CRABTREE
Counseling & Consulting
commit~connect~change

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

HIPAA Notice of Privacy Practices
Your Information * Your Rights * Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

"Protected Health Information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Rights Regarding your PHI

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the future

Your Rights

When it comes to your health information, you have certain rights. This

section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

● You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

● We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

● You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

● We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communication

● You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

● We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

● You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

● If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we've shared information

● You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

● We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

● If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

● We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

● You can complain if you feel we have violated your rights by contacting us at rcrabtreecac@gmail.com

● You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

● We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

● Share information with your family, close friends, or others involved in your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission.

● The sharing of psychotherapy notes.

Other Uses or Disclosures

If you give us permission, how would we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you

● We can use your health information and share it with other professionals

who are treating you. Example: Your physician and I may need to coordinate your care.

Treat you

● We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for services

● We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Do research

● We can use or share your information for health research.

Comply with the law

● We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

● For workers' compensation claims
● For law enforcement purposes or with a law enforcement official
● With health oversight agencies for activities authorized by law
● For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

● We can share health information about you in response to a court or administrative order

Our Responsibilities

● We are required by law to maintain the privacy and security of your protected health information.
● We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
● We must follow the duties and privacy practices described in this notice

and give you a copy of it.
● We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

By placing your signature below, you attest that you have read and understand your rights and responsibilities under federal law regarding your PHI.

Sign:_____

Client Legal Name - First, Last	Date of Birth	Today's Date

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

CRABTREE
Counseling & Consulting
commit~connect~change

CONSENT FOR DIGITAL VIDEO OR AUDIO RECORDING

Counseling Process:

Our primary purpose is to help you become more effective in dealing with concerns that influence your ability to achieve success in pursuit of personal goals. We want to help you explore your concerns, provide support, and help you incorporate your goals into a plan for the future.

Confidentiality:

Information about you that is obtained during a counseling session will not be revealed to anyone outside the counseling relationship without your consent except where disclosure is required by law:
• Where there is reasonable suspicion of abuse to children or elderly persons.
• Where you present a serious danger to yourself or to others.
• Where ordered by a court to disclose information.

Release of Information and Permission to Record/Observe/Consult:

The counselor you are scheduled to see today is completing the requirements of a Licensed Clinical Mental Health Counselor Associate (LCMHCA) in the state of North Carolina. As a client, I give my permission for the counselor to share information regarding my counseling session(s) with the assigned supervisors for the purpose of supervision and evaluation of the below named counselor. Information will otherwise be kept confidential as allowed by law. I give my permission for the use of recording devices, including audio and video, as well as observation through private live-stream or in the same room during my counseling sessions. I recognize that the counselor has reporting requirements in situations where a danger to myself or others is believed to exist. My signature below indicates that I give Sadie Hamilton (therapist) permission to audio and videotape and that I understand the following:

1. I can request that the audio or video recording be turned off at any time. I may also request that the tape, or any portion of it, be erased.
2. I can revoke my permission for you to record me at any time.
3. The contents of the taped sessions are confidential, and the information will not be shared outside of your individual, peer, and group supervision.
4. The recordings will be stored in a secure location and not be used for any other purpose without my written permission.
5. The recordings will be erased after they have served their professional purpose.

Client Signature:

Date

_____ _____

Legal Guardian Signature

Date

_____ _____

Counselors Signature

Date

_____ _____

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

CRABTREE
Counseling & Consulting
commit~connect~change

CONSENT TO PSYCHOTHERAPY

Welcome to Crabtree Counseling and Consulting, PLLC. This document contains important information about my professional services and business policies. It also contains summary information about 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.

Although these documents are long and sometimes complex, it is very important that you understand them. Signing this document represents an agreement between us. We can discuss any questions you have when you sign or at any point in the future.

I. PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. As a client in psychotherapy, you have certain rights and responsibilities. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

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 unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. 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. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. By signing this form you give me permission to develop a treatment plan and diagnosis if need. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

II. APPOINTMENTS

Appointments will ordinarily be 55 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide 24hr notice. If you miss a session without canceling, or cancel with less than 24hr notice, my policy is to collect A Full Session Fee (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment.

You’re also responsible for coming to your session on time; if you are late, your appointment still needs to end on time.

III. PROFESSIONAL FEES

The standard fee for the initial intake is $215 and each subsequent session is $185. You are responsible for paying at the time of your session unless prior arrangements were made.

If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

IV. INSURANCE
To set realistic treatment goals and priorities, it is important to evaluate your resources available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require your authorization to provide a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). This information 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, I 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee.

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by Cash or Credit Card. Some insurance companies may also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use

a participating provider, I will refer you to a colleague.

V. PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents.

If I refuse your request for access to your records, you have the right to have my decision reviewed by another mental health professional. We can discuss upon your request. You also have the right to request that a copy of your file be made available to other health care providers.

VI. CONFIDENTIALITY
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices provided to you. Please remember that you may reopen the conversation at any time during our work together.

VII. PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions). In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

VIII. CONTACTING ME
The best way to contact me Rebecca Crabtree is at rcrabtreecac@gmail.com or 336-303-1414 and for Sadie Hamilton at shamiltonccac@gmail.com or 336-310-6779.

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters.

If, for unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or feel unable to keep yourself safe, please go to your local hospital Emergency Room or call 911 and ask to speak to the mental health worker on call. I 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 practice.

IX. OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or former clients.

X. CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature Here: _____

Print Name Here: _____

Client Legal Name - First, Last

Date of Birth

Client Address

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

CRABTREE
Counseling & Consulting
commit~connect~change

I _____ **authorize:** _____
Client Legal Name - First, Last — Therapist Name

- [ ] To Send
- [ ] To Receive

The following information:

- [ ] Medical history and evaluation(s)
- [ ] Mental health evaluations
- [ ] Developmental and/or social history
- [ ] Educational records
- [ ] Progress notes, and treatment or closing summary
- [ ] Other

To be provided to or released from:

_____ _____
Provider Name — Phone #

Your relationship to client:

- ○ Self
- ○ Parent/legal guardian
- ○ Personal representative
- ○ Other

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Case review
- ☐ Updating files
- ☐ Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed of what information will be given, its purpose, and who will receive the information.

I understand that I have a right to receive a copy of this authorization.

I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach/provide a copy of that documentation to this authorization to receive this protected health information.

Signature _____ Date _____

Provider Signature _____ Date _____

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

CRABTREE
Counseling & Consulting
commit~connect~change

Consent to Treatment of a Minor

Client Legal Name - First, Last _____ Date of Birth _____

I, _____ give my consent to **Crabtree Counseling and Consulting**
Enter Name Here:

to provide treatment and therapy necessary or advisable for my child. I understand

I may stop treatment at any time and that **Crabtree Counseling and Consulting** has the same right.

I realize that my child's treatment is confidential. Information may not be released without my written consent except in the event that an issue is raised which in the therapist's judgment would endanger my child's welfare. I would be notified, as would appropriate authorities and resources, if indicated. (see "HIPAA Notice of Privacy Practices")

My child's therapist may determine with my child that my participation is needed to treat or discuss specific specific issues, with or without my child present.

Parent/Legal Guardian Signature:

_____

Today's Date _____ Relationship to Client: _____

Child's Signature (if indicated)

_____

CRABTREE
Counseling & Consulting
commit~connect~change

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

Client Financial Responsibility

Thank you for choosing Crabtree Counseling and Consulting for care. We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.

1. I agree that I am legally responsible and agree to pay to the Provider for all fees, charges, and expenses incurred by the below Client or owed to Crabtree Counseling and Consulting in connection to Provider providing care to Client.

2. I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.

3. I acknowledge that a no show or late cancellation will result in me being charged the full session fee.

"You will not be charge a cancellation fee in the event of illness or pet emergencies, but you will be charged for canceling due to work conflicts."

Signature:

_____ Date: _____

Print Client Legal Name - First, Last:

_____

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

CRABTREE
Counseling & Consulting
commit~connect~change

Informed Consent for Telehealth

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing healthcare services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful particularly during the Coronavirus (COVID-19) pandemic in ensuring continuity of care, as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks.

Risks to Confidentiality:

As telehealth sessions take place outside of Crabtree Counseling and Consulting, PLLC, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of

our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues Related to Technology:

There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation or stored data could be accessed by unauthorized people or companies.

Crisis Management and Intervention:

Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. We may not have an option of in-person services presently, but in a crisis situation, you may require a higher level of services. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telehealth work.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Professional Disclosure Statement still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telehealth

During this time, it may not be possible to engage in in-person sessions to “check-in” with one another. I will let you know if I decide that telehealth is no longer the most appropriate form of treatment for you. If you decide telehealth is not optimal for you,

it is important to let me know. We will discuss options of engaging in referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person treatment. To address some of these difficulties, we will create an emergency plan before engaging in telehealth services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as technological connection failure, and you are having an emergency, do not call me back; instead, call 9-1-1, 9-8-8 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-connect you via the telehealth platform on which we agreed to conduct treatment. If I do not connect via the telehealth platform within two (2) minutes, then call me on the phone number I provided you For Rebecca Crabtree (336)-303-1414 or for Sadie Hamilton (336) 310-6779 .

Fees

The same fee rates will apply for telehealth as apply for in-person therapy. Some insurers are waiving co-pays during this time. It is important that you contact your insurer to determine if there are applicable co-pays or fees which you are responsible for. Insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic therapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these sessions will be covered.

If there is a technological failure and we are unable to resume the

connection, you will only be charged the prorated amount of actual session time.

Records

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our treatment together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Signature: _____

_____	_____	_____
Date	**Client Legal Name**	**Date of Birth**

CRABTREE
Counseling & Consulting
commit~connect~change

1509 S HAWTHORNE RD
WINSTON SALEM, NC 27103-4125
(336) 303-1414

Practice Policies

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for
emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or
treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies
of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information,
consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

TREATMENT

Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. By signing this form you give permission for the Therapists to make clinical assessments, diagnosis, and treatment plan/interventions at the intake session based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences.

When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic
relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Legal Name - First, Last _____

Client Signature: _____ Date _____

1509 S. Hawthorne Rd
W-S, NC 27103
336-303-1414
rcrabtreecac@gmail.com

CRABTREE
Counseling & Consulting
commit-connect-change

Treatment Plan For:_____

Staff and Client/Legally Responsible Person sign below whenever the plan is implemented/reviewed/revised.			
Date	**Staff Signature**	**Date**	**I have had input into this plan and I agree with this plan. (Client/Legally Responsible Person Signature)**

Professional Disclosure Statement

Sadie Hamilton, LCMHCA, MHS, BS
Office: (336) 310-6779
Email: shamiltonccac@gmail.com

Welcome and thank you for allowing me to take part in your life's journey. This statement will inform you of my background, counseling approaches, and your rights. This document is required by both North Carolina Administrative Codes Rule .0204 of Chapter 53, Title 21 and the NC GS 90-343. If you have any questions, please feel free to discuss them with me at any time.

Qualifications:
I am currently a Licensed Clinical Mental Health Counselor Associate (LCMHCA) (License #A20428) in the state of North Carolina, approved by the Board of North Carolina. I graduated from Catawba College in 2024 with a Master's in Health Science (MHS) in Clinical Mental Health Counseling. I also received my Bachelor of Science in May of 2022 from Catawba College. I have one year experience completing my practicum and internship working with children in the elementary school setting. My formal education has prepared me to counsel individuals including children, adolescents, and adults, as well as couples, families, and groups.

Restricted Licensure:
I am currently a Licensed Clinical Mental Health Counselor Associate (LCMHCA) in the state of North Carolina. Currently, I am under the supervision of Jacqueline Aldridge. If you have any questions and/or concerns, please reach out to her using the information provided below:

Jacqueline Aldridge NCLCMHCS, NCC, RPT-S, PSC
5170 Hwy 105 Suite #1
Banner Elk, NC 28604
Office: (828) 773-6014/ (828) 898-4145
Email: jaldridgecounseling@gmail.com

Areas of Expertise:
My educational training has prepared me to work with a variety of issues that children, adolescents, adults, families, and couples experience. These areas include but are not limited to anxiety, depression, addiction, grief and loss, relationship issues, and behavioral issues.

Counseling Relationship:
I want to first acknowledge the courage that it takes to seek counseling services and coming in today as a first step. I look forward to working with you and determining what best fits your needs. I see counseling as a process in which you and I, as client and counselor, work together to understand and build trust in a counseling relationship. By working as a team, we will explore and define current problem situations, develop future goals for improved life satisfaction, and work towards realization of those goals. I acknowledge the impact of family on the health of each child, adolescent, and adult. Thus, I like to incorporate and invite caregivers and family to be a part of treatment planning. I will look to you to keep me aware of your needs so we can try to resolve any issues and/or difficulties that may arise. I like to incorporate play, behavioral interventions, sensorimotor, and psychoeducation into sessions to help children, adolescents, family, and caregivers feel comfortable during the counseling process.

I work from an eclectic counseling viewpoint, allowing a mix of directive and non-directive techniques to best fit the need of the client. My primary theoretical orientation is cognitive-behavioral theory (CBT). I find that active incorporation of a client's strengths will encourage clients to be more fully engaged in therapy which in turn leads to positive outcomes. I also integrate aspects of reality, person-centered, and post-modern therapy. I work mainly with elementary school aged students providing services in a wide range of areas. Any client who needs services that I am not able to offer will be referred to an appropriate service/agency.

When working with a client, utilization of a diagnosis can assist in your care and treatment. A diagnosis will help guide treatment planning and communication with other professionals. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) will be used to base all diagnosis on. I will document and make a diagnosis part of your record.

Appointments are typically scheduled once a week or every other week (bi-weekly) for approximately 50 minutes, with the first session devoted to gathering necessary information. I feel that clients and their families can benefit tremendously from open communication with other professionals such as primary care providers. I will only communicate and work with other professionals with your written consent. The purpose of communication and collaboration with other professionals would be to aid with your treatment plan as my client.

Office Procedures:
Appointments are typically set at the close of each session. I have morning and afternoon appointments available. Appointments may be scheduled, rescheduled, or cancelled with 24-hour notice by calling my voicemail number. The fee that will be collected for a 50-minute session with a single client will be $125. Payment is expected at the time of service. As a courtesy, we will bill your insurance company, HMO, responsible party or third-party for you if requested. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due before the next session. Cash, checks, MasterCard, and Visa are acceptable forms of payment.

Patient Rights and Use of Diagnosis:
Every client has the right to accept or deny any therapeutic modality presented during the counseling process. The process of termination of the counseling relationship can be made at any time. Some health insurance companies will reimburse clients for counseling services, and some will not. In addition, most will require that a diagnosis of a mental-health condition and indication of "illness" must be established before they will agree to reimburse. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance record. If you would like to request a copy of your records, this will be permitted for a processing fee.

Confidentiality and Privileged Communication:
Any information shared in our counseling session will be confidential and will become a part of your clinical record which is accessible to you upon request. Treatment will be kept in confidence and is protected by Federal Law and regulations. The release of information will only occur through your informed, signed, and witnessed consent. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: a) if a client poses danger to themselves or others, b) if I suspect abuse or neglect of children or other persons presumed to have limited ability to care for themselves, c) if a client is under the age of 18 and parents or guardians have control of the client's legal rights, d) if there is a court order, or e) if the client gives written permission to release information. In the instance of participation in group counseling, I cannot guarantee confidentiality from other group members. However, I will do everything I can to ensure all members understand confidentiality policies and that breaching confidentiality will result in automatic dismissal from the group.

Counseling Relationship:
As a professional counselor, we must abide by certain ethical codes regarding dual relationships. It is important that our contact is limited to the therapeutic setting. If we see each other in regular social settings, I will not address you in public unless you initiate the interaction first. I want to protect both your confidentiality and the professional nature of our relationship. For appropriate privacy and confidentiality, I hold a strict policy against engaging with clients using any avenue of social media.

Complaints:
Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors P.O. Box 77819
Greensboro, NC 27417 Phone: 844-622-3572 or 336-217-6007 Fax: 336-217-9450 E-mail:
Complaints@ncblcmhc.org

Acceptance of Terms
We agree to these terms and will abide by these guidelines. By signing below, you consent to counseling and understand the information provided above.

Client's Signature or Signature of legal Guardian

Client Legal Name -

Date

Therapist Signature

Date

LCMHC Professional Disclosure Statement
Rebecca Crabtree, MA, LCMHC
Office: 336-303-1414 Email: rcrabtreecac@gmail.com

This document is designed to inform you about my background and to ensure that you understand our professional therapeutic relationship, your rights as a client, and office policies and procedures for Crabtree Counseling and Consulting, PLLC.

Qualifications: I received my Master of Counseling from Concordia University of Irvine in 2019. I am a licensed Clinical Mental Health Counselor Associate in North Carolina (license #15791). Currently I have 6 years of experience in my career as a counselor.

Areas of Expertise: My educational training prepares me to work with a variety of issues that adults, families, couples, and children experience. These areas include but are not limited to anxiety and depression, grief and loss, addictions, marriage/family, relationship issues, behavioral issues, and spiritual concerns. In addition to formal training in my graduate program, I have expertise in working with children that have developmental delays, autism, ADHD, and physical handicaps.

Counseling Relationship: I see counseling as a process in which you the client, and I, the Counselor come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for improved life and work systematically toward realizing those goals. I acknowledge the impact of family on the health of each child and adolescent. Therefore, I like to incorporate and invite caregivers and family to be a part of the treatment planning. You agree to keep me aware of your needs, resolving any difficulties which may arise. You are free to terminate counseling at any time. I like to incorporate play, behavioral interventions, sensorimotor, and psychoeducation exercise into sessions to help children, adolescents, and caregivers feel more comfortable in the process.

I work from a Christian worldview but respect the beliefs of all people. I provide counseling services that range from short term counseling and brief therapy models to more long-term approaches. The nature of the issue presented by the client has a great deal to do with this. Any client who is in need of a service that I am not able to offer will be referred to an appropriate service/agency.

It is important for you to understand that health insurance often require that a diagnosis and reason for treatment is provided before they agree to reimburse you. The Diagnostic and Statistical Manual 5th Edition is used to base all diagnoses on. In the event a diagnosis is required, l will inform you of that diagnosis prior to submission to the health insurance company. Any diagnosis will become part of your permanent insurance records.

Session Fees and Length of Sessions: Counseling sessions are 53 minutes, and our Standard Rate is $150/session. If you have insurance coverage for mental health services and wish to utilize that coverage, you will be responsible to pay any co-payment, deductible, or co-insurance at each session. All payments required by you are due at the beginning of each session by credit card. Your agreed upon fee is $_____.

Appointments are typically set at the close of each session. I have morning and afternoon appointments available. Appointments may be scheduled, rescheduled, or cancelled with 24 hours' notice by calling me at the number provided or by email. I believe that clients and their families greatly benefit from open communication with other professionals such as the primary care doctors. Only with written permission will I communicate and work with any other professionals. The purpose would be to determine a holistic treatment plan.

Confidentiality and Privileged Communication: All information you share with me during our sessions will be handled with great care and respect. The privacy and confidentiality of our sessions are a privilege of yours and protected by state law and profession's ethical standards. All our communication becomes part of the clinical record, that is kept in a secure location. Records are the property of Rebecca Crabtree, but you have the right to request a copy of your record, and this request must be made in writing. In the case of unforeseen circumstances such as death or incapacitation, your files will remain held securely and confidentially.

I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: **(1)** you direct me in writing to disclose information to someone else, **(2)** it is determined you are a danger to yourself or others. **(3)** there is reasonable suspicion of the neglect or abuse of and minor, elderly individual or a disabled individual. **(4)** I seek professional consultation or supervision concerning your treatment, or **(5)** I am ordered by a court to disclose information. **(6)** if you take legal action against me, you forfeit your right to confidentiality. If you wish to contest the disclosure of your records under these **(5, 6)** circumstances, you may do so in writing within ten (10) days of our office receiving notice of the records request.

Aside from these circumstances, I will not tell anyone anything about your treatment, diagnosis, history, or even that you are a client, without your full knowledge and a signed consent to release information form.

Finally, if you choose to communicate via e-mail or text message, please know that I cannot ensure, nor will I be held responsible for a breech in confidentiality. E-mail and text messaging have no confidentiality in the view of the court, and CCAC advises against its use outside the scope of appointment related reminders.

Counseling Relationship: Because we are professional counselors, we must abide by a certain ethical code regarding dual relationships. It is important that our contact is limited to the therapeutic setting. If we see each other in regular social settings, I will not address you in public unless you initiate the interaction. I desire to protect both your confidentiality and the professional nature of our relationship. For appropriate privacy and confidentiality, I hold a strict policy against engaging with clients using any avenue of social media.

Complaint Procedures: Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblcmhc.org

Acceptance of Terms:
We agree to these terms and will abide by these guidelines.

Client: _____ Date: _____

Counselor: _____ Date: _____

Parental Authorization for Minors:

I, _____, give permission for Rebecca Crabtree, to conduct counseling with my (relationship) _____, (Name of Minor)_____.