CORE BALANCE
COUNSELING

We, _____ and _____ ,
Client Name Printed Client Name Printed

hereby attest that we have voluntarily entered into treatment at Core Balance Counseling (CBC) for couples or marriage therapy.

The rights, risks and benefits associated with the treatment have been explained to us. We understand that the treatment may be discontinued at any time by either party. CBC encourages that this decision be discussed with the attending Provider. This will help facilitate a more appropriate plan for discharge.

Purpose of Treatment:

We understand that couples therapy begins with an evaluation of our relationship, past and present. We understand that because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice on the right Provider for us. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits, such as, processing negative experiences and/or developing coping skills to help increase the quality of life. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen.

We understand that as part of the initial assessment, our provider will meet with us together and will likely want to meet with each individual alone one time and then return together to identify the treatment goals. After the initial assessment, both individuals must attend all sessions. If only one member of the couple is present, it will be a missed appointment and our cancellation policy will apply.

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Goals of Treatment and Plans:

Current and background information will be collected to help identify our therapeutic needs; this includes identifying a diagnosis. The purpose of the diagnosis is to help develop a plan consistent with your abilities, temperament, development level and circumstances. Psychotherapy requires a very active effort on your part, we agree to share responsibility with our Provider for the therapy process, including goal setting and termination. In order to be the most successful, we will have to work on practicing skills outside of sessions. We have the right to set our own goals and develop a Treatment Plan that is consistent with our goals, and counseling services may be provided in an individual, family, group and/or couples basis. Over time our goals may change, as circumstances change. Reviewing our Treatment Plan is something that will be done throughout treatment; according to our treatment needs. Different techniques and models of counseling will be used, according to our treatment goals. We also have the right to refuse any recommended treatment or withdraw consent to treatment. If refusal takes place, we will be advised of the consequences of the withdrawal or refusal.

We understand that therapeutic focus in couples or marriage therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. We also understand that if remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.

Notice of Confidentiality and Professional Record Keeping:

The confidentiality of client information and records is protected under Federal Regulations and State Law, according to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. We have the right to request that a copy of our file be made available to any other health care provider at our written request. This request must be submitted in writing and provided to the CBC Clinical Director. Please refer to your "Notice of Privacy Practices," for additional information.

We understand that additional confidentiality practices for couples or marriage therapy will be covered in our "Confidentiality Contract for Couples or Martial Therapy."

Client Responsibilities:

As clients in psychotherapy, we have certain rights and responsibilities that are important for us to understand. There are also legal limitations to those rights that we should be aware of and we have corresponding responsibilities to our Provider. Clients have the responsibility to keep their Provider informed of contact information, changes in condition, voice if they feel the treatment plan needs to be updated, and keep up to date any releases of information.

Grievance Procedure:

We understand that as a client of CBC we have the ability to submit a complaint/concern, without fear of retaliation or discrimination.

Non-Voluntary Discharge from Treatment:

If a Provider chooses to terminate services before the planned discharge, it is considered involuntary termination. Criteria for an involuntary termination are as follows:

- When a client is no longer willing to participate in his/her treatment plan or work toward agreed upon treatment objectives;
- Upon discovery that a client did not fit the admission criteria or that there were service limitations in the treatment of a particular client & the client would need to be referred elsewhere for services;
- When a client becomes abusive or makes sexual advances towards a counselor or other clients; or
- When a client is no longer compliant with the mandated parameters to treatment and/or re-offends during the course of treatment.

Consent for Behavioral Telehealth:

- I understand that my health care provider and I have decided to engage in sessions virtually.

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- We understand that we are legally required to physically be in the state of Arizona at the time of service for all virtual appointments.
- Our health care provider explained to us how the video conference technology will be used for sessions and that it will not be the same as a direct client/health care provider visit since we will not be in the same room as my provider.
- We understand that telehealth has potential benefits including easier access to care and the convenience of private meetings from a location of my choosing.
- We understand there are potential risks to this technology, including internet connection issues and interruptions, unauthorized access, and technical difficulties. We understand that our healthcare provider or we can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
- We have had a direct conversation with our provider, during which we had the opportunity to ask questions regarding this procedure. Our questions have been answered and the risks, benefits, and any practical alternatives have been discussed with us in a language in which we understand.

Use of Technology:

Telehealth is a service we offer and we do use HIPAA compliant platforms. Any communication with your provider outside of session must be limited to scheduling purposes. You are encouraged to communicate with your provider only through your secure patient portal. It is at your provider's discretion to offer communication via text, however, that is only to be used to communicate if you are running late or need to reschedule.

Appointments, Billing, Cancellation Policy:

Appointments will ordinarily be 53 minutes in duration, and scheduled according to your treatment needs. Sessions with an intern will be 45 minutes. **If you need to cancel or reschedule a session, CBC requires that you provide 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the amount of your provider's full private pay rate. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee as described above. In addition, you are**

RESPONSIBLE FOR COMING TO YOUR SESSION ON TIME; IF YOU ARE MORE THAN 10 MINUTES LATE, IT IS YOUR PROVIDER'S DISCRETION TO OFFER A SHORTER APPOINTMENT, HOWEVER, IT WILL STILL END ON TIME.

CONTACTING YOUR PROVIDER:

YOUR PROVIDER MAY NOT BE IMMEDIATELY AVAILABLE BY TELEPHONE AND IS UNABLE TO PROVIDE CRISIS COUNSELING. IF YOU ARE EXPERIENCING AN EMERGENCY OR FEEL THAT YOU WERE UNABLE TO KEEP YOURSELF SAFE, CALL, TEXT, OR VISIT MIND 24/7 AT **1.844.MIND24**, GO TO THE NEAREST EMERGENCY ROOM, OR CALL **911**. YOU MAY ALSO CALL OR TEXT THE MENTAL HEALTH EMERGENCY NUMBER AT **988**.

WE WILL MAKE EVERY ATTEMPT TO INFORM YOU IN ADVANCE OF PLANNED ABSENCES, AND PROVIDE YOU WITH THE NAME AND PHONE NUMBER OF THE MENTAL HEALTH PROFESSIONAL COVERING MY CASES. IN THE EVENT, YOUR ASSIGNED PROVIDER IS NO LONGER ABLE TO CONTINUE SERVICES, YOU WILL BE REASSIGNED TO ANOTHER PROVIDER. IT WILL BE YOUR CHOICE IF YOU WOULD LIKE TO CONTINUE TREATMENT SERVICES OR BE TRANSFERRED TO ANOTHER PROVIDER. YOUR CASE MAY BE STAFFED IN A GROUP SUPERVISION SETTING FOR CLINICAL FEEDBACK ON THE BEST PRACTICE APPROACH, BUT YOUR NAME WILL NOT BE RELEASED.

LEGAL, LETTER, AND OTHER REQUESTS:

WE UNDERSTAND THAT OUR PROVIDER WILL NOT BE ABLE TO WRITE ANY LETTER, COMPLETE FMLA PAPERWORK, OR ANY OTHER LEGAL OR MEDICAL DOCUMENTATION. WE UNDERSTAND THAT OUR PROVIDER WILL NOT BE ABLE TO PROVIDE ANYTHING OTHER THAN OUR CHART AND THAT REQUESTS FOR OUR PROVIDER'S OPINION RELATED TO BUT NOT LIMITED TO ISSUES RELATED TO CUSTODY, VISITATION, COMPETENCY, MENTAL HEALTH OR MEDICAL STATUS, AND/OR OTHER COURT OR MEDICALLY RELATED ISSUES WILL NOT BE PROVIDED.

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 contact them at 480-912-7201.

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.

Confidentiality Contract Agreement for Couples or Marriage Therapy

We, _____ and _____ , hereby attest
Printed Name of Client Printed Name of Client
that we have voluntarily entered into treatment with CBC for couples or marriage therapy. This contract agreement will be between the above parties and is intended to hold, in good faith, that we will respect our therapeutic process and disclosures.

Confidentiality and Marriage / Couples Therapy: We have read and understand the "Notice of Privacy Practices" and limits of confidentiality by Arizona State law, and we have received a copy to keep.

We understand it is important to protect information given or discussed in therapeutic sessions. We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving us.

We agree not to subpoena our Provider to testify for or against either party, or to provide records in a court action. We understand anything either of us tells our Provider, individually, whether on the phone or in an individual meeting, may not be held as confidential, and at discretion of our Provider, may be shared with the spouse/partner during a subsequent couple session.

We also understand it is not a legally binding contract, but this emphasizes the importance of protecting the confidentiality of the therapy relationship, and reduces the likelihood that either member of the couple would then try to use the information from therapy as evidence against the other member of the couple. We also understand we have a right to our records.

Parties Acknowledgements – Initial Applicable Areas of Consent

By initialing and signing below, we agree to uphold our confidentiality.

_____ _____ I agree that I shall not, for any reason, attempt to subpoena my Provider for testimony, or subpoena any records Initial for any legal proceedings.

_____ _____ I acknowledge that the goal of psychotherapy, either individual or couples therapy, is for the sole initial purpose of the improvement of psychological distress and that the process of psychotherapy depends on trust and openness during the therapy sessions.

_____ _____ I understand by requesting treatment services, the information given to my provider during the therapy process will not be used against the other party in a judicial setting or legal process.

Acknowledgement of Intake Forms

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

- Informed In-person Consent
- Informed Telehealth Consent

- Office Policy and Financial Responsibility Statement
- Notification of Supervision (if applicable)
- HIPAA

By signing this agreement, I am acknowledging that I have read, understand, and agree to adhere to Core Balance Counseling 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).

_____ _____

Signature of Client 1 Date

_____ _____

Signature of Client 2 Date

_____ _____

Provider Signature Date

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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 changes in my privacy practices, I will change this Notice and make the new Notice available upon request.

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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.

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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.

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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(PHI) of an 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.]

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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