INTEGRATED CONCEPTS FOR FAMILIES, INC.
619 MAIN STREET
PALMETTO, GA 30268

CONSENT OF TREATMENT

I do hereby seek and consent to take part in the treatment provided by this agency. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I (or my child) may stop treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I may be charged for that appointment.

I am aware that an agent of my insurance company or other third-party may be given information about the type (s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) **Date**

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist **Date**

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INFORMED CONSENT

1. INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor

HIPPA Privacy Notice for Mental Health and Substance Abuse Programs

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective: December 1, 2006

Integrated Concepts For Families, Inc. is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse health care administered by this agency. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.
The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.
We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it in our agency office or on our website.

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **To process** claims for health care services you receive

- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.

- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.

- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFCS, Psychiatric Hospital, CMHC, etc., we may share summary information and admission and discharge information with the referral source. In addition, we may share other health information with the referral source for case management purposes if the referral source agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws relating to job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then we must obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you have given us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based upon your authorization. To revoke an authorization, contact the phone number listed below on this notice.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will make every attempt to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address.
- **You have the right to view and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to June 1, 2005; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures of which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our office.

EXERCISING YOUR RIGHTS

- **Contacting Integrated Concepts for Families, Inc.** If you have any questions about this notice or want to exercise any of your rights, please call
- **770-463-0202.** Please specify that your question or concern is in reference to your mental health and/or substance abuse protected health information.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

Compliance Department – Privacy Complaints
619 Main Street
Palmetto, GA 30268

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any adverse action against you for filing a complaint.**

Acknowledgment of Receipt

Of

Privacy Notice

Printed Name Client	**Parent or Guardian Printed Name**
Signature of Client	**Parent or Guardian Signature**
Signature of Therapist	**Date**

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

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

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

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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Insurance Verification Worksheet

Client Name: _____Parent Name: (if child is client) _____

Insurance Information: *Please phone your Insurance Company and fill out this form the best you can.* ***This is Very helpful information if you are unfamiliar with your coverage.***

Name of Insurance:
_____Phone:_____

Claims Address:
_____

Insured's Name: _____ ID #:
_____

Plan/Grp #: _____

When you call be sure to write down the name of the person that you talk to for later reference.
HMO Contact Person: _____ Date, Time of call:
_____

Say, "I'm calling to clarify my benefits and coverage for out-patient mental health." (They will ask for your member ID #) Ask enough questions to complete all of the information. Incomplete information will require another phone call.

Is my therapist, _____, on the Participating Provider List? (Name your therapist; you may find that information on your insurance's website, but do remember that the website might not be up to date).

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CONSENT FOR TELECOMMUNICATION

Telehealth will provide you with delivery of services through various methods of technology. Below we have offered methods of communication with real time options to better serve you. In order to deliver services in this manner we must obtain a HIPAA disclosure to protect our right and yours (consumer, parent, and guardian).

Please check, initial in box next to communication and provide signature and date of consent acknowledging what forms of communication ICFF staff can communicate with you.

	Consent/ Do Not Consent	Contact Information
Texting Initial: _____	☐ Consent ☐ Do Not Consent	
Email Initial: _____	☐ Consent ☐ Do Not Consent	
Skype Initial: _____	☐ Consent ☐ Do Not Consent	
Facebook Initial: _____	☐ Consent ☐ Do Not Consent	
Voicemail Initial: _____	☐ Consent ☐ Do Not Consent	
Telephone Initial: _____	☐ Consent ☐ Do Not Consent	
Video conference Initial: _____	☐ Consent ☐ Do Not Consent	

_____

Print Name

_____ _____

Signature Date