EMPOWERING HEALTHCARE SERVICES

TELEHEALTH VERBAL/CONSENT FORM

I, _____(Client) hereby consent to engage in Telehealth with _____ (Therapist).

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form or obtaining verbal consent, I understand and agree to the following:

1.

I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] that my therapist explained to me and that also apply to my Telehealth services.

2.

I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3.

I understand that miscommunication between myself and my therapist may occur via Telehealth.

4.

I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5.

I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6.

I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7.

I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8.

I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9.

I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form].

10.

I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

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Telehealth Consent Form

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____

Client's Signature

_____

Date

_____

Patient's Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with _____,

Client's Full Name

Client understands and agrees to the above advisements, and Client has verbally consented to receiving psychotherapy services from Empowering Healthcare Services.

_____

Full Name of Therapist via Telehealth.

_____

Therapist's Signature

_____

Date

Reason unable to sign _____

_____

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How to Obtain Consent for Telehealth

The purpose of consent forms is to document that a discussion took place and that the patient was informed and was able to understand the information provided.

Before the consent discussion

- Mail or use your patient portal to send the form in advance, so patients can review it ahead of time.
- Arrange for a qualified interpreter if your patient does not speak English very well. Use the interpreter for the entire consent discussion.

During the consent discussion

- Use the consent form as a checklist to make sure you discussed all the information required by informed consent rules.
- Use easy-to-understand language.

Overview

Regardless of a patient's health literacy level, it is important that staff ensure that patients understand the information they have been given. The teach-back method is a way of checking understanding by asking patients to state in their own wordswhat they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand. The related show-me method allows staff to confirm that patients are able to follow specific instructions (e.g., how to use an inhaler).

- The teach-back and show-me methods are valuable tools for everyone to use with each patient and for all clinic staff to use. These methods can help you:
- Improve patient understanding and adherence.
- Decrease call backs and cancelled appointments.
- Improve patient satisfaction and outcomes.

Fact

Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect

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Verbal consent should be used as a last resort when other methods of obtaining consent e.g., electronic or wet signature cannot be done. . Documentation of verbal consent must clearly indicate why verbal consent was obtained (e.g. reason other methods could not be used, result of COVID-19 emergency, etc.) and include the date verbal consent was obtained.

Once your patient has decided to use telehealth for an appointment, you may be required to get their official informed consent.

While specific informed consent laws vary by state, these common sense actions are always a good idea:

- When you meet with a patient, explain what they can expect from the telehealth visit and what their rights are.
- Check in with the patient about their responsibilities during online counseling or other telebehavioral health visits. This might mean specific steps like wearing headphones and finding a place to be alone during the visit to ensure privacy on their end.
- If there's anyone observing the visit, tell the patient and get their consent at the start.
- Instruct patients to complete required forms ahead of time and bring them to their visit.
- Ensure the informed consent and other compliance documentation has been received and/or is documented during check-in, including verbal consent.

Make sure to have your medical/intake forms reviewed by your legal team. Obtaining informed consent with your patient is typically done before the first appointment.

<u>What is telephone therapy called?</u>

What Is Teletherapy. Teletherapy, also known as **online therapy, e-therapy, e-counseling, or cyber-counseling**, involves providing mental health services and support over the internet. Services can be offered through email, text messaging, video conferencing, online chat, messaging, or internet phone.

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Under this notice, covered health care providers that seek additional privacy protections should use technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements in connection with the provision of their video communication products. The list below includes some vendors that say they provide HIPAA-compliant video communication products these are hood alternatives when Therapy Notes Portal is unavailable or if client is having a diffucult time signing up on Therapy Notes Portal.

Although it's always important to confirm, examples of vendors who say they meet HIPAA requirements include:

- Skype for Business / Microsoft Teams
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings / Webex Teams
- Amazon Chime
- GoToMeeting
- Spruce Health Care Messenger

a little bit of body text

Intake Assessment Protocol

The Intake Assessment identifies symptoms and issues that brought the client into counseling/therapy. It is the direct link to the Treatment Plan and the identified symptoms/issues that drive the diagnosis, and the notion that counseling/therapy will reduce/eliminate these symptoms and empower the client/family to independently manage them. That said, the client's goals and expectations can also be explored and identified. This is also a pivotal time to identify the client's strengths that the clinician and support team will utilize to help the client achieve their goals.

Before the session -

1. Gather the client's referral information and/or review their chart in Therapy Notes.
    - Review any previous documentation.
    - Get report from previous clinician when possible.

2. Make contact with client within 24 hours of referral to schedule an initial intake session.
    - This may also mean contacting the client's listed emergency contact, family member, or POA if applicable.
    - This may also mean contacting facility staff if client resides in a Personal Care Home (PCH) or Assisted Living Facility (ALF).

During initial Intake Assessment -

1. Collect copies of all insurance and identification (Driver's Licence).
2. Complete entire intake with client, collecting as much information as possible including all medication.
3. Complete Treatment Plan during initial intake session *(if applicable).*
4. Review with client and get signatures on Consent for Treatment and Insurance Information and Release.
5. Get contact information for PCP
    - Inform PCP of referral for services and request order if possible.
6. Collaborate with involved family members and/or staff.
7. Review counseling/therapy guidelines with the client/family.
    - **Duration** - Review length of sessions (usually 45-60 minutes). Explain how frequently you are able to see client based on your assessment and medical necessity (weekly, bi-weekly, etc.)
    - **Confidentiality** - To be discussed in-depth with signing consents. Advise client that the details of sessions will remain confidential, but you may note broad topics to involved family/staff. Also explain laws as they pertain to Suicidality/Issues of Abuse and Neglect.

- **Agreements** - This is a good time to set consistent sessions with client. Make sure that client, family, and staff has your direct contact information should they need to reschedule or call.
- **Documation** - Be sure to update the client's chart with any new information gained such as demographic or emergency contact information.

Sample Intake Screen in Therapy Notes -

Presenting Problem - Clearly state why the patient is seeking treatment - what led to the referral- etc

Current Mental Status - This is a checkbox section

Safety Issues - checkbox

Background Information

Identification: age, ethnicity, religion, marital status, etc.

History of Present Problem: symptoms, onset, duration, frequency, etc

Past Psychiatric History: prior treatment, symptoms, hospitalization, suicide attempts, violent history

Trauma History: nature of trauma etc

Family Psychiatric History: history of mental illness in family, diagnosis

Medical Conditions & History: Ex - hx of HTN and high cholesterol

Current Medications: ask for list

Substance Use: if any

Family History: family of origin, relationships with parents, relationships with siblings

Social History: significant relationship, social support, nature/quality of relationship

Developmental History: Did PT meet all milestones

Educational / Occupational History: Highest level of education completed. Job history

Legal History: Any issues with the law

Strengths / Liabilities: Strengths such as family involvement, literacy, etc. Liabilities - medical condition etc

Other Information: Anything relevant to mental health

Diagnosis - This is either pre-existing or based on assessment. You should also have the tools to be used in assessment.

Initial Visit Checklist

- Patient Demographics (name, DOB, social, address, phone number)
- Confirm that the referral information is correct/updated in Therapy Notes
- Consents Forms completed and signed
- Insurance information verified (photo of Insurance Cards uploaded into chart front and back)
- Family contact information (if applicable)
- Caregiver contact information and agency information (if applicable),
- Other agencies involved in patient's care
- Assessment/Intake
- Plan of care
- Next visit date (schedule inside of Therapy Notes)

CONSENT TO TREATMENT

Thank you for choosing Empowering Healthcare Services. Your initial appointment will take approximately 60 minutes. The fee for the intake session is $275.00, and subsequent sessions is $200.00. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have any other questions or concerns, please ask us and we will try our best to give you all the information you need. You can reach our office by email at info@empoweringhealthcareservices.com or phone at Our clinicians use a variety of approaches that are both evidenced-based and individualized to serve each client. We believe that our clients are ultimately the experts in their own lives. Throughout the therapeutic relation will be discuss treatment practices, goals, plan limitations.

HIPAA

This document also contains summary information about the Health Insurance Portability and Accountability ACT (HIPAA). HIPAA is a federal law that mandates privacy requirements and patient rights pertaining to the use and disclosure of you Protected Health Information (PHI) in connection with treatment, payment and health care operations. HIPAA requires me to provide you with a Notice of Privacy Practices (which is attached to this agreement). It explains HIPAA and its application to your PHI in great detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it contains important information about your rights, and we ask that you review them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; or unless there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or unless you have not satisfied any financial obligations you have incurred.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then by Georgia State Law, I am obligated to report this to the Department of Child Protective Services, d) where you sign a release of information to have specific information shared and 3) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. In the unlikely event that your clinician is unable to provide ongoing services, a EHS clinician will provide those services and maintain your records for a period of 7 years. If an emergency situation arises for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency series in the community (911) for those services. EHS clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

APPOINTMENTS AND CANCELLATION POLICY:

All services are by appointment only. If you must cancel an appointment, please let EHS now as far in advance as possible, but at least 24 hours business days in advance so that we can offer that time to someone else.
We will make every effort to offer an alternative appointment during the scheduled week. **Failure to cancel within 24 hours results in a late cancellation/no show fee of $150.00.**

For couples/family therapy appointments, we only meet when all parties are present. So if one person is late or unable to keep the appointment, we will not meet.

There are many valid reasons for late cancellations (sick child, business meeting, traffic jam). I make only one exception to this policy. If there is an area emergency (i.e. major snow storm), there is no charge for a late or missed appointment. For all other late cancels, there is a fee of $150.00.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed the cancellation/no show fee.

SERVICE FEES: Payment is due at the time of your scheduled session, and will be billed to your credit/bank card on file. Any insurance co-pays or deductibles are due at the time of the session. Unfortunately, we cannot extend credit or provide services until payment is made. *Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason.*

Fees will be discussed during the initial consultation. A statement for insurance submission and for your records will be available by the first week of the month for the previous month.

FINANCIAL/INSURANCE ISSUES: **If you have a health insurance plan, your visits may be reimbursed.** The monthly statement provided contains the standard information needed to swiftly process your claims. Most insurance plans cover a portion of fees for counselors, although the percentages and amounts vary widely. EHS will provide billing services to your insurance company for services provided.

While a patient's diagnosis is very sensitive information and is generally treated as such by insurance carriers. We cannot guarantee how any insurance carrier or employer respects this information. If you prefer that I do not release information to your insurance company for reimbursement purposes, or if your insurance carrier fails to reimburse you at the level you expected, you remain responsible for the fee for services.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that I provide you. Georgia permits me to send some information without your consent in order to file appropriate claims. We are required to provide them with a clinical diagnosis. Sometimes we are required to provide additional clinical information such as a treatment plans or summaries or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Georgia law prevents insurers from making unreasonable demands for information, but there are no specific guidelines about what unreasonable includes. If we believe that your health insurance company is requesting an unreasonable amount of information, we will call it to your attention and we can discuss what to do. You can instruct us not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. Once the insurance company has this information, it will

become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it (see fee schedule if applicable).

We sincerely appreciate your cooperation and if, at any time, you have any questions regarding insurance, fees, or payments please feel free to ask. You may have a copy of this form if requested.

CONTACT IN BETWEEN SESSIONS

Although we do not take calls when we are in session, we typically check the voicemail and email at the end of every hour. If you leave a message or an email, we will answer it as soon as other demands permit. Generally, calls and emails are returned within the same day, with the exception being weekends and holidays. If your call is urgent, please state that at the beginning of your message, as we may not fully listen to messages until the end of the day. Calls and emails at night and on weekends will usually be returned during the next business day.

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

ELECTRONIC COMMUNICATION: Telephone and email are not encrypted methods of communication, and some confidentiality risks exits with their use. Counselors at Friends in Transition sometimes communicate using these mediums. If you would prefer to not be contacted by telephone or email, please inform your counselor and we will honor this request.

CLIENT FOLLOW UP: Your counselor may follow up with you after counseling has ended. 1 month, 3 month, and 6 month follow up calls help us to see if gains made in counseling have been maintained. In addition, someone from our team might call you to ask for your feedback on your experience at EHS Services. If you would prefer not to be contacted, simply inform your counselor and your preferences will be respected.

We, the counselor and client, have read and fully understand and agree to honor this agreement.

Client(s)_____ Date_____

Parent/Guardian)_____ Date_____

Provider_____ Date_____

Please read the following items and ask any questions that you have of your counselor.

1. Services offered by Empowering Healthcare Services, LLC are offered to help clients (and family) cope with depression, anxiety, dementia, adjust to grief, loss, transitional anxiety (such as move into a senior living facility), and other mental illnesses.
2. All counseling sessions will adhere to the American Counseling Association Ethical Standards.
3. Clients may be requested to complete the Brief Symptom Inventory (BSI), in addition to other assessment that may benefit treatment. The Brief Symptom Inventory is an assessment tool that gives the counselor an overview of the client's symptoms and the severity at a specific point in time.
4. All counseling relationships as well as storage and disposal of records will be kept confidential within legal and ethical limitations. Unless the client poses harm to the Counselor, the client will be informed when information regarding the client is being released. Information may be released without the written consent of the client in the following circumstances:
    a. The client poses harm to himself or others
    b. Suspected abuse of children or the elderly
    c. The client is under the age of 16 and has been sexually or physically abused, raped or the victim of another crime.
    d. When information is ordered by a court subpoena or a parole officer
    e. The client requires hospitalization
5. Deception in any form will not knowingly be used as a form of treatment
6. A primary goal of intervention is for the client to be able to live effectively within his or her own value system
7. Effectiveness of interventions with individuals is greatest when clients share all information related to the problem(s).
8. The purposes, goals, techniques, procedural rules, limitations, risks, and benefits of the intervention have been explained. The client has the opportunity to discuss the type of counseling relationship and intervention proposed and have any questions answered.
9. Clients in a helping relationship with other human services professional must inform all professionals.
10. Clients have a right to terminate counseling at any time.
11. The client understands his/her financial obligations. If appointments are not cancelled within a 24 hour notice, the client will be responsible for fees. In addition, any fees charged to the clinic for release of information will be the responsibility of the client.
12. During the first interview, the therapist will assess the client to determine if he/she is likely to benefit from guidance, counseling, and/or assessment. The counselor may inquire about goals, life history, mental status, and source of occupational and emotional difficulty, if any.
13. If the client does not present for three consecutive sessions and does not notify his/her counselor that he/she will not be able to attend, the counselor will assume the client has prematurely terminated, and will close his/her file. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

14. If the client is not seen over a 30 day period of time the case will be closed. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

Concerning written correspondence:

☐ I can be notified via email if my counselor needs to send me written correspondence concerning my case.

☐ I can be notified via mail if my counselor needs to send me written correspondence concerning my case.

☐ Please do not contact me via writing, I prefer you only contact me via telephone.

I have read this informed consent and understand that my participation in therapy does not constitute any promise or guarantee of results. I understand that I am financially responsible for all incurred costs of treatment. I agree that anytime I am unable to keep a scheduled appointment, I will notify my counselor 24 hours prior to my appointment. If I fail to do this, I will be charged for the missed appointment.

_____ _____

Client Signature and Date Counselor Signature and Date

_____

Parent/Guardian Signature and Date

Client Insurance Information and Release

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to **Empowering Healthcare Services, LLC** for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Name _____ Signature_____

Date _____

Insurance Information

Company Name: _____ Telephone #_____

Policy Holder's Name _____

Policy #_____ Group # _____

Policy Holders Social Security Number _____-_____-____ Subscribers DOB: _____

Relationship to client: _____

Client's Name: _____ Client DOB:_____

To be completed by Billing Office

Date: _____ Spoke with: _____ In Network or Out of Network

Policy effective :_____ Copay per visit: $_____ Coinsurance per visit: $_____

Deductible amount: $_____ Deductible met: $_____

Max Visits/Max Payable per Year _____ Out of Pocket per Year_____

Exclusions to Policy: _____

Claims Address: _____

Authorization #_____Sessions Approved_____ Auth. Dates: _____ thru _____

Release of Information Form

Patient Name (Last, First): _____
DOB: _____
Address:_____
Social Security #: _____

I voluntarily authorized and request disclosures (including paper, oral and electronic interchange) of current medical records for (patient name) _____ to Empower Healthcare Services.

I hereby release all physicians and/or hospitals listed below on this form all legal liability that may arise from the release of any information from my medical records pursuant to this authorization, including but not limited to release of drug or alcohol abuse, psychiatric, psychological, or infectious disease information protected under State or Federal Laws.

I authorize Empower Healthcare Services to contact any healthcare provider deemed necessary for continuation of my care and well being. This form authorizes healthcare providers, state and city agencies to discuss my health information related to my treatment and/or benefits for health services.

Patient/Caregiver Signature: _____ Date: _____

Physician Name: _____ Phone: _____ Fax: _____

Address: _____

Patients Primary Caregiver: _____ Phone: _____ Fax: _____

Address: _____

Email: _____

Other:

Name: _____ Relationship: _____

Phone: _____ Fax: _____ E-mail: _____

Address: _____

Empowering Healthcare Services
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http://empoweringhealthcareservices.com

ABOUT US

Our team of expert clinicians utilize a number of evidenced- based therapeutic approaches such as (but not limited) to the following;

Cognitive Behavioral Therapy

Explores patients' beliefs and thoughts to change behavior and manage emotions.

Psychodynamic Therapy

Explores past conflicts in relation to current problems. It includes the theory that unconscious issues surface in troubling emotions and behavior in the present.

Solution-Focused Therapy

Redefines and solves problems in a short-term, goal-oriented approach. Focuses on the present and future rather than the past.

Narrative Therapy

Throughout life, personal experiences become personal stories. People give these stories meaning, and the stories help shape a person's identity. Narrative therapy uses the power of these stories to help people discover their life purpose. This is often done by assigning that person the role of "narrator" in their own story.

Validation therapy

This a way to approach older adults with empathy and understanding. It is often used to comfort and reassure people who are living with Alzheimer's disease or another kind of dementia.

Transition Counseling

We provide support through the transitional process for individuals that have just moved from their home to an independent living community or assisted living facility. This service may be initiated by facility or family.

Family-Based Therapy for Dementia Caregiving

Understanding that the diagnosis of Dementia affects the entire family and the journey is difficult for all involved, we provide family therapy to both caregivers and care-receivers as a unit to address the unique needs created by this disease, process the emotions that accompany, and also teach skills to lower frustration and improve relationship as disease progresses.

Individual Psychotherapy

We meet with our clients for 60-minute sessions at a frequency dictated by the clinical need (usually once a week) for an average of 6-15 months. We meet our clients where ever home may be; assisted living facilities, personal care homes, skilled nursing facilities, memory care units, private homes, etc. We utilize a variety of therapeutic modalities such as Cognitive Behavioral Therapy (CBT), Solution Focused Therapy, Grief Therapy, Validation Therapy, Motivational Interviewing, Narrative Therapy, and more.

This is Empowering Healthcare Services. We are a group of Licensed Clinical Social Workers approved with Medicare, Medicaid, and other private insurance companies to provide mental health services. As a team, we have all individually gained much experience in the treatment of depression, anxiety, stress, trauma, grief, family conflict, caregiver issues, adjustment to illness/disability, and transitional life changes. We can help provide you or your loved ones with the necessary skills, support, and psychotherapy services to improve their quality of life and create a sense of wellbeing. We are a mobile team who will take our care to where ever

7 Benefits of Senior Counseling

- POSITIVE LIFESTYLE CHANGES AND COPING SKILLS
- ADJUSTING TO LIFE CHANGES
- MANAGING GRIEF AND LOSS
- ACCEPTING A HEALTH DIAGNOSIS
- STRENGTHENING COGNITIVE FUNCTION
- RESOLVING PROBLEMS FROM THE PAST
- COMBATING LONELINESS

CONTACT US

404-734-9637

850-688-6761

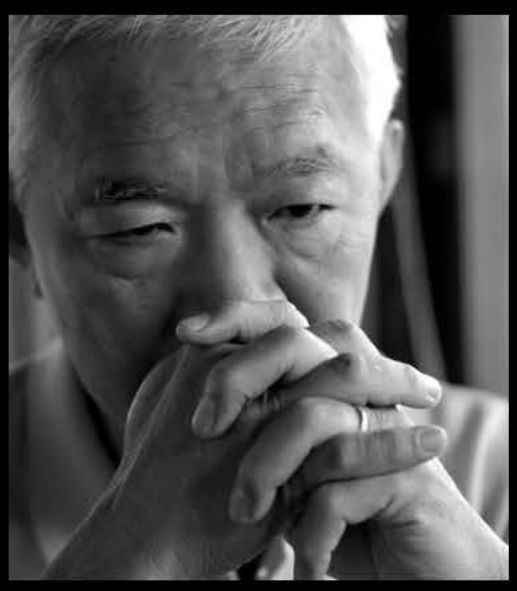
FAX 678-840-3887

WWW.EMPOWERINGHEALTHCARESERVICES.COM

EMPOWERING HEALTHCARE SERVICES

Empowering Healthcare Services

care that comes to you...



Therapy&Counseling Options:

CognitiveBehavioralTherapy
PsychodynamicTherapy
Solution-FocusedTherapy
NarrativeTherapy
ValidationTherapy
TransitionCounseling
PalliativeCounseling

Are You Experiencing Any Of The Following :

-Recentt loss
-Frequent crying
-Difficultysleeping
-Decreased energy
-Feeling hopeless
-Persistent sadness anxious or "empty"mood
-Thoughts of suicide
-Moving or talking slowly
-Difficulty concentrating, remembering making decisions

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Empowering Healthcare Services

Managing Mental Health In A Long Term Care Facility

We provide a full range of psychological and mental health counseling services at nursing homes and assisted living facilities for residents and their families. Our therapist are fully licensed and compassionate in the care they give.

No addtional costs

Our programs are delivered at no additional cost to the facility because our services are covered by Medicare, Medicaid, and the resident's supplemental insurance. This allows us to provide much needed counseling for your residents at no additional out of pocket cost to you.

Essential services provided with professionalism and care. We conduct psychological assessments, develop individual treatment plans with individual and family counseling, offer therapy treatment programs, and create specialized mental health programs: all provided on-site where our dedicated team assists your staff in monitoring the mental health of your residents.

Our dedicated and experienced team. All of our staff are licensed mental health professionals who are compassionate caregivers with experience in geriatric counseling. All of our licensed staff come to you with a wealth of experience and a sensitive approach in providing counseling and psychological services for your residents.

What kind of therapies does Empowering offer?

- Cognitive Behavioral Therapy - working to change unhelpful thinking and behavior
- Problem Solving Therapy - helping by teaching the effective management of negative effects of stressful events that can occur in life
- Supportive Therapy - working to improve or reinforce self-esteem, self-reliance, and psychological well-being
- Reminiscence Therapy - trying to achieve happiness through positive reminders from an individual's past life experiences.
- Sleep and Relaxation Coaching - helping to slow down anxious and stressful thinking to allow for peace of mind, relaxation, and rest
- Pain Management Therapy - offering treatment in place of medication that helps with chronic pain associated with aging or from disabilities
- Bereavement Therapy - helping to come to terms with the loss of a loved one, or with significant lifestyle change

404-734 -9637 or 850-688-6761

www.empoweringhealthcareservices.com