Expansion Counseling Services

ADULT CONSENT PACKET

Client Name:_____ CID#:_____

CONSUMER INFORMATION:

*Full name as it appears on insurance:

_____

Last First Middle Initial suffix

*DOB:	Sex:	Race:
*Current Address:		
*Phone Number(s):	E-mail:	
School/Employer:	Grade:	
Referred by:		

INSURANCE INFORMATION:

Insurance/ ID#:	Social Security #:

EMERGENCY CONTACT INFORMATION

*Name/ Relationship to Client:	*Phone #:
Address (if different than above):	

PARENT/GUARDIAN INFORMATION

Mother's Name:	Legal Guardian: ☐ Yes ☐ No
Address:	Home/Cell/Work #:
Father's Name:	Legal Guardian: ☐ Yes ☐ No
Address:	Home/Cell/Work #:
Other Guardian Name:	Relationship to Client:
Address:	Home/Cell/Work #:

Client Name:_____ CID#:_____

PREVIOUS COUNSELING/MENTAL HEALTH INFORMATION

Have you had previous counseling?	Agency/Clinician's Name:

Issues addressed/ Previous Diagnosis(es):

Previous Behavioral/ Mental Health Hospitalizations?

History of Trauma (experienced and/or witnessed) / Sexual assault: Yes_____ No_____

Has client received psychiatric or psychological services in the past 2 years? Yes____ No_____

Psychiatrist Contact info:

Psychologist Contact info:

Do you authorize ECS to request records from psychiatrist and/ or psychologist? Yes_____ No_____

ADDICTIVE BEHAVIORS/SUBSTANCE USE HISTORY:

Are you currently using alcohol or any other substances? Yes_____ No_____

Substances Used: Alcohol___ Opioids___ Methadone___ Sedatives___ Cocaine___ Stimulants___ Marijuana___ Hallucinogens___ Nicotine___ Caffeine____ Inhalants ___

Other: _____

Age of Onset: Date last used:

Have you ever received any substance abuse services/treatment? Yes____ No_____

Name of facility: Date of admission: Duration:

MEDICAL/HEALTH INFORMATION

Dear ECS Client: We are required to have contact information for your primary care provider (PCP) in your file, and to communicate with your provider regarding your treatment here at ECS. Please provide the requested information regarding your PCP in the spaces below to help us maintain accurate records.

In addition, please sign and date the attached release of information form so that we may provide regular updates to your doctor.

PCP/Pediatrician name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Medical History/ Present medical concerns:

Are you currently taking any medications? Yes____ No____ Which Medication(s)? _____

_____

Previous Medications? _____

Client Name:_____ CID#:_____

CONSUMER'S RESPONSIBILITIES

As a client, you and/ or your representative are expected to:

- Provide complete and accurate information about your health, including present conditions, past illness, hospitalization, medications, natural products and vitamins, and any other health related matters.
- Provide complete and accurate information including your full name, address, home telephone number, date of birth, social security number, insurance provider, and employer when it is necessary.
- Ask questions when you do not understand what your therapist or another member of your healthcare team tell you about your diagnosis or treatment. Inform your therapist if you anticipate any problems in your treatment, or if you are considering alternative therapies.
- Keep appointments, be on time for appointments, and call us as soon as possible if you cannot keep your appointments.
- Leave valuable items at home and only bring what is necessary.
- Abide by all facility rules and regulations
  No Smoking
  Weapons are prohibited on premises
  Treat staff, other consumers and visitors with courtesy and respect.
- Know your health insurance and related policies concerning required pre approvals, co-pays, covered services admissions, and the services covered by our insurance provider; provide complete and accurate information for insurance claims and work with the facility's administrator to make payment arrangements.
- Pay your treatment bills in a timely manner, and ask questions if there is a financial issue that you do not understand.

OUTPATIENT SERVICES CONSUMER COMPLAINT PROCEDURES

The staff at Expansion Counseling Services, LLC wants to know that you are satisfied with your individualized program. We also understand that with any ongoing relationship there may be times of conflict. It is important to all of us that you feel any of your complaints or concerns are heard. The following is a guideline and timeframe for filing and complaints.

"Should I feel uncomfortable bringing my concerns to my counselor or feel that the situation has not been resolved to my satisfaction; I can contact the Clinical Director, Eboni Mormant, at the offices of Expansion Counseling Services, LLC at 770-910-9162. I can expect this situation to be resolved in five (5) business days. I may expect to schedule a staffing with myself and the concerned parties at the offices of Expansion Counseling Services, LLC. Should this be necessary, I understand that Expansion Counseling Services, LLC will provide transportation to ensure that there are no barriers to my attending this staffing."

Please note that any concern or complaint is to make Expansion Counseling Services, LLC a better agency to serve its consumers. Filing a complaint will not interfere with services that are needed nor any reprimand or recourse to filing a complaint. Again, we believe that in working together to address conflict and concerns can only serve to help you reach your goals in your case plan through the services that are provided by Expansion Counseling Services, LLC.

Parent/Guardian (if under 18) or Consumer Signature Date

Client Name:_____ CID#:_____

SUMMARY OF CONSUMER RIGHTS AND RESPONSIBILITES

When you receive services from Expansion Counseling Services, your rights are protected by the Georgia Department of Human Resources. A full copy of the rules is available to you at the program where you are served. Below is a simplified outline of those rights.

Your rights include:

- The right to have care suited to your needs.
- The right to receive services that respect your dignity and protect your health and safety.
- The right to be informed of the benefits and risks of your service plan.
- The right to participate in planning your own program.
- The right to refuse service, unless physician thinks that refusal would be unsafe for you and others.
- The right to prompt and confidential services even if it is determined you are unable to pay.
- The right to review your records with the physician unless he or she thinks it is not in your best interest.
- The right to exercise all civil, political, personal and property rights to which you are entitled as a citizen.
- The right to remain free of physical restraints or time-out procedures unless such measures are required for providing effective treatment, or protecting the safety of yourself or others.
- The right to be free of physical, sexual, or verbal abuse.
- The right, if you are a residential consumer, to converse privately, to have reasonable access to a phone, to receive and send mail, to have visitors and retain your personal effects and money.
- The right to receive services without discrimination on the basis of political affiliation religion, race, color, gender, sexual orientation, mental or physical handicap, national origin or age.
- The right to file a complaint if you think any of these rights have been restricted or denied.
- Right to obtain a copy of the program's most recent report of licensing inspection upon written request.
- Right to request in writing a review of your file.
- Right to be promptly informed of any changes to the treatment plan.

CONFIDENTIALITY

Please be advised: Your records will be maintained according to strict guidelines regarding confidentiality. Your written permission is required to release any information.

Exceptions to the written consent are as follows:

- Intent you may have to harm yourself or others.
- Expansion Counseling employees are "mandate" reports and by law must report any suspected abuse, neglect, or domestic violence.
- Records, in certain circumstances, may be subpoenaed in court cases.

If you have any questions concerning any of this above, please consult with your case therapist.

Client Name:_____ CID#:_____

COMMUNICATION PREFERENCE
Our staff will need to contact you to schedule and/or reschedule appointments. To schedule follow-up visits and other such administrative issues. To ensure confidential communication, please provide your preferred method of contact:
Preferred Phone #: ☐ Work ☐ Cell ☐ Home
Preferred time of day to call: Morning ☐ Afternoon ☐ Evening ☐
Is it ok to leave a voice message including name of our facility/staff? _____ Is it ok to send text messages? _____
Do you have concerns with ECS sending mail to your home? _____(if yes, see below)
What is the preferred address for written confidential communication, if different than address listed above?
Can post cards/ letters which identify our facility (Expansion Counseling Services) be sent to this address?

PERSONAL/LEGAL INFORMATION:
Spiritual Beliefs/Church Affiliation:
Criminal/ Legal history? Yes_____ No_____(if yes please explain below)
Is there or will there be any potential court involvement?
Personal/ Legal representative:
DFCS or DJJ Contact Info:
Do you have proof of power of attorney or guardianship with you?

SAFETY CONTRACT

I, _____, promise not to harm or injure myself or others in any way.

If I have thoughts/feelings of harming myself or others, I will contact:

911
GA Crisis and Access Line:
(1-800-273-TALK) 1-800-SUICIDE
1-800-784- 1-800-273-8255
24 HOUR Crisis Line 770-422-0202 (24/7)

Or I will go to the nearest hospital or emergency room department for help.

Consumer Signature Date

CRISIS LINE REFERRAL TO GEORGIA CRISIS AND ACCESS LINE (GCAL):

1-800-715-4225

I, _____ understand and acknowledge that I have received the Georgia Crisis and Access Line phone number for crisis situations, in the unlikely event that my team members are unavailable. Crisis situations could include, but are not limited to, self or dependent being at imminent risk of harm to self or other. I understand and acknowledge that if I (or my family member) is in a crisis situation and my team members cannot be reached for immediate assistance, I will call 1-800-715-4225 and/or 911.

Signature of Consumer or Legal Guardian:

_____

CANCELLATION/NO SHOW POLICY

I, _____ understand that if I do not cancel a scheduled appointment within 48hrs, that I will be billed. In addition, I understand that if I do not show for a scheduled appointment that I will be billed. There is an out of pocket fee of $25.00 if appointment is cancelled less than 24 hrs. in advance or if I do not show up to appointment.

_____ _____

Signature of Client/Guardian Date

DISCHARGE SERVICES

By signing this, I attest that I have been involved in the discharge planning for my services and understand that once discharged, mental health services will be closed with Expansion Counseling Services, LLC.

_____ _____

Signature of Client/Guardian Date

Client Name:_____ CID#:_____

Acknowledgement of Insurance Policy regarding uninsured/private/self-pay consumers

I, _____ (Consumer/Parent/Guardian) have read and understand Expansion Counseling Services, LLC insurance policy regarding assisting families in acquiring insurance. I agree to adhere to this policy and pursue insurance benefits with the state or from private as we participate in services with Expansion Counseling Services, LLC. I also understand that I am held liable for any charges incurred that my insurance company will not cover (i.e. co-pays).

***Please note that in order to bill your insurance company, ECS must provide a psychiatric diagnosis on your behalf. Disclosure of confidential information is required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims; in some instances background information on your case, a treatment plan, and certain other information may be requested; in rare cases a copy of your entire counseling record may be requested by the insurer. ECS has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future capacity to obtain health or life insurance. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the Medical Information Bureau (MIB), a national data bank. MIB is a membership organization of life insurance companies. When you apply for life, health, or disability insurance, the company makes a report to MIB, and it receives any information that MIB may have on you. Psychiatric conditions might affect your future insurability or admission to the military. We encourage you to carefully weigh the economic benefits of using insurance against the privacy risks that arise from sharing the information described above. You will maintain much greater control over potentially sensitive details of your life by paying privately for services.*

_____ _____

Signature of Client Date

Acknowledgement of Freedom of Choice

I, _____ have voluntarily enrolled in Mental Health Services provided by Expansion Counseling Services, LLC. I understand that I have the right to select the provider of my choice. I have, of my own free will selected Expansion Counseling Services, LLC as my Mental Health Service provider.

_____ _____

Signature of Client Date

Acknowledgement of Consumer Complaint Procedures Agency Copy

I, _____ (Consumer)have read and understand Expansion Counseling Services, LLC Consumer Complaint Procedures regarding how to make a formal complaint about treatment with services. I agree to adhere to this policy and pursue insurance benefits with the state as we participate in services with Expansion Counseling Services, LLC.

_____ _____

Client Signature Date

Insurance Verification

Client Name: _____

Date of Birth: _____

Current Insurance(s):

- Medicaid-ID # _____
- Other Insurance- (i.e. Anthem, Humana, Aetna, etc)# _____
- Uninsured

Other insurance information:

Insurance company name: _____

Policy holders name (parent's name): _____

I, _____, sign that the above child has no additional insurance other than the above.

_____ _____

(Client Signature) (Date)

Authorization to Release/Receive Information

Consumer: _____

Social Security Number: _____ DOB: _____

This authorizes Expansion Counseling Services, LLC to release/receive in writing or through telephone contact, general medical, psychological/psychiatric information including alcohol/drug abuse or addiction from my record in accordance with Georgia's Statues and the State of Georgia and Federal Administration Rules and Regulations to/from:

Name :_____

Address/Phone/Fax#: _____

Information to be released:

- Medical Histories and Physicals
- Progress Notes
- School Records
- Reports from Psychological Testing
- Results from Drug Screens
- Treatment Plan
- Assessment Report
- Close Summary
- Other

Purpose of Release;

- Continued Treatment
- Case Planning
- Other

Expires in one (1) year from date of signature or expires on _____ (date specified)

All information I hereby authorize to be obtained from or released to Expansion Counseling Services, LLC will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect unless I specify an expiration date. If this release is for court order psychological evaluation, it is understood that the report will be used as evidence in court. The psychological evaluation report will be released to the referring agency/attorney and you may request information from that agency of attorney. It is understood that this consent is subject to revocation at any time by the undersigned except to the extent that action has already been taken in compliance with this consent. Notice of Prohibition on Redisclosure: This information had been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other investigation is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby release Expansion Counseling Services, LLC from all legal responsibility that may arise from the release of the above requested information. This authorization is fully understood and it is made voluntarily and with informed consent on my part.

Signature (client/guardian): _____ Date:_____

The Health Insurance Portability and Accountability Act (HIPAA)

The primary goal of this law is to make it easier for people to keep health insurance, and help the industry control administrative costs. This statement of our rights covers Title II of the act and was put into effect on April 14, 2003. The goal for the privacy rule under HIPAA provides protection for all clients.

The following statements are to explain your rights as a client/employee of Expansion Counseling Services, LLC under HIPAA.

1. All files and other documentation containing and of your private and confidential information will be maintained in a secure location at all times.
2. All staff members, student interns, and volunteers at Expansion Counseling sign confidentiality agreements that maintain that all information regarding clients will be held in confidence and that all individuals are personally liable for any violation for this agreement.
3. Clients referred by the Department of Family and Children Services should note that the Department of Human Services and the Division of Family and Children Services are **business associates** with Expansion Counseling Information regarding your case is shared with **business associates** and confidentiality with regards to the Department of Family and Children Services is limited.
4. You have the right to review your file at any time. Please note if a client is referred to our agency by the Department of Family and Children Services for and evaluation, assessment, homestead therapy, or wraparound services, all records, notes and evaluations are considered the property of the Department of Family and Children Services and may only be released by the country that holds those files.
5. Expansion Counseling maintains assurance for all **business associates** that private information will be appropriately safeguarded. You have the right to review **business associates** agreements held at the offices of Expansion Counseling Services, LLC.
6. Your identifiable information may not be released by Expansion Counseling Services, LLC. To any other than a **business associate** without your prior written consent. Identifiable information includes: your name, social security number, Medicaid number, insurance information, address, phone number, dates of services, and treatment records.
7. Permitted disclosures that may not require written consent include:

- To you the individual
- For payment, treatment, and health care operations
- For public policy
- As required by law
- For public health
- About victims of abuse, neglect, or domestic violence
- For judicial and administrative proceedings
- For law enforcement excluding substance abuse treatment notes
- Information about decedents
- To avert a serious threat to healthy and or/ safety

8. Authorization is required for disclosures not permitted by the Privacy Rule. Authorization must have an expiration and statement that is recoverable.
9. You may request a copy of your file at any time. Requests must be made in writing and/or emailed to admin@expansioncounselingservices.net. Copies will be made within thirty days after the receipt of written and/or emailed request. Copies are charged at .50 per page and $150.00 for an entire file payable upon delivery. Exceptions to this standard are: clients referred by the Department of Family and Children Services where the Department is a **business associate.** These clients must request copies of their files through the county of Department of Family and Children Services office.

Client Name:_____ CID#:_____

10. Upon reviewing copies of your record, you may request, in writing, to an amendment to your file. Requests are to be submitted to the Compliance Officer at Expansion Counseling Service, LLC. We have exactly sixty days from the receipt of the request to respond in writing to your amendment request. If an amendment is denied, you will receive an explanation.

11. You have the right to an accounting of all disclosures made by Expansion Counseling Services, LLC. Of your private health information on the six years or less prior to the date requested.

12. Complaints with the regards to your privacy rights may be made to the following:

Expansion Counseling Services, LLC	Clinical Director	770.910.9162
Expansion Counseling Services, LLC	Compliance Officer	770.910.9768-Fax

13. Complaints will be received and submitted to the Continuous Quality Improvement committee. A response to all complaints **w**ill be made within 60 days or receipt. Complaints may also be made to:

Department of Health and Human Services, Office of Civil Rights

200 Independence Ave. SW

Washington, DC 20201

Toll free (877) 696-6775

14. You have the right to confidential communications between yourself and Expansion Counseling Service, LLC.

I understand my rights under HIPAA.

_____ _____

Signature Date

Client Name:_____ CID#:_____

CONSENT FOR ASSESSMENT AND TREATMENT

Name:_____DOB:_____ID#_____

I understand that as a consumer of Expansion Counseling Services, LLC mental health and substance abuse program, I am eligible to receive a range of services provided by Expansion Counseling Services, LLC's clinical staff. The type and extent of services that I will receive will be determined following an initial assessment with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks or months.

I understand that all information shared with the clinicians at Expansion Counseling Services, LLC is confidential and no information will be released without my consent. During the course of treatment at Expansion Counseling Services, LLC, it may be necessary for my therapist to communicate with other healthcare providers about my treatment. While written authorization will not be requested, prior to any discussion with other providers, I understand that my therapist will discuss these communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentially which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or the elder and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such request.

I understand that Expansion Counseling Services, LLC services are provided by a range of mental health professionals some of whom may not be licensed and that all unlicensed professionals are supervised by licensed staff.

I understand that the information listed below will be explained to me by a trained staff during my orientation and will become a part of my record:

A. The program's service and treatment

B. The specific condition that will be treated

C. The expected charges for services including any charges that might be billed separately

D. The clients Rights and Responsibilities

E. The rights of Expansion Counseling Services, LLC to obtain information about my treatment

F. The procedures for complaint and question resolution

Client Name:_____ CID#:_____

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that I am expected to conduct myself in an appropriate and respectful manner and to follow the program rules.

I understand that if I have any questions regarding this consent from or about the services offered at Expansion Counseling Services, LLC, I may discuss with my therapist.

I have read and understand the above statements and I have consented to participate in all the assessments and services offered to me by Expansion Counseling Services, LLC. I understand that I may stop treatment at any time, but if treatment is ordered by courts I may receive legal consequences.

Signatures:

_____ _____

Consumer/Guardian (PRINT) Date

_____ _____

Consumer/Guardian (SIGN) Date

Client Name:_____ CID#:_____

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

Thank you so much for choosing the services that we provide at Expansion Counseling Services. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health.

TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality.

Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it.

Therefore, I do not utilize texting in my therapy practice in regards to counseling sessions, and I will not respond to a text message regarding confidential information for your protection. If you happen to send me a text message by accident, you need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email: Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy. I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc: It is my policy not to accept "friend" or "connection" requests from any current or former client on my personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. However, Expansion Counseling Center may have a professional Facebook page. You are welcome to "follow" us on this professional page where we will post counseling information. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Expansion Counseling Services. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Google, Bing, etc.:

Client Name:_____ CID#:_____

It is our policy not to search for our clients on Google, Bing or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself with us as you feel appropriate. If there is content on the Internet that you would like to share with is for therapeutic reasons, please print this material out and bring it to your session.

Blogs:

We may post counseling information on our professional blog. If you have an interest in following our blog, please feel free to do so. However, please be mindful that the general public may see that you're following Expansion Counseling Center's blog. Once again, maintaining your confidentiality is a priority.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. We utilize Doxy.me and Zoom which are both HIPAA compatible versions that are encrypted to the federal standards. We have signed a HIPAA Business Associate Agreement (BAA) which means that both platforms assume responsibility for keeping our interaction secure and confidential. We will provide you with detailed instructions on how to log in securely prior to your appointment. We ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with us at the time of your appointment. I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Faxing Medical Records:

If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, we may recommend that you visit certain websites for pertinent information or self-help. We may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that we do not make these recommendations. Please let us know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:

Your communications with us will become part of a clinical record of treatment and it is referred to as

Protected Health Information (PHI). Your PHI will be stored electronically with whatever online appointment/scheduler we are using at the time, which all utilized will be secure storage companies who have signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will

maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption.

Electronic Transfer of PHI for Billing Purposes:

If we are credentialed with and a provider for your insurance, please know that we utilize a billing service/person(s) who has access to your PHI. Your PHI will be securely transferred electronically to whichever electronic billing that we are utilizing. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption.

Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:

We utilize Square as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit cardholder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Expansion Counseling Services, LLC.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your

Client Name:_____ CID#:_____

responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time

We are required to make sure that you're aware that we are located in the Southern Region and abide by Eastern Standard Time. Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry a beeper nor are we available at all times. If at any time this does not feel like sufficient support, please inform us and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We will return phone calls within 24-48 hours. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from us, but do one or more of the following:

· Call Behavioral Health Link/GCAL: 800-715-4225

· Call Summit Ridge Hospital at 678-442-5858

· Call Ridgeview Institute at 770.434.4567

· Call Peachford Hospital at 770.454.5589

· Call Lifeline at (800) 273-8255 (National Crisis Line)

· Call 911.

· Go to the emergency room of your choice..

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

· You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and TeleMental Health services are not appropriate.

· We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or is determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: _____ Phone: _____

· You agree to inform us of the address where you are at the beginning of every TeleMental Health session.

· You agree to inform us of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital: _____ Phone: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and we have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call your designated therapist. If we are on a phone session and we get disconnected, please call us back or contact your therapist to schedule another session. If the issue is due to your therapists' phone service, and they are not able to reconnect, we will not charge you for that session.

Structure and Cost of Sessions

We may provide phone, and/or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you. The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in our general "Information, Authorization, and Consent to Treatment" form. We agree to provide TeleMental Health therapy for the fee of $50-$110 per 55-60 minute session and $100-$165 per 90 minute session for UNINSURED clients. We require a credit card ahead of time for TeleMental Health therapy for ease of billing for UNINSURED clients.

Client Name:_____ CID#:_____

For UNINSURED clients: Please sign the Credit Card Payment Form, which will be sent to you separately and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment and the services that we provided. The receipt of payment & services completed may also be used as a statement for insurance if applicable to you (see below).

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services. As stated above, we will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify us at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, we might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that could easily pick up if you were in the office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and strongly encourage you to let us know if something we've done or said has upset you. We invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Requirement

If we agree that TeleMental Health services are the primary way we choose to conduct sessions, we require one face-to-face meeting at the onset of treatment. We prefer for this initial meeting to take place in our therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, we will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing us to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to our practice, and we will be utilizing that technology unless otherwise negotiated by you.

Email, Video Conferencing, Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment. Please print, date, and sign your name below indicating that you have read and understand the contents of the form, you agree to these policies, and you are authorizing us to utilize the TeleMental Health methods discussed.

_____ _____

Client/Guardian Name (Please Print) Date

_____

Client/Guardian Signature

My signature below indicates that we have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature Date

Client Name:_____ CID#:_____

CONSENT TO USE OF ELECTRONIC SIGNATURE

PLEASE NOTE THAT PRIOR TO YOUR INITIAL APPOINTMENT, WE ARE REQUIRED BY FEDERAL ACCREDITATION STANDARDS TO HAVE THE CLIENT AND/OR LEGAL GUARDIAN'S (IF APPLICABLE) **CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION** (IF YOU ARE USING INSURANCE) COMPLETED AND SIGNED. IF YOU ARE USING INSURANCE, WE ALSO REQUIRE THE **VERIFICATION OF INSURANCE** PAGE TO BE COMPLETED AND SIGNED. IN ADDITION, THE ENTIRE CONSENT PACKET MUST BE COMPLETED AND SIGNED ANNUALLY (1X/YEAR) IF YOU REMAIN IN SERVICES AND THE TREATMENT PLAN SIGNATURE SHEET MUST BE COMPLETED AND SIGNED SEMI-ANNUALLY (2X/YEAR).

BY SIGNING BELOW, YOU GIVE PERMISSION FOR EXPANSION COUNSELING SERVICES, LLC IF NEEDED TO UTILIZE YOU AND/OR YOUR CHILD'S ELECTRONIC SIGNATURE AS NEEDED ONLY FOR THE FOLLOWING FORMS IF THEY ARE NOT SIGNED:

- • CONSENT TO TREATMENT
- • AUTHORIZATION TO RELEASE INFORMATION (INSURANCE COMPANY ONLY)
- • VERIFICATION OF INSURANCE
- • TREATMENT PLAN SIGNATURE SHEET

I _____ _____ CONSENT TO ALLOW EXPANSIONCOUNSELING SERVICES TO UTILIZE MY ELECTRONIC SIGNATURE IF NEEDED FOR CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION (FOR INSURANCE COMPANIES ONLY), VERIFICATION OF INSURANCE AND TREATMENT PLAN SIGNATURE SHEET FORMS. I UNDERSTAND THAT MY ELECTRONIC SIGNATURE WILL NEVER BE USED FOR ANY OTHER PURPOSES AND RELEASE EXPANSION COUNSELING SERVICES, LLC FROM ANY LIABILITY IN REGARD TO USE OF MY ELECTRONIC SIGNATURE FOR THE ABOVE MENTIONED PURPOSES.

I understand this agreement and that I may withdraw my consent at any time (in writing) by informing the Expansion Counseling Services, LLC staff and signing below.

_____

Signature Date

Withdrawal of electronic signature services (sign and date):

_____

Signature of Client/Guardian Date

Use this space only if parent/client/guardian withdraws consent.

Rvsd 3/4/22

Client Name:_____ CID#:_____

ADVANCED DIRECTIVE:

This form is a combined durable power of attorney for health care and a living will (in some jurisdictions). With this form, you can name someone to make medical decisions for you if in the future you're unable to make those decisions for yourself. You can also say what medical treatments you don't want if in the future you're unable to make your wishes known.

Instructions

Read each section carefully. Before you fill out the form talk to the person you want to name, to make sure that he/she understands your wishes and is willing to take the responsibility. Write your initials in the blank spaces before the choices you want to make. Write your initials only beside the choices you want under parts 1, 2 and 3 of this form. Your advance directive should be valid for whatever part(s) you fill in, as long as it is properly signed.

Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should write on this form that there are additional pages to your advance directive. Sign the form and have it witnessed. Give copies to your doctor, your nurse, the person you name to make your medical decisions for you, people in your family and anyone else who might be involved in your care. Discuss your advance directive with them.

Understand that you may change or cancel this document at any time.

__ I consent to complete this form (Please proceed with entire form process below)

__ I do not wish to complete this form

Definitions to know

Advance Directive- A written document (form) that tells what a person wants or doesn't want if he/she in the future can't make his/her wishes known about medical treatment.
Artificial nutrition and hydration- When food and water are fed to a person through a tube.
Autopsy- An examination done on a dead body to find the cause of death.
Comfort Care- Care that helps to keep a person comfortable but doesn't make him/her get well. Bathing, tuening and keeping a person's lips moist are types of comfort care.
CPR (cardiopulmonary resuscitation)- Treatment to try to restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat or by other treatment.
Durable power of attorney for health care- an advance directive that tells what medical treatment a person does or doesn't want if he/she is not able to make his/her wishes known.
Life sustaining treatment- Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life sustaining treatment.
Living will- an advance directive that tells what medical treatment a person does or doesn't want if he/she is unable to make his/her wishes known.
Organ and tissue donation- when a person permits his/her organs (such as the yes or kidneys) and other parts of the body (such as the skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.
Persistent vegetative state- when a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move, and the eyes may open, but as far as anyone can tell, the person can't think or respond.
Terminal condition- An ongoing condition caused by injury or illness that has no cure from which doctors expect the person to die even with medical treatment. Life sustaining treatments will only prolong the dying process if the person is suffering from a terminal condition.

Client Name:_____ CID#:_____

Complete this portion of Advanced Directive form:

I, _____, write this document as a directive regarding my medical care. I

In the following sections, put the initials of your name in the blank spaces by the choices you want.

PART 1. My Durable Power of Attorney for Health Care

_____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow.

Name:_____
Home Phone:_____ Work Phone:_____
Address:_____
_____

If the person above cannot or will not make decisions for me, I appoint this person:

Name:_____
Home Phone:_____ Work Phone:_____
Address:_____
_____

____I have not appointed anyone to make health care decisions for me in this or any other document.

PART 2. My Living Will

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition

Life sustaining treatments

____ I do not want life sustaining treatment (including CPR) started. If life sustaining treatments are started, I want them stopped.

____ I want the life sustaining treatments that my doctors think are best for me.

____ Other Wishes_____

Artificial Nutrition and Hydration

____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

____Other Wishes_____

Comfort Care

____I want to be kept as comfortable and free of pain as possible, Even if such care prolongs my dying or shortens my life.

____ Other Wishes_____

Client Name:_____ CID#:_____

B. These are my wishes if I am ever in a persistent vegetative state

Life sustaining treatments

____ I do not want life sustaining treatments (including CPR) started. If life sustaining treatments are started, I want them stopped.

____ I want the life sustaining treatments that my doctors think are best for me.

____Other Wishes_____

Artificial nutrition and hydration

____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

____I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

____Other Wishes_____

Comfort Care

____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

____ Other Wishes **_____**

C. Other Directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them below.

_____

PART 3. Other Wishes

A. Organ donation

____I do not wish to donate any of my organs or tissues.

____ I want to donate all of my organs and tissues.

____I only want to donate these organs and tissues._____

____Other Wishes_____

B. Autopsy

____I do not want an autopsy.

____I agree to an autopsy if my doctors wish it.

____Other Wishes_____

C. Other statements about your medical care

If you wish to say more about any of these choices you have made or if you have any other statements to make about your medical care, you may do so on a separate piece of paper. If you do so, put here the number of pages you are adding. _____

PART 4. Signature

A. By my signature below, I show that I understand the purpose and the effect of this document.

Signature_____ Date_____

Address_____
_____

B. Your witnesses' signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage, or adoption nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1 signature:_____ Date:_____
Address_____
_____

Witness #2 signature:_____ Date:_____
Address_____
_____