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Live Life Counseling, LLC

|  |  |
| --- | --- |
| Date: |   |

770-940-9679

 **Client Information Form**

|  |  |
| --- | --- |
| Patient’s Name: |   |
| Date of Birth: |   | Age: |   | SSN#: |   | Sex: | [ ]  F | [ ]  M |
| Address: |   |
| City: |   | State:  |   | Zip Code: |   |
| Home Phone: |   | Work Phone:  |   |
| Cell:  |   | E-mail Address: |   |
| Okay to leave messages on (check all that apply): | [ ]  Home Phone | [ ]  Cell Phone | [ ]  Work Phone | [ ]  E-mail |
| **Insurance Information** |
| Name of Insured: |   | SSN:  |   |
| DOB: |   |
| Member ID: |   | Group #: |   |
| Relationship to Patient: |   |
|
| Employer Name: |   | Occupation: |   |
| Insurance Company Name: |   |
| Insurance Company Mailing Address: |   |
| City: |   | State: |   | Zip Code: |   |
| Insurance Company Phone #: |   |
| **Emergency Contact Information Section** |
| Emergency Contact Name: |   |
| Phone: |   | Relationship: |   |
| **Responsible Party Information** |
| Parent/Guardian: |   |
| DOB: |   | SSN: |   |
| Address: |   | City: |   |
| Phone #: |   |

**INSURANCE ASSIGNMENT AND RELEASE**:

I understand I am responsible for obtaining initial authorization from my insurance company if I plan to utilize insurance benefits. I authorize payment of any insurance benefits directly to Live Life Counseling, LLC for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of any medical information necessary to process claims and secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

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| --- | --- | --- |
| Responsible Party Signature | Relationship to Patient |  Date |

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**Live Life Counseling, LLC**

770-940-9679

Account #:

CONSENT FOR TREATMENT

Thank you for choosing Live Life Counseling, LLC. Please take a moment to review our philosophy and guidelines for providing counseling services.

**Cancellations:** Cancellations must be made within 24 hours of scheduled appointment time. If notification is not received within that time, the missed appointment will be billed at the regular rate. Insurance does not cover missed appointments; therefore, clients will owe the full fee of $100 if cancellation is not received within 24 hours. If no one is available to take your call, please leave a message or e-mail cbooz@livelife-counseling.com.

**Fee for service**: A 50 minute session will be billed at an hourly rate. Assessments are billed at a flat rate. Cost of the assessments depends upon the type of assessment being requested.

**Termination of Clients:** All clients at Live Life Counseling, LLC, will be considered a new client if they are not seen by a provider for 90 days, upon return. If a client fails to participate in therapy (non-compliance, no-shows or cancelations) the therapist has the right to terminated the therapeutic relationship. Termination of a client and therapist relationship is best to do in person at the last session

**Court:**

If Therapist is subpoenaed to court the fee for service is $300 an hour. Written notarized affidavits are $450.00. Request for patient records is a $25 charge.

**E-mails and Phone Calls outside of session:**

A phone call will be billed to the customer the same as being involved in a session. Payment is due for the phone call at the next session or needs to be mailed to Live Life Counseling.

E-mails might not be answered if Therapist feels the issue would be better addressed during the next session. More than one e-mail a month, which needs to be responded to will result in a $20 dollar fee for service. Payment is due at the next session or needs to be mailed to Live Life Counseling**.**

**Confidentiality:** Live Life Counseling is legally bound by our professional code of ethics to maintain client confidentiality, with the following exceptions:

1. To disclose reports of child abuse.

2. To prevent clear and immediate danger to self or others.

3. When the therapist is a defendant in a civil, criminal, or disciplinary action arising from the

 therapeutic involvement.

4. If there is a signed consent to release information.

**Consultation and Supervision**: Occasionally, when a child or family is not making progress in therapy, we may wish to obtain consultation and/or supervision from a qualified professional outside the agency to assist us in providing the best possible services. If we determine that there is a need for consultation we will discuss this option with you and obtain your permission. This service will be billed at the hourly rate.

**Consent for Release of Information**: If it is necessary to contact other agencies to give or receive information about you, your family or your child, we will obtain your written permission. A parent or guardian must sign the consent forms for children and adolescents.

**Crisis Line**: Please call 911 if you have an emergency. Please be respectful when using the after hour crisis line. Please leave a message and therapist will call you back as soon possible.

 In Case of an Emergency

 If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

* Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
* Call Ridgeview Institute at 770.434.4567 or local hospital
* Call Peachford Hospital at 770.454.5589 or local hospital
* Call Lifeline at (800) 273-8255 (National Crisis Line)
* Call 911.
* Go to the emergency room of your choice.

I have read the above information and understand the consent for treatment.

Client signature Date

# CONFIDENTIAL

#  INFORMATION, AUTHORIZATION, &

# CONSENT TO TELEMENTAL HEALTH

 Thank you so much for choosing the services that I provide. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

 “TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.” (Georgia Code 135-11-.01) TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

 **Text Messaging:**

 Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

**Email:**

 Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

**Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:**

 It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

**Faxing Medical Records:**

 If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine. However, my fax machine is kept behind two locks in my office. And, when my fax machine needs to be replaced, I will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

**Electronic Transfer of PHI for Billing Purposes:** If I am credentialed with your insurance, please know that I utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to Waystar. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

**Electronic Transfer of PHI for Certain Credit Card Transactions:** I utilize Transact as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill.

Consent to TeleMental Health Services

 Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

* Texting
* Email
* Video Conferencing
* Website Portal
* Electronic Chat Forum
* Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

                                                                                                                                                      **Client Name (Please Print) Date**

**Name:                                                        Social Security Number:**

**Date:                      Account #:**

**Treatment Consent Form**

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Live Life Counseling, LLC. This form documents that the client has consented to treatment at Live Life Counseling, LLC including but not limited to, assessments, psychotherapy and counseling. This allows the professional staff at Live Life Counseling, LLC to provide services to you.

This form provides evidence that no guarantee is made by any professional at Live Life Counseling, LLC concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at Live Life Counseling, LLC. If you have any questions concerning this or any other matter, it is your responsibility to ask your therapist or assessor. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I,                                                            , for

 (Print your name) (Print the client’s name)

do hereby voluntarily consent to an assessment, care and/or treatment by                                           , I am aware that the practice of medicine, psychiatry, clinical psychology, clinical social work, and other therapy by the licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the assessment and counseling process and that I share responsibility for treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way as is applicable.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

(Sign your name) (Date)

(Witness) (Date)

**Authorization to Disclose Protected Health Information to Primary Care Physician**

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health

care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will

not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I,

 (Member Name) (Member Identification Number-Optional) (Subscriber Identification Number) (Date of Birth MM/DD/YYYY)

authorize                                                          , to release protected health information related to my evaluation and treatment to:

 (Provider Name – Please Print)

**PCP Name:**                                                                                     **PCP Phone:**

**PCP Address:**

 (Street) (City) (State) (Zip Code)

|  |
| --- |
| **Information should be completed by Behavioral Health Provider**  |
| I saw                                                                      on                                        for                                                                      (Patient Name – Please Print) (Date) (Reason/Diagnosis |
| Summary:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| If you have any questions or would like to discuss this case in greater detail, please call me at:                                                             (Phone Number)                                                                                                                                                                                                              (Provider Signature) (Provider Printed Name) (Licensure) |
| **Patient Rights** |

* You can end this authorization (permission to use or disclose information) any time by contacting:

**.**

* If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
* You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
* Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
* You have a right to a copy of this signed authorization. Please keep a copy for your records.
* You do not have to agree to this request to use or disclose your information.

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| **A. Patient Authorization** |

I the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in

any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above

information and give my authorization: **PATIENT PLEASE CHECK ONE:**

To release any applicable mental health/substance abuse information to my primary care physician.

To release only medication information to my primary care physician**.**

 I DO NOT give my authorization to release any information to my primary care physician.

 (Patient’s Signature) (Date) (Signature of Patient’s Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient:

|  |
| --- |
| **PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND** **KEEP THE ORIGINAL IN THE TREATMENT RECORD.** |

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

 MEMBERS’ RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members’ Rights Statement of Members’ Responsibilities

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| --- | --- | --- |
| Members have the right to:* Be treated with dignity and respect.
* Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
* Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
* Easily access timely care.
* Know about their treatment choices. This is regardless of cost or coverage by the member’s benefit plan.
* Share in developing their plan of care.
* Information in a language they can understand.
* A clear explanation of their condition and treatment options.
* Information about Medicaid, its practitioners, services and role in the treatment process.
* Information about clinical guidelines used in providing and managing their care.
* Ask their provider about their work history and training.
* Give input on the Members’ Rights and Responsibilities policy.
* Know about advocacy and community groups and prevention services.
* Freely file a complaint or appeal and to learn how to do so.
* Know of their rights and responsibilities in the treatment process.
* Receive services that will not jeopardize their employment.
* Request certain preferences in a provider.
* Have provider decisions about their care made without regard to financial incentives.
 |  | Members have the responsibility to:* Treat those giving them care with dignity and respect.
* Give providers information they need. This is so providers can deliver the best possible care.
* Ask questions about their care. This is to help them understand their care.
* Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
* Follow the agreed upon medication plan.
* Tell their provider and primary care physician about medication changes, including medications give to them by others.
* Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits.
* Let their provider know when the treatment plan isn’t working for them.
* Let their providers know about problems with paying fees.
* Report abuse and fraud.
* Openly report concerns about the quality of care they receive.

***My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information***.                                                                        Member Signature Date***The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.***                                                                                Provider signature Date |

**Live Life Counseling, LLC**

## 770-940-9679

## Privacy Notice

Effective Date: July 13, 2009

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL & PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION**

# PLEASE REVIEW THIS NOTICE CAREFULLY

# Please Note: A more thorough explanation of the Live Life Counseling, LLC Privacy Notice can be obtained at any time by requesting a copy from Live Life Counseling, LLC or sending a request to cbooz@livelife-counseling.com.

* Your confidential health information may be released to and shared with other members of the treatment team and/or agency as needed to provide you and your family with quality care and treatment.
* Your confidential health information may be released to your insurance provider for reimbursement for the services provided to you and your family.
* Your confidential health information may be released to public or law enforcement officials in the event of an investigation in which you and/or child are a victim of an alleged abuse, crime or domestic violence or in the cases of missing persons.
* Your confidential health information may be released to other health care providers in the event of a need for emergency care.
* As required by law, your confidential health information may be released to a public health organization or federal organization to report communicable disease or untoward event to a biological product (food or medication).
* Your confidential health information may not be released for any other purpose than that which is identified in this notice (including the more detailed notice).
* Your confidential health information may be released only after receiving written authorization from you and/or your parent/legal guardian. You may revoke your authorization to release confidential health information at any time.
* You may be contacted by LLC Counseling, LLC staff to remind you of any appointment or other health services that may be of interest to you and/or your family.
* You have the right to restrict the uses/disclosures of your confidential health information. However, LLC Counseling, LLC may choose to refuse your restriction if it is in conflict of providing you and your family with quality health care or in the event of an emergency situation.
* You have the right to receive confidential communications about your health care.
* You have the right to review and photocopy any/all portions of your health information. However, LLC Counseling, LLC does reserve the right to refuse copies of portions of the clinical record as allowed by law.
* You have the right to make changes to your health information. However, LLC Counseling, LLC does reserve the right to refuse copies of portions of the clinical record as allowed by law.
* LLC Counseling, LLC is required by law to maintain your health information confidentially.
* Upon request, you have the right to receive a more thorough Notice of Privacy Practices. This can be requested at any time from the Office Manager.
* LLC Counseling, LLC is bound to our Notice of Privacy Practices. We reserve the right to make changes as necessary. If changes are made, you may receive an updated copy of the LLC Counseling, LLC Notice of Privacy Practices.

**Live Life Counseling, LLC**

 770-940-9679

## Privacy Notice

#### EFFECTIVE DATE Account #:

This Notice is in effect as of                                                           .

**ACKNOWLEDGEMENT of RECEIPT:**

I acknowledge that I have received a copy of the Live Life Counseling, LLC Privacy Notice

Name of Individual (Printed) Signature of Individual/Parent

Signature of Legal Representative

(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed:             /              /              Witness: