Dynamic Achievement Solutions, LLC

"Igniting and motivating individuals to reach their potential"

Dr. Lateshia Woodley, LPC, NCC Rosalind Polk-Hall, LPC, NCC Nikhol B. Jackson, LAPC

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Informed Consent and Confidentiality

You will be given copies of the following forms when you come to Dynamic Achievement Solutions, LLC for the first time. Please feel free to discuss any questions you may have about them with the therapist. You will also be asked to sign an Acknowledgment of Consent for Treatment indicating that you have received these forms and had the opportunity to read and discuss them.

Welcome to Dynamic Achievement Solutions, LLC for Counseling and Psychological Services where we believe "your healing is just a journey away." Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document and ask your therapist about any portions which may be unclear to you.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices. The accompanying Notice of Privacy Practices explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before we provide any services. You may revoke this Agreement in writing at any time.

Services

Psychological services we provide include individual, couples, and group psychotherapy, career counseling, post secondary option training workshops, as well as psychological testing. Psychotherapy is not easily described in general statements. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Your first meeting with the therapist will offer you some sense of what therapy will entail and how she will work with you to address your concerns. You should evaluate this information and determine whether you feel comfortable working with your therapist. If you have questions about our procedures, you should discuss them with your therapist. You have the right to ask for the rationale for any aspect of your treatment or to decline any part of your treatment.

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If you are here for psychological testing, you have the right to an explanation of what the test(s) being administered are, and you may decline participation at any time. You also have the right to a summary (which may be either verbal or written) of any test results.

Eligibility and Fees
Dynamic Achievement Solutions, LLC services are available to individuals, couples, families, adolescents and children.

Payment for all services is due upon check- in at the facility. Upon your first visit you will be asked to provide a credit or debit card to place in your file. Payments can be made by credit card, debit card, cash, money order or check. Checks may be scanned immediately through our check verification system and your bank account will charged the full amount at that time. Several services are available on a sliding fee scale for individuals with financial needs. Ask your therapist for more information.

Policies Regarding Appointments
Your appointment time is allotted just for you. If you cannot make a scheduled appointment, it is your responsibility to call and cancel or reschedule your session within 48 hours of the scheduled appointment time. Appointments (except workshops) that are missed by clients, not canceled or rescheduled within the 48 hour time frame will result in a charge of an amount equal to half of the service fee for the scheduled service.

Please note that email is not a secure form of communication and is not recommended as a means of contacting your therapist for any treatment-related concerns. Unless your therapist and you agree otherwise, please call to leave any messages, and talk with the front desk staff if you need to cancel or reschedule an appointment. Note that any communication you have with a therapist outside of a regular appointment session may be recorded in your file at Dynamic Achievement Solutions, LLC. Communication could be information shared face-to-face with your therapist, email messages, phone calls, etc.

In an Emergency
In some instances, you might need immediate help at a time when your therapist is unavailable. Should these emergencies involve suicidal thoughts, thoughts of wanting to hurt someone else, or thoughts of committing dangerous acts, please call 911 or seek immediate assistance at your local mental health hospital or regular hospital emergency room and ask for a mental health professional.

Limits of Confidentiality
The law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form. There are other situations that require you provide written, advance consent. Your signature on the accompanying Acknowledgment of Informed Consent to Treatment form provides consent for those activities, as follows:

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- Because of our training mission, your therapist may ask your permission to record sessions for confidential supervisory and training purposes. Audiotapes and videotapes are kept in a locked cabinet. Occasionally, tapes and other clinical materials (e.g. test results) may be presented in case conferences or other internal Dynamic Achievement Solutions, LLC training seminars for our professional staff. In such instances, potentially identifying information about you will be altered to protect your anonymity.
- Your therapist may also occasionally find it helpful to consult with other therapists. If you don't object, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record.
- Finally, we may employ administrative staff and need to share protected information with them for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All staff members will be trained about protecting your privacy and will be required to agree not to release any information outside Dynamic Achievement Solutions, LLC without the permission of a professional staff member.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against a therapist, we may disclose relevant information regarding that client in order to defend the therapist.
- If a client files a worker's compensation claim, we must, upon appropriate request, provide a copy of the client's record or a report of her/his treatment.

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment.

- If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
- If the therapist believes you present a clear and substantial danger of harm to yourself or another/others, he or she will take protective actions. These may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and notifying the police.

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While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read our Notice of Privacy Practices for more detailed explanations, and discuss with the staff member you meet with any questions or concerns you may have.

Professional Records
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that we receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $.10 per page. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, your therapist may also keep a set of psychotherapy notes which are for his or her own use and designed to assist your therapist in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except under rare legal circumstances.

Minors
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

Group / Workshop Presentations In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind me. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality, you cannot be certain that they will always keep what you say in the group confidential.

In Conclusion
Your signature on the accompanying Acknowledgment of Informed Consent to Treatment form

indicates you have read the information in this document and agree to abide by its terms during our professional relationship.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by Dynamic Achievement Solutions, LLC for Counseling and Psychological Services and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, assessments, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of Dynamic Achievement Solutions, LLC, the information within which belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of Georgia law.

Your mental health and/or medical record serves as

- a basis for planning your care and treatment
- a means of communication among the health professionals who may contribute to your care
- a legal document describing the care you received
- a means by which you or a third-party payer can verify that services billed were actually provided
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Dynamic Achievement Solutions, LLC for Counseling and Psychological Services

We are required to:

-Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you.

-Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy, upon request.

-Notify you if we are unable to agree to a requested restriction.

-Accommodate reasonable requests to communicate with you about protected health information by alternative means or at alternative locations, e.g. you may not want a family member to know that you are being seen at Dynamic Achievement Solutions, LLC. At your request, we will communicate with you, if needed, at a different location.

-Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights
You have the right to:
-review and obtain a paper copy of the notice of privacy practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of, psychotherapy notes and a few other exceptions may apply. Copy charges may apply.
-request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission by your mental health clinician.
-revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
-request a restriction on certain uses and disclosures of protected health information, but we are not required to agree to the restriction request. You should address your restriction request in writing to Dynamic Achievement Solutions, LLC Director. We will notify you within 10 days if we cannot agree to the restriction.
-request that we amend your health information by submitting a written request with the reasons supporting the request to the Dynamic Achievement Solutions, LLC director. We are not required to agree to the requested amendment.
-obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations and certain other activities.
-request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment and Health Operations
I. Dynamic Achievement Solutions, LLC will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by your psychologist/counselor or from a nurse, physician, dentist or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

For payment, if applicable: We may send a bill for testing to your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations. Members of Dynamic Achievement Solutions, LLC Administration may use information in your health record to assess the performance and operations of our services. This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

Disclosure to others outside of Dynamic Achievement Solutions, LLC: If you give us a written

authorization, you may revoke it in writing at any time, but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except as described below to report serious threat to health or safety or child and adult abuse or neglect.

II. Dynamic Achievement Solutions, LLC will use your PHI, without your consent or authorization, in the following circumstances:

Child Abuse: If we have reasonable cause to suspect that a child known to us in the course of professional duties has been abused or neglected, or have reason to believe that a child known to us in the course of our professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department.

Adult and Domestic Abuse: If we believe that a vulnerable adult (ex. incapacitated or facility resident) is the victim of abuse, neglect or domestic violence or the possible victim of other crimes, we may report such information to the relevant county department or state official.

Serious Threat to Health or Safety: If we have reason to believe, exercising best judgment and our professional care and skill, that you may cause serious harm to yourself or another person, we may take steps, without your consent, to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in order to protect you or another person from harm. This may include instituting commitment proceedings.

Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered.

As required by law for national security and law enforcement: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.

Law/Health Oversight: As required by law we may disclose your health information. For example, if the Georgia Professional Licensing Counselors, Social Workers, Marriage and Family board requests that we release records to them in order to investigate a complaint against a provider, we must comply with such a request.

Worker's Compensation: We may disclose health information to the extent authorized by you and to the

extent necessary to comply with laws relating to workers compensation or other similar programs established by law; we may be required to testify.

As required by law for purposes of public health: e.g. as required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Business Associates: There are some services provided to Dynamic Achievement Solutions, LLC through contracts with business associates. Examples include computer support for our scheduling system and scoring of tests. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. Business associates are required to safeguard your information.

For More Information or to report a problem
If you have questions and would like additional information, please ask your therapist. He/she will provide you with additional information.

If you are concerned that your privacy rights have been violated, or if you disagree with a decision we have made about access to your health information, or if you would like to make a request to amend or restrict the use or disclosure of your health information, you may contact:

Dynamic Achievement Solutions' Professional Counselors:
Dr. Lateshia Woodley, LPC, NCC
Rosalind Polk- Hall, LPC, NCC
Nikhol B. Jackson, LAPC
Dynamic Achievement Solutions, LLC
259 Arrowhead Blvd Suite C-1
Jonesboro, GA, 30236
Phone: 770-477-7726

If you believe that your privacy rights have been violated, you can also file a complaint with the Georgia Professional Licensing Counselors, Social Workers, Marriage and Family
207 Coliseum Dr.
Macon, GA 31217
Phone number: 478-207-2440
Web site address http:// www.sos.state.ga.us/plb/default.htm

Dynamic Achievement Solutions, LLC respects your right to the privacy of your health information. There will be no retaliation in any way for filing a complaint with us or the Georgia Professional Licensing Counselors, Social Workers, Marriage and Family.

I have read the above terms and conditions. I agree to the terms and conditions and understand that I have the opportunity to discuss them further with the therapist.

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_____

Client's Signature and Date

_____

Print Name

_____

Parent's Signature and Date

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CONSENT FORM FOR THE TREATMENT OF MINORS

I _____

give my consent that Dynamic Achievement Solutions' Professional Counselor(s), will be conducting psychotherapy

with _____._____

My relationship to the client (parent, uncle, etc.): _____

I was notified that the holder of the privilege is (parent, guardian, etc.)

_____

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Informed Consent & Confidentiality form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dynamic Achievement Solutions' Professional Counselor(s)'s judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date

_____	_____	_____	_____
Name (print)		Relationship	

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BIOGRAPHICAL INFORMATION-INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Informed Consent & Confidentiality. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: ____ DATE:_____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: H: _____ Cell: _____ W/Off: _____ FAX: _____

FOR ROUTINE MESSAGES: Phone #_____ E-mail: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ E-mail: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you, etc…):

_____

_____

Estimate the severity of above problem (circle one): Mild----------Moderate----------Severe----------Very severe

CURRENT: Marital status:__Live with someone:__ Name: _____Years: ____

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile)**:**

_____

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____

Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

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1._____

2._____

3._____

4._____

5._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

Mother:_____

_____

_____

Step-parents_____

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____

2._____

3._____

4._____

5._____

MEDICAL DOCTOR/S (name /phone): _____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

_____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

_____

_____

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SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

_____

_____

DO YOU HAVE ACESS TO ANY GUNS OR WEAPONS IN YOUR HOME? YES OR NO

_____

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc)**:**

_____

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name of therapist, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. _____

_____

_____

2. _____

_____

_____

3. *USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS*

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

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IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time

_____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____

_____

_____

What gives you the most joy or pleasure in your life?

_____

_____

_____

_____

What are your main worries and fears?

_____

_____

_____

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

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AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I authorize Dynamic Achievement Solutions' Professional Counselor(s) to **discuss** (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. _____
2. _____
3. _____
4. _____
5. _____

For the following reason(s):
____ Consultation/Psychotherapy,
____ Evaluation,
____ Other: _____

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Informed Consent & Confidentiality form.

_____ _____ _____
Name (print) Signature Date

_____ _____ _____
Name (print)

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Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

I, _____ agree to pay for psychotherapy services

and other clinical services for (patient name)_____ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

- Payment will be made as follows ; (check one):
  ____x___ At the time of service
  _____ Within two weeks of receiving an invoice
  _____ Others (specify): _____
- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $ _____ per _____ minute session unless otherwise specified. For more details, see previous informed consent.
- Please inform the therapist ahead of time or as soon as you know if there are changes in your ability or willingness to pay.
- Services will be terminated if timely payment is not made as agreed to by this consent.
- Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the named above patient.
- Upon your request and upon obtaining client's written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.
- This agreement supplements previous informed consents.

Signature of Client: _____ ***Date:***_____

Signature of Payee: _____Date: _____

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