Consent for Group Counseling

Counselor (if applicable): ______________________ Client First Name: ______________________ Middle Initial: ____ Client Last Name: ________________________ Address: ________________________________ City: _____________State: _____Zip Code: _______	Emergency Contact Name: ____ Relation to Client: ____ Emergency Contact Phone #: ____
gender identity: ___________ Pronouns: _______________ Email: __________________________________ Phone: __________________________________ Preferred Communication: ___________________	PRIMARY INSURANCE: __________________________ MEMBER ID: __________________________ GROUP #: ___________________________ SSN: _______________ DOB: _______________

Informed Consent for Group Therapy

The success of group therapy depends upon a high degree of trust between you, your group facilitator, and fellow group members. This document has been prepared to fully inform you of what to expect from group therapy, your group, and your group facilitator.

Understanding Group Therapy

Group therapy is a process of understanding more about yourself and others in a safe environment. In DBT group sessions, you will have the opportunity to explore patterns of thinking and behaving that are similar to how you relate to others in your life. Objectives of group therapy include, but are not limited to:

- Develop skills to assist you in reaching your goals.
- Feel a sense of support from other group members.
- Understand more about yourself and your family system.
- Identify and explore thoughts, feelings, and behaviors that hold you back.
- Learn how to improve relationships with others.

You are welcome to share as much or as little about yourself while in the group, however, the more open you are the better experience you will have. You are welcome to ask questions at any time. The more deeply you understand this process of therapy, the more effectively you will be able to incorporate positive change into your life.

Confidentiality

It is important that you feel comfortable in group to talk freely about whatever is bothering you. Sometimes you might want to discuss things that you do not want those outside of the group to know about. You have the expectation of privacy in group sessions.

Group Member's Agreement for Confidentiality

All members of the group will be asked to agree to a high level of confidentiality in the group sessions. This means that each participant agrees not to share any other group member's identity and personal information with others. It is appropriate to share your personal reaction and feelings about the group with others, but please do not share other people's stories with anyone outside of group.

Consistent Attendance

It is very important that you consistently attend scheduled group therapy sessions. Although illness, unexpected events, or vacations may occasionally interrupt your therapy, consistent attendance plays a vital role in helping you, and your fellow group members achieve your desired goals. Please be aware that your absences negatively influence the progress of yourself and other group members. If for any reason you are unable to attend a group session, please inform your group facilitator. Once starting a group, you are responsible for the full fee even if you do not attend all six sessions. Some insurance is accepted. In the event insurance does not cover group sessions, you will be responsible for the out-of-pocket expense.

HIPAA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review it *CAREFULLY.*

The privacy of your health information is important to me.

MY LEGAL DUTY

I am required by applicable federal and state law, as well as the ethics of the counseling profession, to maintain the privacy of your health information. I am also required to give you this Notice about my practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2006 and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information that I created or received before I made the changes. Before I make significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for
additional copies of this Notice, please contact me using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for ***treatment, payment,*** and ***healthcare operations***. For example:

> ***TREATMENT:*** I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
>
> ***PAYMENT:*** I may use and disclose your health information to obtain payment for services I provide to you.

HEALTHCARE OPERATIONS: I may use and disclose your health information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to my use of your health information for *treatment, payment,* or *healthcare operations,* you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: I may disclose your health information to you, as described in the *Patient Rights* section of this NOTICE. I may disclose your health information to a family member, friend, or other person to the extent necessary to help with healthcare or with payment for your healthcare, but only if you agree that I may do so.

PERSONS INVOLVED IN CARE: I may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general conditions, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: I will not use your health information for marketing communications.

REQUIRED BY LAW: I may use or disclose your health information when I am required to do so by law.

ABUSE OR NEGLECT: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials' health information required by lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: I may use or disclose your health information to provide you with appointment reminders (such as phone or voice messages).

PATIENT RIGHTS:

ACCESS: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. I will charge you a fee for expenses such as copy costs and copy/preparation time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you for my time (at my regular hourly rate of $150), copy costs, and postage if you want the copies mailed to you. If you request an alternate format or a summary/explanation of your health information, I will charge my regular hourly fee for providing your health information in that format.

[Note: In the event that your records are co-mingled (i.e., if you are a part of a Child Custody Evaluation, Family Court Case, family therapy, mediation, or marriage counseling), I need a signed consent by all parties involved in order to release records. Third party records in your file (i.e. doctors, other professionals, and references) have the right to confidentiality, and will not be released by this office unless ordered to do so by law. Please contact those professionals directly for records.]

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which I or my business
associates disclosed your health information for purposes, other *than treatment, payment, healthcare operations* and certain other activities, for the last six years, but not before January 1, 2006. If you request this accounting more than once in a 12-month

period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

I support your right to privacy of your healthcare information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services

Office Policy and Financial Responsibility Statement

Please carefully read the following information regarding private pay rates, insurance, length of sessions, late arrivals, late cancellations, and emergency calls.

Private Pay Rates:

- DBT Group Therapy: $20 per session
- By agreeing to the private pay rate, you are consenting to opt out of any insurance claim submission or reimbursement from insurance. Once a session is paid at the private pay rate, Gilbert Counselors, LLC will not submit a claim to insurance. Gilbert Counselors will provide a superbill if you request it.

Insurance and Financial Responsibility Statement:

- If you have insurance that covers the group, and it will cover the $20 private pay rate, we will gladly bill your insurance for coverage.
- We do bill some insurance companies, depending on the counselor. Billing insurance does not guarantee payment for services. It is your responsibility to verify your insurance benefits and associated costs. Copays and/or out-of-pocket costs are due at the time of service.
- **You are responsible for any balance resulting from, but not limited to copays, coinsurance, deductible, unpaid claims, etc. The non-insurance rates will be assessed for any missed appointments.**
- You will be charged the private pay rate for missed appointments. A pattern of canceled or missed sessions may be indicative of problems in commitment to therapy and will be addressed in session. Missing or canceling three sessions within a 90-day period may result in termination of services. If you are late to an appointment, the therapy session will still end at the scheduled time. A missed appointment fee is **not** eligible for reimbursement with a FSA, HSA, or HRA. This fee will be charged to another form of payment, such as a credit card.
- Payment is due at the beginning of each session. Core Balance Counseling accepts HSA/HRA cards, cash, check, or credit card. Returned checks will be assessed a processing fee of $25.00.
- You are financially responsible for all charges incurred for treatment. You will be held liable for any balance due on this account and that this balance will be due and payable on demand. Overdue accounts, with my name on them, may be submitted to a collection agency.

NOTE REGARDING CRISIS & EMERGENCIES

The office line of Core Balance Counseling, LLC as well as the therapists′ individual phone number is NOT an emergency number. If you are experiencing a non-emergency and need to contact a mental health professional for assistance, you may leave a voicemail and the front desk, or your therapist, will get back to you as soon as possible or within 24-48 hours Monday-Friday.

Emergency Medical Services:
If the situation is potentially life-threatening, get immediate emergency assistance by calling 911, available 24 hours a day, or go to the closest emergency room.

In the event of an emergency and you need immediate help, please call the **Crisis Line at (602) 222-9444**.
The **988 Suicide & Crisis Lifeline** (formerly known as the National Suicide Prevention Lifeline) offers 24/7 access to call, text, and chat with trained crisis counselors. Learn more here: https://www.samhsa.gov/find-help/988/faqs

For mental health and substance abuse disorders, you can find a treatment facility by visiting https://findtreatment.gov/

Other resources are available on our website, www.corebalancecounseling.com

Notification of Supervision: Clinical Interns and Licensed Associate Counselors

This notification is being provided to you for transparency and coordination of care. I am a Master's level therapist, and I provide therapy under clinical supervision. Please note that as a therapist I discuss my cases with my supervisor who provides clinical oversight over the services I provide within the practice. My supervisor is a Licensed Professional Counselor who is approved by the Arizona Board of Behavioral Health Examiners to provide clinical supervision to providers that are clinical interns or licensed at the associate level. If you would like to contact my supervisor directly to discuss treatment or address concerns, you may request their contact information.

Your active participation in treatment decisions is crucial to meeting identified goals. All services are voluntary (unless otherwise specified), and you have the right to end services at any time. There could be times when we might advise against ending services, as it could lead to greater risks. However, you are entitled to decline services at any time and at your own discretion.

Acknowledgement of Intake Forms

I acknowledge that I have read and agree with the following documents:

- HIPAA
- Informed In-person Group Consent
- Office Policy and Financial Responsibility Statement
- Notification of Supervision (if applicable)

By signing this agreement, I am acknowledging that I have read, understand, and agree to adhere to Gilbert Counselors' Clinical Policies and Procedures regarding Registration Policy and Procedure, No Show/Cancellation Policy and Procedure, Billing Policy and Procedure, HIPAA and Consents regarding Treatment, Telehealth, and Group Therapy (if applicable).

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Name of Client as well as Guardian if applicable

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Signature of Client or Guardian   Date