SUMMIT
COUNSELING SERVICES

Today's Date: _____

Name:	Date of Birth:
SSN:	Phone:
Email:	
Physical Address: _____ _____ _____	Mailing Address (if different) _____ _____ _____

Name of Person Responsible for Payment (Check this box if same as person listed above ☐)

If different please list below:

Name:	Their Phone:
Their DOB:	
Their Address: _____ _____ _____	

Client Rights/Informed Consent

CLIENT RIGHTS: As a consumer of services of Summit Counseling Services, you have the right:

1) To be treated with respect and dignity in a culturally sensitive manner
2) To be informed of eligibility criteria for the service in which you participate
3) To receive assistance with any communication barriers which make it difficult for you to receive services
4) To be free from discrimination while receiving services
5) To have access to your file according to federal/state/agency regulations and standards
6) To terminate services at any time
7) To be free from exploitation for the benefit or advantage of a staff member
8) To report complaints/grievances using the agency guidelines provided to you
9) To confidentiality as defined by policy and law. Summit Counseling Services maintains a strict policy on confidentiality of information (verbal, written, or electronic form). All information you share, or which we become aware of through our work with you will remain confidential. (According to state and federal statutes, Addiction records 42CFR Part 2) There are some circumstances in which this policy becomes void and we are required by law to release information:
   - If we become aware that you may be a danger to yourself or others
   - If we become aware of or suspect child abuse or neglect or vulnerable adult abuse and/or neglect
   - If we become aware of a medical emergency
   - If we are court ordered to testify or to submit our records to the court
   - If we become aware you have intent to commit a crime on the property
   - According to State and National Ethic Policies if you are a third-party person sitting in on another client's session(s), you do not have the expectation of confidentiality. Confidentiality is afforded to the identified client only.

SUMMIT'S EXPECTATIONS: As Summit Counseling Services provides services, it is expected:

l) That clients will be present and on time for appointments.

2) <u>Rescheduling or cancellations must be 24 hours in advance of appointment or appointment will be automatically billed to client at full billing rate of session</u>.
3) That clients will participate in service planning
4) That clients will not exhibit abusive threatening, or assaultive behavior
5) The clients will not be under the influence of chemicals during services
6) That clients will respect and protect the privacy of other client's information of which they may become aware

Summit Counseling Services reserves the right to deny services based on the above criteria.

INFORMED CONSENT: Informed consent is a process throughout the service relationship where discussion occurs between client and service providers. Clients have opportunities to ask questions in order to understand options available to them, consequences of different choices, and how the organization can help them achieve their choices. The following are components of informed consent:

1) Fees and payments
2) Staff qualifications, training, experience, credentials and Professional Statements, if applicable;
3) The types of services to be provided, expected length of services, results of any tests/assessments;
4) Risks, benefits and alternatives to service;
5) Range of services available through Summit Counseling Services;
6) Your active participation in your service plan with freedom to revise goals throughout service;
7) Possible outcomes of service;
8) Procedure for case closure

Summit Counseling Services is a training agency and participates with multiple colleges to assist in the training of their students. From time to time, students are required to share minimal information with their supervisors in order to benefit their educational opportunities and training.

Summit Counseling Services Operates as a Community Behavioral Health Clinic. We are not trained as experts. It is for this reason we will not write letters of recommendation, testify in child custody disputes, divorce cases, or other civil litigation.

1 HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTAND THE ABOVE INFORMATION.

The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Client Signature_____ Date_____

Parent/Guardian signature_____ Date_____

Witness/Staff presenting information_____ Date_____

☐ Client was offered a copy of this document

Technology Waiver

Communication by Email, Text Message, or Video Conferencing

It may become beneficial during your treatment to communicate using technology. At the present time SUMMIT COUNSELING SERVICE Inc. utilizes Microsoft Teams software and has been assured that their conferencing systems meet the criteria to maintain confidentiality according to federal statute 42 CFR, Part 2 and HIPPA confidentiality requirements. As a policy practice, we work hard to ensure that all communication with patients and/or families via technology is secure.

CONSENT FOR TRANSMISSION OF PREOTECTED HEALTH/ADDICTION INFORMATION BY SECURE/NON-SECURE MEANS

I consent to allow you to use secure/non-secure technology to transmit to me protected health information:

- Information related to scheduling of meetings and appointments
- Information related to referral sources
- Information related to evaluation, assessment, and programming

I have been informed of the risk, including but not limited to my confidentiality in treatment, of transmitting my protected health/addiction information by secure/unsecured means. I understand that I am not required to sign this agreement in order to receive treatment, however it may limit my treatment options in regard to accessibility. I also understand that I may terminate this consent at any time. **The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.**

_____ _____

Signature of Client Date

_____ _____

Witness Date

Authorization for Release of Information to Insurance Company

I authorize Summit Counseling Services and all business partners to release billing information which may include client name, date, type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of collecting insurance benefits or for authorization of additional sessions for:

Client Name: _____

Date of Birth: _____

Address: _____

Phone: _____

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Brenda Owen.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following your last appointment, unless otherwise restricted.
- **NO SHOW OR LATE CANCELLATION FEES WILL BE THE SOLE RESPONSIBILITY OF THE CLIENT**

Insurance Carrier— Name and Date of Birth	
Insurance Company-	
Insurance company address:	
Insurance Company Phone Number:	
Policy Number:	
Group Number if applicable	
Date coverage started if listed on card	
Co pay listed on card	

Although your insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental health benefits may differ from your medical benefits, so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will he responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees**. The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.**

Insurance Carrier: _____

Carrier's Relationship to Client: _____

Carrier's Place of Employment: _____

Carrier's Date of Birth: _____

Carrier's Phone: _____

Signature: _____ Date: _____

SUMMIT
COUNSELING SERVICES

PHONE 701-334-6242 FAX: 701-713-3299

Grievance Process: If at any time a client has an issue or concern with a staff member infringing on their rights, they are encouraged to first to attempt to address this issue with the person with whom the infringement allegedly took place with. If the client is unable to get satisfaction, clients are encouraged to fill out the grievance form provided in all offices utilized by Summit Counseling Services or from any staff person that provides services for Summit Counseling Services and submit it to the owner/operator of Summit Counseling Services. Clients will be appraised of their right to file a grievance with the Boards of Addiction

Counseling Examiners North Dakota Board of Counseling Examiners and North Dakota Board of Social Work Examiners. They will be provided with the telephone numbers, web site information and/or address of the appropriate board/or boards.

- Summit Counseling Services shall protect the fundamental human, civil, constitutional and statutory rights of each client
- As appropriate Summit Counseling Services shall inform the client, the client's family or the client's leg I guardian of their status as authorized by the client who is 14 years or older. Summit Counseling Services is only licensed for adult addiction programming and does not provide adolescent addiction programming at this time.
- Summit Counseling Services shall evaluate to ensure no restrictions were placed on the rights of individual clients and shall document in the clinical records the clinical rationale for, such restrictions.
- Grievances must be investigated and addressed by the owner/operator of the agency within 20 working days of receipt of grievance. Should the client believe that the grievance was not addressed appropriately they will be referred to the appropriate State Licensing Agency Board for resolution.

3111 E. Broadway Ave, Bismarck ND 58501

26 1st St E, Dickinson ND, 58601

(Administrative Office) 1500 14th St W Suite 290, Williston ND 58801

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GRIEVANCE FORM

Name: _____ Date: _____

Reason for Services: _____

Description of the grievance. What are your concerns?

_____

_____

_____

_____

_____

Signature: _____ Date:_____

The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Administrative Use Only

Date reviewed and signature of SUMMIT COUNSELING SUPERVISOR:

_____

Follow up comments: _____

_____

Correction Procedure/Results of inquiry: _____

_____

Summit Counseling Supervisor Signature:

_____ Date:_____