to your physical or mental health. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If we do not maintain the PHI you requested and if we know where the PHI is located, we will tell you how to redirect your request. That disclosure would be detrimental to your physical or mental health. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If we do not maintain the PHI you requested and if we know where the PHI is located, we will tell you how to redirect your request.
Right to Amend. If you believe that your PHI maintained by us is inaccurate or incomplete, you may ask us to correct your PHI. Your amendment must be written or types on a separate sheet of paper and specify

why you believe the information is inaccurate or incorrect. You should sign and date the amendment and submit it to our Privacy Officer (Office Administrator) at KCounseling LLC at 415 Cowart Ave., Suite A, Valdosta, GA 31602. We generally can deny your request if your request related to PHI: (i) not created by KCounseling LLC; (ii)not part of the records KCounseling LLC maintains, (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your right to; (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement , submit a request that any future disclosures of the relevant PHI be made with a copy of your request and KCounseling LLC's denial attached; and (iii) complain about the denial.

Right to an Accounting of Disclosures. You have the right to request and receive a list of disclosures we have made of your PHI we have made at any time during the last six (1) years prior to the date of the request (provided that such a list would not include disclosures made prior to April 14, 2013) The list will not include disclosures made at your request, with your authorization, and does not include disclosures made to prior to April 14, 2013. The list will not include disclosures made at your request, with your authorization and does not include certain uses and disclosures to which the Notice already applies, such as those; (i) for treatment, payment, and health care operations; (ii) made to you; (iii) KCounseling LLC's patient directory or to person involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. To request an accounting of disclosures you must submit your request in writing to our Privacy Officer (Office Administrator) at **KCounseling LLC at 415 Cowart Ave., Suite A, Valdosta, GA 31602**. The request should state the time period for which you wish to receive an accounting. The first accounting you request within each calendar year, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge, and you may choose to withdraw or modify your request before we incur any costs.

Right to Request Restrictions. You have the right to request that we restrict the use or disclosure of your PHI. To request a restriction, you must write to our Privacy Officer (Office Administrator) at **411 Cowart Ave., Suite C, Valdosta, GA 31602.** We are not required to agree to a restriction, but if we do agree, we will honor your request unless the disclosure of PHI is needed to provide you with the emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your care only by a particular means or at particular locations. For example, you may request that communications be made to your work address. You must write to our Privacy Officer (Office Administrator) at **411 Cowart Ave., Suite C, Valdosta, GA 31602**. We will accommodate all reasonable requests. You do not need to give us a reason for the request, but your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you may still obtain a paper copy. To obtain a paper copy, contact our Privacy Officer (Office Administrator) at **411 Cowart Ave., Suite C, Valdosta, GA 31602.**

V. Confidentiality of Substance Abuse Records

For individuals who have received treatment, diagnosis or referral for treatment form a drug or alcohol abuse program, federal law and regulations protect the confidentiality of drug or alcohol abuse treatment records. As a general rule we may not disclose to a person outside the program that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless; you authorized the disclosure in writing, the disclosure is authorized by an appropriate court order, the disclosure is made to medical personnel in a medical emergency, to qualified personnel for research, audit or program evaluation purposes, or you threaten to commit a crime either at the drug abuse or alcohol programs. Federal laws and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state of local authorities.

VI. AIDS Confidentiality Information

AIDS confidential information, including HIV Status or test 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, 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.

VII. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us about a privacy violation, contact our Privacy Officer (Office Administrator) **at 411 Cowart Ave., Suite C, Valdosta, GA 31602**. All complaints about privacy violation must be submitted in writing, and our Privacy Officer will assist you with writing your complaint; if you request such assistance. We will not retaliate against you for filing a complaint. The Privacy Officer will send a copy of your complaint to the Chair of our Consumer Rights Committee, who will also provide you with assistance if you ask for it (**see also Consumer Rights Notices posted at all our service locations**).

VIII. Changes to this Notice

We reserve the right to change the terms of our Notice. We Also reserve the right to make the revised or changed Notice effective for all PHI we already have about you as well as any PHI we receive in the future. We will post a copy of the current Notice at our main office and at each site where we provide care. You may also obtain a copy by calling us 229-249-0097 and request that a copy is sent in the mail or by asking for one any tie you are at our offices.

Acknowledgement of HIPPA Disclosure Policy

By signing below, I acknowledge I have been advised of KCounseling LLC being HIPPA compliant in its handling of protected health information. I have been advised that a copy of the HIPPA Notice of Privacy Practices is attached and is also available upon my review.

By signing below, I acknowledge I have reviewed the following policies from KCounseling LLC.

Client-Patient Agreement & Financial Responsibility
Consent to Treatment
No Show, Late Cancellation, & Co-Payment Policy
Payment Consent Form
Social Media Policy
HIPPA Disclosure Policy

Client(s) Name/Signature: _____ Date: _____

Parent/Guardian Signature, if Client is a Minor: _____

Witness Signature: _____ Date: _____