CORE BALANCE
COUNSELING

Counselor: _____	Phone:_____
Client First Name: _____	Preferred Communication:_____
Middle Initial: _____	Emergency Contact Name: _____
Client Last Name: _____	Relation to Patient:_____
Address: _____	Emergency Contact Phone #:_____
City: _____State: _____ Zip: _____	
SSN: _____ DOB: _____	
gender identity: _____	Primary Insurance:_____
Pronouns: _____	Member ID: _____
Email: _____	Group # :_____

Please Note:

As a courtesy we will bill your insurance carrier on your behalf; however, we are not liable to any expenses that are not covered by insurance, and we reserve the right to contact you for payment.

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_____

Client Printed Name

Welcome to Core Balance Counseling! We are delighted that you have chosen us to embark on this journey toward healing, self-discovery, and transformation. Before we commence our therapeutic relationship, it is essential to establish a clear understanding of the guidelines, expectations, and rights that shape our collaboration.

This document serves as your informed consent, outlining the nature of the therapeutic process, confidentiality, potential risks, and your rights as a client. It is designed to ensure transparency, empower you with knowledge, and foster a safe and trusting therapeutic environment.

As we embark on this journey together, we encourage you to read this informed consent thoroughly and feel free to ask any questions or seek clarification on any aspect. Your well-being is our priority, and we are committed to providing you with the support and guidance necessary for your personal growth and healing.
Thank you for choosing Core Balance Counseling. We look forward to working collaboratively with you.

During our first session we will discuss:

- I agree to participate in therapy services with Core Balance Counseling.
- I understand that participating in these services is voluntary and collaborative.
- I agree to verbally advise my therapist when I decide to terminate services. I understand that, unless otherwise contacted, no contact for 30 days will result in file closure; my file may be reopened upon agreement by both parties.
- I understand that I will be participating in therapy services to address issues and concerns that I share with my therapist. I understand that the focus of the services is on helping me reach my individual goals. I understand that there are no guarantees that the services will make me, or my partner/family members feel better or resolve my problems,

issues, or concerns. Furthermore, I understand that the counseling process can open levels of awareness that are painful (e.g., I could feel upset, anxious, angry, and/or uncomfortable).

- I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitation to confidentiality and cases when one or more of the following occur: intent to commit suicide; intent to commit homicide; any other act or intention to act in a way that may be a danger to self or others; information regarding child or elder abuse that mental health care providers are mandated by law to report; a court subpoena for records; information regarding unprofessional conduct by another behavioral health professional. In addition, I understand that my therapist is justified in informing an identifiable third-party of risk of contagious/fatal disease.
- I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary to ensure quality care. I understand that my identity will be protected.
- I understand that email, fax, and cell phone communications are **NOT** guaranteed confidential methods of communication. Therefore, I understand that if I choose to contact my therapist via one of these methods, it is by choice, and that therefore relinquishes my rights of confidentiality. I understand that any communication with my counselor outside of sessions must be limited to scheduling.
- I understand that I have a right to request a copy of my record in writing. I understand that I also have the right to sign a written authorization that will allow my therapist to give and/or receive information verbally and in writing with individuals or entities that I designated.
- I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however, I have the right to refuse treatment and to withdraw my informed consent from my treatment providing a written request. I understand that if I submit this request, Core Balance Counseling will no longer be able to provide me with services.
- I understand that my therapist and/or Core Balance Counseling has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e., referral to another therapist or practice/treatment provider).
- I understand that the therapy relationship is exclusively therapeutic (e.g., it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that my therapist and I are clear in our roles for treatment and that my confidentiality is maintained.

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Consent for Behavioral Telehealth:

- I understand that my health care provider and I have decided to engage in sessions virtually.
- I understand that I am legally required to physically be in the state of Arizona at the time of service for all virtual appointments.
- My health care provider explained to me 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 I will not be in the same room as my provider.
- I understand that telehealth has potential benefits including easier access to care and the convenience of private meetings from a location of my choosing.
- I understand there are potential risks to this technology, including internet connection issues and interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
- I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I 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. We encourage you 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 **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 YOUR CASE. IN THE EVENT THAT 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, 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 MY 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.

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).

_____

Client Name Printed Signature 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.

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 may 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.

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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.

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