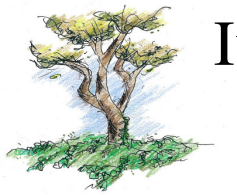


Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

Welcome to Ivyland Counseling Center.

In seeking counseling, you have taken an important step. We often find it to be a turning point in one's life. It not only takes wisdom to recognize the need for counseling, but it takes courage to face decisions that have to be made. To save you time and worry, let us offer a few important ideas about the counseling experience awaiting you.

First – Your counselor will try to merit your confidence. We know it is not easy to talk to a stranger, especially about intimate things that come out in counseling. Therefore, we will try and establish a level of acceptance and understanding as soon as possible. What we share together will remain completely confidential. There are only three exceptions. As required by law, we have to disclose what you say if we believe you are a danger to yourself, someone else, or can no longer take care of basic responsibilities such as food, shelter and clothing. One additional case for children and elder/dependent adults is if we believe that someone is or has harmed you, we may need to report that information to the proper agencies. These are the only exceptions. If you have any questions or concerns with this or any other issue in your counseling experience with us, do not hesitate to talk with your counselor about it.

Second – It is important you tell the whole story. We know that personal, marital, and family problems can be quite complex. Conflicts in relationships are rarely one-sided. Evaluations must be made from varied perspectives. An open mind is as valuable as the time spent in counseling. Let's tackle the problem and not decide whose fault it is.

Third – If your problem is important enough to bring you into counseling, don't expect it to be resolved in one interview. The number of sessions needed is primarily dependent on the number of individuals involved and the intensity/complexity of the problems described. We have had clients come in for over a year, but the average is closer to ten sessions. Terminating or changing the frequency of your sessions is best decided when we agree that your goals have been satisfied.

Fourth – Our clients are charged according to the counselor they see and the client's individual financial situation. A typical counseling session is approximately 45 minutes to an hour in length.

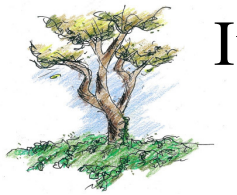
Fifth – Our staff of licensed counselors currently include Clinical Psychologists. However, in the near future we may add Marriage, Family and Child Counselors and Clinical Social Workers. In addition, we will occasionally have psychologist interns and marriage, family and child counseling interns. All interns are fully supervised by the licensed and experienced professionals on our staff.

Sixth – Your counseling session is reserved for you and your counselor. You will need to call and cancel if you are not able to make your scheduled appointment, so your counselor may schedule other clients during that time. Your consideration of this point will be greatly appreciated. Each counselor will establish a minimum cancellation time with you that may result in a fee if dishonored.

Seventh – Counseling sessions usually take place weekly. What you do during the rest of your week will determine the success of counseling. There are no pat formulas that guarantee success. We will not judge or moralize. We do not give "advice" and demand that you accept it. We try to point out guidelines and help you explore your individual possibilities, but the decisions and choices are yours. You have to live with them.

Eighth – Your files are not open to anyone except your counselor.

We hope these guidelines help you to achieve maximum success in your counseling experience with us.



Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

Consent for Outpatient Treatment

1. Outpatient treatment may include diagnostic services, crisis intervention, individual, group, or family therapy, or case management services. Outpatient services are provided by a qualified professional staff member of the Ivyland Counseling Center.

2. Outpatient treatment consists of face-to-face contact between a qualified professional and the individual focusing on the presenting problem and associated feelings, assessing possible causes of the problem and previous attempts to cope with it, and possible alternative courses of action and their consequences. The frequency and type of treatment will be decided between you and your therapist.

3. You are expected to benefit from therapy, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.

4. You will be expected to pay all or some part of the cost of treatment services received. The therapist in advance of commencing treatment negotiates the amount you pay for treatment. If legal action is initiated to collect your bill, you will be responsible for paying all reasonable attorneys' fees and court costs in addition to any judgment rendered against you.

5. Failure to keep your appointments or to follow treatment recommendations may result in your treatment being discontinued. If you cannot keep your appointment, you are expected to notify your therapist as soon as possible. If you do not notify your therapist in sufficient time for him/her to adjust his/her schedule, you will be responsible for any standard payment associated with the scheduled session.

6. All information and records obtained in the course of treatment shall remain confidential and will not be released without your written consent except under the following conditions:

    a. You are a non-emancipated minor, ward of the court, or an LPS conservatee.
    b. To governmental law agencies to protect the lives of federal and state elective constitutional officers and their families.
    c. To the courts if ordered by a Judge or if otherwise necessary to the administration of justice
    d. To prevent bodily harm to another person (Tarasoff vs. Regents of University of California, 1976).
    e. To juvenile authorities when child abuse is observed or suspected (Penal Code Section 11165, et seq.).
    f. Under certain circumstances as set forth in Welfare and Institutions Code Sections 5328 through 5328.9, which you may read upon request.
    g. To prevent self induced harm or death (Johnson vs. County of Los Angeles, 1983).

7. You have a right to accept, refuse, or stop treatment at any time.

8. For the duration of treatment, I authorize Ivyland Counseling Center or Glenn A. Heinrichs, Ph.D. to receive payment of medical benefits for any and all health insurance plans for which I am covered.

I have read the above and I agree to accept treatment, and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.

Client:_____

Parent/Guardian/Conservator:_____

Date:_____

Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

For Office Use
I C Dx

Initial Child/Adolescent Contact Form

Identifying Data - Child

Date:_____

Child's Name:_____ Date of Birth:_____

OK to text?
Y N

Address: Street _____ Cell Phone:_____

Address: City State, Zip _____ Home Phone:_____

School & Grade:_____ Religion:_____

Ethnicity:_____ Sex:_____ Birthplace:_____

SSN:_____

Siblings Names & Ages:_____

Parental Information

Father's Name:_____ Mother's Name:_____

Step-Father's Name:_____ Step-Mother's Name:_____

Address(if different from Child's) Address(if different from Child's)

Street _____ Street _____

City State, Zip _____ City State, Zip _____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

Email:_____ Email:_____

Occupation:_____ Occupation:_____

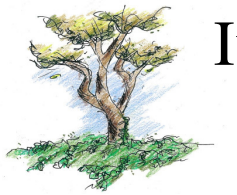
Parents are currently: Single / Married / Remarried / Separated / Widowed / Divorced / Other

If divorced, what are the custody arrangements?

Physical_____ Legal_____

Briefly list the reason for coming here today:

How did you hear about Ivyland Counseling Center?



Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

NOTICE OF PRIVACY PRACTICES

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. EFFECTIVE 04/14/03

Your health information is personal and private, and we must protect it. This notice tells you how the law requires or permits us to use and disclose your health information. It also tells you what your rights are and what we must do to use and disclose your health information.

We must by law:

- keep your health information (also known as "protected health information" or "PHI") private
- give you this Notice of our legal duties and privacy practices regarding your PHI
- obey the terms of the current Notice in effect

Changes to this Notice: We have the right to make changes to this Notice and to apply those changes to your PHI. If we make changes, you have the right to receive a copy of them in writing. To obtain a copy, you may ask your service provider or any staff person.

HOW THE LAW PERMITS US TO USE AND DISCLOSE INFORMATION ABOUT YOU

We may use or give out your health information (PHI) for treatment, payment or health care operations. These are some examples:

- **For Treatment:** Health care professionals, such as doctors and therapists working on your case, may talk privately to determine the best care for you. They may look at health care services you had before or may have later on.
- **For Payment:** We need to use and disclose information about you to get paid for services we have given you. For example, insurance companies ask that our bills have descriptions of the treatment and services we gave you to get payment.
- **For Health Care Operations:** We may use and disclose information about you to make sure that the services you get meet certain state and federal regulations. For example, we may use your protected health information to review services you have received to make sure you are getting the right care.

USES AND DISCLOSURES THAT DO NOT NEED YOUR AUTHORIZATION

- **To Other Government Agencies Providing Benefits or Services:** We may give information about you to other government agencies that are giving you benefits or services. The information we release about you must be necessary for you to receive those benefits or services.
- **To Keep You Informed:** We may call or write to let you know about your appointments. We may also send you information about other treatments that may be of interest to you.
- **Research:** We may give your PHI to researchers for a research project that has gone through a special approval process. Researchers must protect the PHI they receive.
- **As Required by Law:** We will give your PHI when required to do so by federal or state law.
- **To Prevent a Serious Threat to Health or Safety:** We may use and give your PHI to prevent a serious threat to your health and safety or to the health and safety of the public or another person.
- **Workers' Compensation**: We may give your PHI for worker's compensation or programs that may give you benefits for work-related injuries or illness.
- **Public Health Activitie**s: We may give your PHI for public health activities, such as to stop or control disease, stop injury or disability, and report abuse or neglect of children, elders and dependent adults.
- **Health Oversight Activities**: We may give your PHI to a health oversight agency as authorized by law. Oversight is needed to monitor the health care system, government programs and compliance with civil rights laws.
- **Lawsuits and Other Legal Actions**: If you have a lawsuit or legal action, we may give your PHI in response to a court order.
- **Law Enforcement**: We may give your PHI when asked to do so by law enforcement officials:
    - In response to a court order, warrant, or similar process;
    - To find a suspect, fugitive, witness, or missing person;
    - If you are a victim of a crime and unable to agree to give information
    - To report criminal conduct at any of our locations; or
    - To give information about a crime or criminal in emergency circumstances.
- **Coroners and Medical Examiners:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

• **National Security and Intelligence Activities**: We may give your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
• **Protective Services for the President and Others**: We may give your PHI to authorized federal officials so they may protect the President and other heads of state or do special investigations.

Other uses and disclosures of your PHI, not covered by this Notice or the laws that apply to us, will be made only with your written authorization. If you give us authorization to use or give out your PHI, you can change your mind at any time by letting your service provider know in writing. If you change your mind, we will stop using or disclosing your PHI, but we cannot take back anything already given out. We must keep records of the care that we gave you.

YOUR RIGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION (PHI)

• **Right to See and Copy**: Federal regulations say that you have the right to ask to see and copy your PHI. However, psychiatric and drug and alcohol treatment information is covered by other laws. Because of these laws, your request to see and copy your PHI may be denied. You can get a handout about access to your records by asking your health care provider. A therapist will approve or deny your request. If approved, we may charge a fee for the costs of copying and sending out your PHI. We may also ask if a summary, instead of the complete record, may be given to you. If your request is denied, you may appeal and ask that another therapist review your request.
• **Right to Ask for an Amendment**: If you believe that the information we have about you is incorrect or incomplete, you may request changes be made to your PHI as long as we maintain this information. While we will accept requests for changes, we are not required to agree to the changes. We may deny your request to change PHI if it came from another health care provider, if it is part of the PHI that you were not permitted to see and copy, or if your PHI is found to be accurate and complete.
• **Right to Know to Whom We Gave Your PHI:** You have the right to ask us to let you know to whom we may have given your PHI. Under federal guidelines, this is a list of anyone that was given your PHI not used for treatment, payment and health care operations or as required by law mentioned above. To get the list, you must ask your service provider in writing for it. You cannot ask for a list during a time period over six years ago or before April 14, 2003. The first list you ask for within a 12-month period will be free. For more lists, we may charge you for the cost of copying and sending the list. We will let you know the cost, and you may choose to stop or change your request before it costs you anything.
• **Right to Ask Us to Limit PHI:** You have the right to ask us to limit the PHI that the law lets us use or give about you for treatment, payment or health care operations. *We don't have to agree to your request.* If we do agree, we will comply with your request unless the PHI is needed to give you emergency treatment. To request limits, you must ask your service provider in writing. You must tell us (1) what PHI you want to limit; (2) whether you want to limit its use, disclosure or both; and (3) to whom you want the limits to apply.
• **Right to Ask for Privacy:** You have the right to ask us to tell you about appointments or other matters related to your treatment in a specific way or at a specific location. For example you can ask that we contact you at a certain phone number or by mail. To request that certain information be kept private, you must ask your service provider in writing. You must tell us how or where you wish to be contacted.
• **Right to a Paper Copy of This Notice:** You may ask us for a copy of this Notice at any time. Even if you have agreed to receive this Notice by e-mail, we will give you a paper copy of this Notice. You may ask any staff person for a copy.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with us or with the Federal Government. ***Filing a complaint will not affect your right to further treatment or future treatment***.

To file a complaint with Ivyland Counseling Center, contact:
Glenn A. Heinrichs, Ph.D.
1210 Old York Road, Suite 202
Warminster, PA 18974
Phone # 215.444.9204
Fax# 215.444.9206
E-mail: *Dr.GAH@IvylandCounselingCenter.com*

To file a complaint with the Federal Government, contact: Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, Region III, Regional Manager, Paul Cushing 150 S. Independence Mall West, Suite 372, Public Ledger Bldg, Philadelphia, PA 19106-9111 - Phone 215-861-4441 - Web site www.hhs.gov/region3 - Hotline 800-368-1019 - Fax 215-861-4431 - TDD 215-861-4440 - E-mail Paul.Cushing@hhs.gov

For additional information call (800) 368-1019 or (866) 627-7748 or fax the U.S. Office of Civil Rights at (415) 437-8329 or (866) 788-4989 TTY or (415) 437-8311 TDD.

Ivyland Counseling Center
1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways in which Ivyland Counseling Center may use or disclose personal health information to provide service.

_____ _____

Client Name (printed) ***Client Signature***

Date _____ _____

If signed by other than client, indicate relationship.

Note: ***Parents must have legal custody. Legal guardians and conservators must show proof.***

OFFICE USE ONLY

Client did receive the Notice of Privacy Practices but did not sign this Acknowledgement of Receipt because:
Client left office before Acknowledgement could be signed.
Client does not wish to sign this form.
Client cannot sign this form because: _____

_____

Client did not receive the Notice of Privacy Practices because:
Client required emergency treatment.
Client declined the Notice and signing of this Acknowledgement.
Other: _____

_____

Name: _____
(Print name of provider or provider's representative)

Signed: _____
(Signature of provider or provider's representative)

45 CFR §164.520 Except in an emergency situation, … make a good faith effort to obtain written acknowledgment of receipt of the Notice…. and if not obtained, document…good faith efforts to obtain such acknowledgment and the reason why…(it)…was not obtained.

Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

INFORMED CONSENT FOR THE USE OF ELECTRONIC MEDIA COMMUNICATION

Telemedicine: Telemedicine is the use of electronic/internet/data transmissions to treat the needs of a client. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Examples of these include, but are not limited to: e-Mail, cell/mobile/VoIP calls, voice-mail, text messaging, Skype, social media sites, and other non-face-to-face interactions.

INFORMED CONSENT

By selecting and signing below, you acknowledge that there are logistical and privacy issues that may or may not be compromised in the use of such systems. We, (Ivyland Counseling Center (ICC), and your clinician), will continue to abide by the HIPAA/PHI standards you have received as part of your Initial Intake Packet. However, please read the following section to show your understanding:

(1) YOU, "the client", retain the option to withhold or withdraw consent to telemedicine at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which YOU would otherwise be entitled.

(2) The risks involved with Telemedicine include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overhead by anyone near you if you do not place yourself in a private area and open to other's intrusion.

The advantages of Telemedicine include the benefit of continuity of care in the absence of your clinician as well as the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the Telemedicine transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is OUR responsibility for the clinician to do the same.

(3) All existing confidentiality protections apply as noted in your HIPAA/PHI information portion of your Initial Intake Packet.

(4) All existing laws regarding client access to medical information and copies of medical records apply.

(5) Dissemination of any client identifiable images or information from the telemedicine interaction to researchers, individuals, physicians, or other persons and entities shall not occur without YOUR consent.

(6) YOU acknowledge that you have both received a copy of this Consent form and have given both written and verbal consent to utilizing Telemedicine as part of your treatment.

(7) The written consent statement signed by YOU shall become part of YOUR medical record.

(8) The failure of any health care practitioner to comply with the above shall constitute unprofessional conduct.

(9) All existing laws regarding surrogate decision-making shall apply. For purposes of this section, surrogate decision-making means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(10) The Clinician will discuss with YOU any fees associated with the use of Electronic Media Communication

Ivyland Counseling Center
1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

ACKNOWLEDGMENT OF the RISKS and BENEFITS of THE USE OF TELEMEDICINE:

I/We, _____, have read the above-mentioned Telemedicine Services and Informed Consent and have chosen the following method of communication in the event that I/We schedule to speak to our clinician via Telemedicine:

____ Video Conference (Via Skype or other form available to me)
____ Telephonic (cell phone usage, text messaging, voice-mail)
____ e-Mail usage
____ No preference
____ I do not wish to participate

I/We understand that there are both risks and benefits as mentioned within this consent form as well as others that I/We may not fully be aware of that can occur with or without our knowledge.

I/We understand that the clinician will use their best efforts to conceal personal information and abide by HIPAA/PHI standards.

I/We will use our best efforts to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information.

I/We understand that there are no universal protocols or protective standards in the use of Telemedicine and I/We, will hold ICC, its clinician, officers, and employees, harmless and free from liability in the event I/We use this method of communication and engage My/Our clinician to receive communication in this manner.

I/We agree that we have been verbally informed in addition to this written informed consent regarding the use of Telemedicine as a means of facilitating My/Our therapy sessions.

Client Signature(s) and Date _____

Clinician Signature and Date _____

REVOCATION OF TELEMEDICINE AUTHORIZATION:

In the event you decide to revoke your authorization and informed consent, please complete the following and fax it to 215-444-9206. It will be placed in your file.

I/We, _____, revoke our prior authorization and informed consent to use Telemedicine as a means of therapy.

I/We further understand that in the event I/We use Telemedicine after this revocation and fail to inform our clinician of our revocation, then such revocation shall become null and void and a new revocation will be required.

Client Signature(s) and Date _____

Clinician Signature and Date_____

Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

Financial Information

Income

Household Member #1

Name DOB DL# SSN

Employer Position # years in field Annual Income

Insurance Carrier Group# Member# Benefit Amount

Employer Position # years in field Annual Income

Insurance Carrier Group# Member# Benefit Amount

Household Member #2

Name DOB DL# SSN

Employer Position # years in field Annual Income

Insurance Carrier Group# Member# Benefit Amount

Employer Position # years in field Annual Income

Insurance Carrier Group# Member# Benefit Amount

Other Miscellaneous Household Income (annual total): _____

Number of dependents in the household:_____