Counsel For Hope

119 Fuchia Lane ~ Lincolnton, NC 28092 ~ (704) 201-9063
125 N Tradd Street ~ Statesville, NC 28687 ~ (704) 201-9063

Client Name:
DOB:
Insurance #:

Date Received: ______________________ Start Date: _____________________

Client's name: ____

Date of Birth: ____________ Gender: ____________ Race: ___________________

Social Security number: ____________________ Primary Language: ______________________

Insurance Provider: _______________________ Insurance Number: _____________________

Phone Number: (Home) ____________________________ (Cell): _________________________

Address: ____

____

Email Address (for patient portal) __________________________________

Reason for referral/presenting concerns:

____

____

____

How long have you been experiencing this concern? ____

What are you wanting to accomplish in counseling? Goals?

____

____

Have you received counseling services in the past? Yes No

If yes, please rate your overall satisfaction with counseling services: __________ (1-10, 10 being best)

If so, what didn't work for you? ____

What did work for you? ____

Service being requested:

Assessment: __ Individual Therapy: __ Family Therapy: __ Group Therapy: __

Parenting Class: __ Anger Management: __ Domestic Violence Group: __

Substance Abuse: __ Other: __

Legal Guardian at Intake: ____________________________ Relationship: ___________________

Alternate Contact Person: ______________________________Relationship: _______________________

Home Phone #: ___________________________________ Alternative Phone #: ___________________

Referral Source: ____

Phone Number: _______________________ Email: ______________________________

Revised 11.4..22

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Client Name:
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Family History:

	Mother	Father	Siblings	Grandparents
Depression				
Bipolar				
Schizophrenia				
Anxiety				
ADHD				
Alcohol Abuse				
Substance Abuse				
Other				

Mother's Name: ________________________________Father's name: ____________________________

Were your parents married? Y or N Still married? Y or N How many siblings? ___________________

Who lives in the current household with you? ____

Have you ever been removed from your parents' custody? Y or N If yes, how old were you? ____________________

DSS involvement: Current History Never

Reasons for DSS involvement:

____

Legal involvement:

Have you ever been arrested for a crime or imprisoned? Y or N

Charges____

Birth to 5 years old:

Birth Place? ___________________Born: on time or early or late? Were there any complications at the birth? Y or N

Complications: ____

Developmental Tasks:

Walking: Normal or Delayed Talking: Normal or Delayed Toilet Trained: Normal or Delayed

School-Aged Children (up to age 18)

Current School: _____________________ Grade: _____________________

Age started school? ____Was in head start or Pre-K? Y or N Bullied in school? Y or N Had friends? Y or N

Comments: ____

Did you drop out of high school? Y or N If so, what grade? ______Why? _________________________________

Comments: ____

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Young Adult and Up (18+)

Graduate from High School? Y or N Did you go to college? Y or N

If so, what college and for what? ___________________________________

Currently employed? Y or N If so, doing what? ___________________________________

If unemployed, seeking employment? Y or N Previous jobs: ___________________________________

Disabled? Y or N Receiving SSI? Y or N Currently applying for disability? Y or N

Relationship status: Married Single (never married) Separated Divorced Widow/Widower

If married, how long? __________ How many times have you been married? _____

If separated, how long have you been separated? ________If divorced, how long were you married? ________

Do you have children? Y or N If so, how many? ______

Medical:

Are you allergic to any medications? Y or N If yes, what medications? ___________________________________

Have you been on medications for your mental health symptoms? Y or N If so, who prescribed? _________________

Name of Medication	Dosage	Administration	How long have you been on them?

Have you been on medications that did not work for you? Y or N If so, which ones? ___________________________

Surgeries: ___________________________________

Medical Diagnoses: ___________________________________

Psychological:

Have you received mental health services before? Y or N Providers: ___________________________________

Current Diagnoses: ___________________________________

Number of psychiatric hospitalizations: In the past year: ____________ Lifetime: ___________________________

Have you ever attempted suicide? Y or N If so, by what means? ___________________________________

Have you ever done anything that caused self-harm? Y or N If so, by what means? ___________________________

Have you ever made plans to seriously injure or hurt someone else? Y or N

Did you follow through with these plans? Y or N To whom and what were your plans? _________________________

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Have you ever experienced or witnessed:

	How old were you?	How long did it last?	Was it reported?
Sexual Abuse			
Rape			
Physical Abuse			
Domestic Violence			
Emotional Abuse			
Homelessness			
Other Traumatic Event:			

Substance Abuse Assessment: *****If currently struggling with substance abuse – please let your counselor know**

Have you ever struggled with substance abuse or alcohol abuse? Y or N

Type of Substance	How old when you started taking it?	How often did (do) you use it?	When was the last time you used it?	On average, how much would you use in a day?

Have you ever received treatment for alcohol or substance abuse? Y or N

Name of treatment provider	Outpatient/Inpatient	Outcome

Strengths/Achievements

What do you feel are your strengths or achievements?

____
____
____

What are your hobbies/areas of interest/things you enjoy doing?

____
____
____

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Acknowledgement of Consumer Choice – fill out at initial intake and annual review

I, ____, (client/guardian), acknowledge that I have been given an opportunity to review a list of Endorsed service Providers.

I understand it is my choice to select an Endorsed Service Provider to address my needs and that I can alert my service provider if I would like to make a change. I can also contact the Governor's Advocacy Council at (800) 821-6922, to request assistance if I experience any difficulty with changing my service provider.

Upon my review of Endorsed Service Providers, I have chosen the following agency as my service provider:

_____Counsel For Hope

_____Other Endorsed Provider - ________________________________

_____Decline, not interested in services at this time

Client/parent/guardian signature ________________________________Date ______________________

CFH Staff/Contractor signature _________________________________Date ______________________

Authorization for Emergency Medical Treatment

I, the client/parent/legal representative of ______________________________________, subject to the conditions set forth below. I consent for my child or myself to receive such medical treatment and/or surgical procedures necessary in the event of an emergency, and to assume the liability for medical expenses involved. This authorization extends to my children's participation in any activity sponsored by Counsel For Hope as a whole, or by workers within each regional unit. Should a medical emergency arise during my or my child's participation in a CFH sponsored event, I understand that reasonable efforts will be made to contact me or my designated alternate at the numbers listed below. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternative could cause, I consent to the administration of medical treatment and/or surgical procedures as deemed necessary by the medical doctor and/or facility and to the immediate administration of life-sustaining measure(s) deemed necessary under the circumstances.

Health Information:

Allergies: ____

Medications: ____

Medical Problems: ____

Does the client have an Advanced Directive? If yes, please provide a copy to CFH? Y/N

Does the client have any communication barriers which may make it difficult to understand him/her? Y/N

If yes, please explain: ____

Preferred Doctor/Medical Facility: _____________________________________Phone: __________________

Client/parent/guardian signature ________________________________Date ____________________

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Staff and Client/Parent/Legal Representative sign below whenever the plan is implemented/reviewed/revised

Date	**Client/Parent/Legal Representative** *I have had input into this plan & I agree with my plan. I chose Counsel For Hope as my provider to provide services to address my symptoms. By signing, I, personally listed my goals to accomplish.*	Staff Signature
____	______________________________________	

Consent For Treatment

1. I request admission for home or office-based services from CFH. I consent to these services and understand I have the right to refuse services at any time and ma withdraw from services at any time and will notify CFH in writing should I decide to do so.
2. In accepting services, I agree to accept the responsibility for participating in developing treatment plan goals for myself and/or my family: attending individual, family and group counseling as determined in my treatment plan or deemed necessary by CFH and communicating my needs or the needs of my family to CFH as they arise.
3. I authorize CFH staff to seek emergency medical or dental care in the event that I or my child has an accident while participating in services. This shall include emergency first aid by authorized personnel of CFH. I further understand that I will assume financial responsibility for any necessary medical or dental care, including payment of physician, emergency room, and/or rescue unit charge.
4. To comply with G.S. 122c-54(h), CFH is required to disclose confidential information for the purpose of complying with mandatory reporting and disclosure laws relevant to the suspicions of abuse, neglect or exploitation of disabled persons.
5. Client records relating to Substance Abuse are protected by Federal Confidentiality Rule (42 CFR Part 2). A general authorization for the release of medical or other information IS NOT sufficient for this purpose.
6. If I am or my child is a member of a recognized Indian tribe, active efforts will be made to prevent removal or support reunification. CFH will have early and ongoing communication with the child's tribe to ensure a full range of resources are made available to the family in support of ICWA's active efforts requirement.
7. I have received a copy of and had the orientation to CFH's Mission Statement, Client's Rights Summary, Client Complaints and Grievances – Hearing and Appeals Regarding Violations of the Client Rights Policy, Client Grievances, Notice of Privacy Practices, and Service Categories and Descriptions. Through the orientation process, the contents were explained to me, especially any rules for group participation, the process for the development of my treatment plan, and how to file a client grievance. I was informed how to contact the Governor's Advocacy Council and local advocacy groups. I understand this information as explained to me.
8. I understand that I am expected to disclose if I currently, or during the course of treatment, test positive for a communicable disease. I further understand that if there was/is a risk of staff exposure, CFH staff is required to file an incident report. In addition, I understand that staff will provide me with the appropriate referrals to community resources.
9. I understand that a discharge plan will be developed in collaboration with the client and the others involved with the participant. This discharge plan will be based on the final assessment of the participant's current status, their remaining service needs, and the mutually agreed-upon goals and will include appropriate referrals for continuing services.

*At age 18, the client is the primary signature unless legalities require otherwise

Client/parent/guardian signature ________________________________Date ______________________

CFH Staff/Contractor signature _________________________________Date ______________________

Step Down Plan:

Individual Therapy:
____

Group Therapy:
____

Substance Abuse Treatment:
____

Medication Management:
____

Community and Natural Supports:
____
____

Client/parent/guardian signature ________________________________Date ______________________

CFH Staff/Contractor signature _________________________________Date ______________________

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Contract Agreement

Counsel For Hope is open to helping everyone in need and assisting to rebuild lives and families. Its goal in the community is to provide services that meet the needs of the individual, couple or family and being flexible with school, work and doctor appointments. However, due to some clients misusing this flexibility and taking time slots and not following through the following will now be put in place.

_____ 1. If you are a private pay client, there is no cost to you except for the following:

a. You have private insurance. You are responsible for copays and if you haven't met your deductible. Your credit card on file will be charged after the session for services
b. If you no show for appointments (this means you did not call 24 hours in advance to cancel or at the time of confirmations or that you were more than 15 minutes late for your appointment) and it was not an emergency (at the discretion of the therapist) you will have to pay for the session at your regular rate –
    i. This fee will be due at your next session. You will receive a bill, afterwards if it is still not paid the amount will be sent to a collections officer.
c. If you are more than 15 minutes late your session will either be rescheduled, or you will be provided a 30-minute session as it is not fair to other clients after your appointment to make them wait.

_____ 2. If DSS or DJJ is involved in your case, the information you provide in session is kept confidential unless mandated or a CFH staff or contractor is the mandated reporter. If requested an account of your sessions is sent to these agencies identifying how many sessions you have kept, how many you have rescheduled and how many you have no showed. (Rescheduled and no-show appointments can hurt your case with either agency.)

_____3. If you receive medication management through Counsel For Hope, there is an agreed upon fee that you will be responsible for.

a. You have private insurance. You are responsible for copays and if you haven't met your deductible. Your credit card on file will be charged after the session for services
b. If you no show for appointments (this means you did not call 24 hours in advance to cancel or at the time of confirmations) and it was not an emergency, you will have to pay for the session at your regular rate –
    i. This fee will be due at your next session. You will receive a bill, afterwards if it is still not paid the amount will be sent to a collections officer.

By initialing and signing the bottom I understand the terms of receiving services from Counsel For Hope and agree to comply within them.

Client (name)______________________

Client/parent/guardian signature ____________________________Date ______________________

CFH Staff/Contractor signature __________________________________Date ______________________

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Telehealth Release I have had a direct conversation with CFH Staff/Contractors during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

1. CFH Staff/Contractors has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that CFH Staff/Contractors or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes in the same way as if I was in the same room as CFH Staff/Contractors.
4. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand; however, there is no guarantee that all treatment of all clients will be effective.
5. I understand that it is my obligation to notify CFH Staff/Contractors of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my [insert discipline] of the change in location.
6. I understand that it is my obligation to notify CFH Staff/Contractors of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify CFH Staff/Contractors at the outset of each session and am aware that confidential information may be discussed.
7. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.
8. I agree that I will not record either through audio or video any of the session, unless I notify CFH Staff/Contractors and this is agreed upon.
9. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.
10. I understand that CFH Staff/Contractors are not responsible for any technological problems of which CFH Staff/Contractors has no control over. I further understand that CFH Staff/Contractors does not guarantee that technology will be available or work as expected.
11. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.
12. I understand that CFH Staff/Contractors or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or CFH Staff/Contractors that the videoconferencing connections or protections are not adequate for the situation.
13. I have had a conversation with CFH Staff/Contractors, during which time I have had the opportunity to ask questions concerning services via telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me.
14. Prior to each session, I will receive a text or email with an email link to enter the “waiting room” until the session begins. There are no passwords or log in required.

By signing this document, I acknowledge:

1. Telehealth platforms are NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.

2. I recognize CFH Staff/Contractors may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or CFH Staff/Contractors is concerned that immediate medical attention is needed.

3. Though my provider and I may be in virtual contact through telehealth services, neither CFH Staff or Contractors provide any medical or emergency or urgent healthcare services or advice. I understand should medical services be required, I will contact my physician. If emergency services are needed, I understand I should call 9-1-1.

4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. Some insurers are waiving co-pays during this time. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

5. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

6. I understand that either I or CFH Staff/Contractors can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

7. That I have read or had this form read and/or had this form explained to me

8. That I fully understand its contents including the risks and benefits of telehealth.

9. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client (name)______________________

Client's/parent/legal representative signature ____________________________Date ____________________

CFH Staff/Contractor signature ____Date ______________________

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Credit Card Authorization

Starting in 2020, Counsel For Hope will keep a credit card on file for **private insurance** clients to allow for ease of payment for sessions and to charge for co-payments, clients that have not met their deductible, or medication management appointments as written in our informed consent. Your card will be charged the next business day following your appointment.

I, ______________________________, authorize_______ Counsel For Hope Staff or Contractors___________

(Name of Client)

With Counsel for Hope to charge my credit card the agreed upon session fee of $_100_________ for payment of sessions and/or missed appointments or cancellations that do not give 24 hrs' notice.

Card Holder Name (as appears of the card) ____

Credit Card #____

Credit Card Type____

Expiration Date____

CVV Security____

Billing Address____

Signature____ Date___________________________

I authorize the above-name business to charge the credit card indicated on this authorization form according to the terms outlined above. I understand this authorization will remain in effect until I cancel it in writing, and I agree to notify the business of any changes in my account information. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute these payments with my credit card company, provided the transactions correspond to the terms indicated in this authorization form.

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Client Name:
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Client Consent

Client Name ________________________________ Date of Birth ______________________________

Copy given to consumer _______ Copy denied ______

I hereby consent to assessment services provided by Counsel For Hope. I understand that I may refuse and all services at any time. Services may include but are not limited to the following outpatient services: individual, family or group therapy, substance abuse services, parenting skills groups, and domestic violence groups. I understand that a written report will be generated from any assessments and this report will be sent to the referring agency given the proper release of protected health information is in order. If I am involved in a court proceeding and a request is made for information about professional services covered under this consent, such information is considered privileged and cannot be disclosed without further authorization. This privilege does not apply if I am being evaluated by a 3rd party or the evaluation is court ordered. In the case of an emergency, I give permission to obtain any emergency services required. I understand that I will be financially responsible for such care.

____ _________________________

Client/ Legally Responsible Person's Signature Date

Client Rights: I have received and read a copy of the Client Rights Summary from CFH. I understand its content regarding client rights and responsibilities and any questions about this Client Rights Summary have been answered.

____ _________________________

Client/ Legally Responsible Person's Signature Date

Emergency Crisis Response Protocol: I acknowledge that I have received and read a copy of the Emergency Crisis Response Protocol for services provided by Counsel For Hope.

____ _________________________

Client/ Legally Responsible Person's Signature Date

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Client Name:
DOB:
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Counsel For Hope: OFFICE POLICIES & GENERAL INFORMATION & CONSENT FOR COUNSELING SERVICES

This form provides information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.
CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.
WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to CFH Staff and Contractors that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the consulting records and/or testimony by CFH Staff and Contractors. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. CFH Staff and Contractors will use their clinical judgment when revealing information between family members.
EMERGENCY: If there is an emergency during therapy, or in the future after termination, where CFH Staff and Contractors becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, CHF staff and Contractors will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, CHF staff and Contractors may also contact the person whose name you have provided on the biographical sheet.
HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct CFH Staff and Contractors, only the minimum necessary information will be communicated to the carrier. CFH Staff and Contractors has no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies.
LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on CFH Staff and Contractors to testify in court or at any other proceeding, nor will a disclosure of the counseling records be requested unless otherwise agreed upon.
CONSULTATION: CFH Staff and contractors consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. The exception is that information will be shared with counselors contracted with CHF Staff and Contractors for continuity of care purposes, peer supervision, or transition of services.
E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on CFH Staff and Contractors laptops are encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Unencrypted email or text provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office. CFH Staff and Contractor's laptops are equipped with a firewall, a virus protection and a password, and he/she backs up all confidential information from her computer on a regular basis onto an encrypted server. Also, be aware that phone messages may be transcribed and sent to CFH Staff and Contractors via unencrypted e-mails. Please notify CFH Staff and Contractors if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it is assumed that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies if you need immediate assistance.
RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of CFH Staff and Contractors profession require that she keeps treatment records for at least __10___ years. Unless otherwise agreed to be necessary, CFH Staff and Contractors retains clinical records only as long as is mandated by North Carolina law. If you have concerns regarding the treatment records, please discuss them with CFH Staff and Contractors. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when CFH Staff and Contractors assesses that releasing such information might be harmful in any way. In such a case, CFH Staff and Contractors will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, CFH Staff and Contractors will release information to any agency/person you specify unless CFH Staff and Contractors assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, CFH Staff and Contractors will release records only for the adult who signed authorizations, unless releases are received from all the adults (or all those who legally can authorize such a release) involved in the treatment.
TELEPHONE & EMERGENCY PROCEDURES: If you need to contact CFH Staff and Contractors between Consultations or Sessions, please leave a message on company voicemail 704-201-9063 and your call will be returned as soon as possible. CFH Staff and Contractors checks messages a few times during the daytime only, unless she is out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Counsel For Hope at 704-201-9063 (John Adriatico), the Suicide Prevention Hotline 1-800-273-8255 or Atrium Health Lincoln Emergency Department at 980-212-2200 or 24-hour crisis line or the Police: 911. Do NOT use texts, email or faxes for emergencies.
PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $_100.00__ per one hour session at the end of each session or at the end of the month unless other arrangements have been made for insurance reimbursement. Please notify CFH Staff and Contractors if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, CFH Staff and Contractors will provide you with a copy of your receipt, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section,

Client Name:
DOB:
Insurance #:

Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in counseling, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, CFH Staff and Contractors can use legal or other means (courts, collection agencies, etc.) to obtain payment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide counseling services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of CFH Staff and Contractors and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Mecklenburg County in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, CFH Staff and Contractors can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. and requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. CFH Staff and Contractors will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. CFH Staff and Contractors may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Counseling may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that consulting will yield positive or intended results. During the course of therapy, CFH Staff and Contractors is likely to draw on various psychological and or behavior analytic approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. CFH Staff and Contractors does not provide custody evaluation recommendation.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, CFH Staff and Contractors will discuss with you a working understanding of the problem, treatment plan, therapeutic objectives/goals, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, CFH Staff and Contractor's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You have the right to ask about other treatments.

TERMINATION: As set forth above, after the first couple of meetings, CFH Staff and Contractors will assess if they can be of benefit to you. CFH Staff and Contractors does not work with clients who, in their opinion, they cannot help. In such a case, if appropriate, she will give you a referral that you can contact. If at any point during counseling, CFH Staff and Contractors either assesses that they are not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, she will discuss with you the termination of treatment. In such a case, if appropriate and/or necessary, they would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, CFH Staff and Contractors will talk to the counselor or consultant of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, for any reason that you do not have to disclose, CFH Staff and Contractors will give you a couple of referrals that you may want to contact, and if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request, if appropriate and possible, CFH Staff and Contractors will provide you with names of qualified professionals.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs CFH Staff and Contractor's objectivity, clinical judgment or can be exploitative in nature. CFH Staff and Contractors will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. CFH Staff and Contractors will never acknowledge working with anyone without his/her written permission. Many clients have chosen CFH Staff and Contractors as their therapist because they knew them before they entered therapy with them, and/or are personally aware of their professional work and achievements. Nevertheless, CFH Staff and Contractors will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. It is your responsibility to advise CFH Staff and Contractors if the dual or multiple relationship becomes uncomfortable for you in any way. CFH Staff and Contractors will always listen carefully and respond to your feedback and will discontinue the dual relationship if you or they feel it interferes with the effectiveness of the therapy or your welfare.

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, CFH Staff and Contractors may conduct a web search on our clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. For this same reason, CFH Staff and Contractors request that clients not communicate with our staff via any interactive or social networking web sites.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Office Policies and General Information, Agreement for Counseling Services and Informed Consent for Counseling carefully; I understand them and agree to comply with them:

Client's Name (print) ___________________________________Signature _________________________________Date _____________

Counsel For Hope

Client Name:

119 Fuchia Lane ~ Lincolnton, NC 28092 ~ (704) 201-9063

DOB:

125 N Tradd Street ~ Statesville, NC 28687 ~ (704) 201-9063

Insurance #:

HIPAA NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS **EFFECTIVE DATE OF THIS NOTICE: January 30, 2013**

I. **THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY** .

II. **PROTECTED HEALTH INFORMATION (PHI):**The PHI constitutes information created or noted by CFH Staff and Contractors that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. CFH Staff and Contractors are required to provide you with this Notice about CFH Staff and Contractors' privacy procedures. This Notice explains when, why, and how CFH Staff and Contractors would use and/or disclose your PHI. Use of PHI means when CFH Staff and Contractors share, apply, utilize, examine, or analyze information within CFH Staff and Contractors practice; PHI is disclosed when CFH Staff and Contractors release, transfer, give, or otherwise reveal it to a third party outside CFH Staff and Contractors practice. With some exceptions, CFH Staff and Contractors may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. Please note that CFH Staff and Contractors reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with CFH Staff and Contractors. Before CFH Staff and Contractors make any important changes to CFH Staff and Contractors policies, CFH Staff and Contractors will immediately change this Notice and post a new copy of it in the CFH Staff and Contractors office. You may also request a copy of this Notice from CFH Staff and Contractors, or you can view a copy of it in CFH Staff and Contractors office.

III. **USE AND DISCLOSURE OF PHI FOR THE PURPOSES OF PROVIDING SERVICES**: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow CFH Staff and Contractors to use and disclose your health information for these purposes. CFH Staff and Contractors will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of CFH Staff and Contractors uses and disclosures, with some examples.

A. **Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** CFH Staff and Contractors may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** CFH Staff and Contractors can use your PHI within CFH Staff and Contractors practice to provide you with mental health treatment, including discussing or sharing your PHI with CFH Staff and Contractors supervisors, trainees and interns. CFH Staff and Contractors may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, CFH Staff and Contractors may disclose your PHI to her/him in order to coordinate your care.
2. **For health care operations.** CFH Staff and Contractors may disclose your PHI to facilitate the efficient and correct operation of CFH Staff and Contractors practice. Examples: Quality control - CFH Staff and Contractors might use your PHI in the evaluation of the quality of health care services that you received or to evaluate the performance of health care professionals who provided you services. CFH Staff and Contractors may also provide your PHI to CFH Staff and Contractors attorneys, accountants, consultants, and others to ensure that CFH Staff and Contractors are in compliance with applicable laws.
3. **To obtain payment for treatment.** CFH Staff and Contractors may use and disclose your PHI to bill and collect payment for the treatment and services CFH Staff and Contractors provided you. Example: CFH Staff and Contractors might send your PHI to your insurance company or health plan in order to get payment for the health care services that CFH Staff and Contractors have provided to you. CFH Staff and Contractors could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for CFH Staff and Contractors office.
4. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that CFH Staff and Contractors attempts to get your consent after treatment is rendered. In the event that CFH Staff and Contractors tries to get your consent, but you are unable to communicate with CFH Staff and Contractors (for example, if you are unconscious or in severe pain) but CFH Staff and Contractors think that you would consent to such treatment if you could, CFH Staff and Contractors may disclose your PHI.

B. **Certain Other Uses and Disclosures Do Not Require Your Consent. CFH Staff and Contractors may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: CFH Staff and Contractors may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. To avoid harm. CFH Staff and Contractors may provide PHI to law enforcement personnel or any persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds, potential harm to another person).
5. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if CFH Staff and Contractors determine that disclosure is necessary to prevent the threatened danger.
6. If disclosure is mandated by the North Carolina Child Abuse and Neglect Reporting law. For example, if CFH Staff and Contractors has a reasonable suspicion of child abuse or neglect.
7. If disclosure is mandated by the North Carolina Elder/Dependent Adult Abuse Reporting law. For example, if CFH Staff and Contractors has a reasonable suspicion of elder abuse or dependent adult abuse.
8. If disclosure is compelled or permitted by the fact that you tell CFH Staff and Contractors of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
9. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, CFH Staff and Contractors may need to give the county coroner information about you.
10. For health oversight activities. Example: CFH Staff and Contractors may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
11. For specific government functions. Examples: CFH Staff and Contractors may disclose PHI of military personnel and veterans under certain circumstances. Also, CFH Staff and Contractors may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
12. For research purposes. In certain circumstances, CFH Staff and Contractors may provide PHI in order to conduct medical research.
13. For Workers' Compensation purposes. CFH Staff and Contractors may provide PHI in order to comply with Workers' Compensation laws.
14. Appointment reminders and health related benefits or services. Examples: CFH Staff and Contractors may use PHI to provide appointment reminders. CFH Staff and Contractors may use PHI to give you information about alternative treatment options, or other health care services or benefits offered.
15. If an arbitrator or arbitration panel compels disclosure. When arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure before an arbitrator or arbitration panel.
16. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
17. If disclosure is otherwise specifically required by law.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object. Disclosures to family, friends, or others**. CFH Staff and Contractors may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
D. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any other situation not described in Sections IIIA, IIIB, and IIIC above, CFH Staff and Contractors will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by CFH Staff and Contractors except action subsequent to the original authorization

CLIENT RIGHTS

A. **The Right to Choose How CFH Staff and Contractors Contact You**. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). CFH Staff and Contractors is obliged to agree to your request providing that CFH Staff and Contractors can give you the PHI, in the format you requested, without undue inconvenience. CFH Staff and Contractors may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

Home: Yes or No Cell: Yes or No May CFH Staff and Contractors leave a message? Yes or No
If not, how may CFH Staff and Contractors contact you? ____________________________

B. **The Right to Release Your Medical Records.** You may provide written authorization to release records to others. You have the right to ask that CFH Staff and Contractors limits how CFH Staff and Contractors uses and discloses your PHI. While CFH Staff and Contractors will consider your request, CFH Staff and Contractors are not legally bound to agree. If CFH Staff and Contractors do agree to your request, CFH Staff and Contractors will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that CFH Staff and Contractors are legally required or permitted to make.
C. **The Right to See and Get Copies of Your Medical Billing Records.** In general, you have the right to see your PHI that is in CFH Staff and Contractors possession, or to get copies of it; however, you must request it in writing. If CFH Staff and Contractors does not have your PHI, but CFH Staff and Contractors knows who does, CFH Staff and Contractors will advise you how you can get it. You will receive a response from CFH Staff and Contractors within 30 days of CFH Staff and Contractors receiving your written request. Under certain circumstances, CFH Staff and Contractors may feel CFH Staff and Contractors must deny your request, but if CFH Staff and Contractors do, CFH Staff and Contractors will give you, in writing, the reasons for the denial. CFH Staff and Contractors will also explain your right to have my denial reviewed. If you ask for copies of your PHI, CFH Staff and Contractors will charge you not more than $.25 per page. CFH Staff and Contractors may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
D. **The Right to Add Information or Amend Your Medical Records.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that CFH Staff and Contractors correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of CFH Staff and Contractors receipt of your request. CFH Staff and Contractors may deny your request. CFH Staff and Contractors denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and CFH Staff and Contractors denial be attached to any future disclosures of your PHI. If CFH Staff and Contractors approve your request, CFH Staff and Contractors will make the change(s) to your PHI. CFH Staff and Contractors will advise others who need to know about the change(s) to your PHI if requested.
E. **The Right to Accounting of Disclosures.** You are entitled to a list of disclosures of your PHI that CFH Staff and Contractors have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment made to you, disclosures pursuant to a signed release, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. After April 15, 2003, disclosure records will be held for six years. CFH Staff and Contractors will respond to your request for an accounting of disclosures within 60 days of receiving your request.
F. **The Right to Request Restrictions on Uses and Disclosures of your Healthcare Information**. Your request must be in writing. To implement the 2013 HITECH Act, the Privacy Rule is amended CFH Staff and Contractors is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. The 2013 Amendments also adopt the proposal in the interim rule requiring CFH Staff and Contractors, to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that CFH Staff and Contractors must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct CFH Staff and Contractors to transmit an electronic copy of PHI to an entity or person designated by the you. Furthermore, the amendments restrict the fees that CFH Staff and Contractors may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Timeline requirement for right of access currently permitted is 30 days, with a one-time extension of 30 additional days.
G. **The Right to Complain.** If, in your opinion, CFH Staff and Contractors may have violated your privacy rights, or if you object to a decision CFH Staff and Contractors made about access to your PHI, you are entitled to file a complaint with the person listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about CFH Staff and Contractors privacy practices, CFH Staff and Contractors will take no retaliatory action against you. If you have any questions about this notice or any complaints about CFH Staff and Contractors privacy practices please contact: CFH Staff and Contractors, 119 Fuchia Lane Lincolnton, NC 28092.
NOTIFICATIONS OF BREACHES. In the case of a breach, CFH Staff and Contractors is required to notify each affected individual whose unsecured PHI has been compromised. If such a breach was caused by a business associate, she will provide the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website.
I acknowledge receipt of this notice

Client's Name (print): ______________________________________Signature: __________________________________Date: __________

Counsel For Hope

119 Fuchia Lane ~ Lincolnton, NC 28092 ~ (704) 201-9063
125 N Tradd Street ~ Statesville, NC 28687 ~ (704) 201-9063

Client Name:
DOB:
Insurance #:

Client Rights Summary

It is the policy of the Counsel For Hope to fully support, endorse and enforce the rights of its clients as promulgated in contract and service program standard. Client shall not be excluded from a program or denied access to services on the basis of race, creed, national origin, color, gender, physical handicap or sexual orientation.

Counsel For Hope does not restrain, secure or provide manual restrictive measures. All efforts to manage client behaviors are verbal and de-escalating techniques and providing support for the client and caregivers. Staff may intervene to address management of age-appropriate but potentially dangerous behavior, for example, to protect a child who runs into the street as to prevent harm to him/her.

The Counsel For Hope ensures the rights of their clients. These rights include:

- The right to services and a treatment plan regardless of your age, race, sex, national origin, or developmental disability.
- The right to be treated with dignity and respect.
- The right to confidentiality including all information in your record except when state law requires or allows disclosure.
- The right to be protected from corporal punishment from CFH employees. You have the right not to be abused by CFH employees.
- The right to contract and consult with your attorney, your private doctor, or others of your choice at your own expense.

Certain Federal and State Statutes may further define the civil rights of individual clients, but for the purpose of this plan, the civil and legal rights of clients will include, but not be limited to your:

- Right to dispose of property
- Right to execute legal documents
- Right to buy or sell
- Right to enter into contractual relationships
- Right to register to vote
- Right to marry and obtain a separation, divorce or annulment
- Right to hold a professional, occupational or vehicle operator's license
- Right to make a will

In addition, your legal rights include the following:

- Reasonable accommodations of the client's disability condition.
- Program admission policies that restrict admission only where the restriction is reasonably related to treatment goals.
- Maximum participation in the development or modification of a timely written treatment plan that is responsive to the client's needs and allows the opportunity for the client to make corrective comments to case records.
- Reasonable assistance to the client in applying and making full use of any public services or benefit to which the client may be entitled to assistance with the complaint process.
- Confidential management of records with legally proper disclosure procedures.
- Upon admission, prompt evaluation and treatment about which information has been provided and for which general consent has been obtained.
- To be treated with dignity, which includes:
    - Being called by preferred or legal name
    - Being protected by reasonable efforts from harm, abuse and exploitation
    - Receiving a copy of the Rules of conduct (where applicable) regarding the services being provided.
    - Receipt of services in the home setting unless circumstances dictate service being provided elsewhere
- To be provided with general information about program services and policies in a manner easily understood.
- To be treated in the least restrictive setting consistent with your condition and availability of services.
- To receive treatment without being subject of experimental or investigation research unless prior informed consent is given and is appropriately documented.
- To have access to consultation and communication in private with lawyers, legislators, clergy, licensed health care practitioners and employees of a protection and advocacy agency at your expense.
- Notification of the availability of a Regional Advocate (where available) and the access to an impartial review procedure regarding any alleged violation of your rights.
- That any incident related to your safety in the community or with staff are handled in a matter that promotes full disclosure to the proper authorities and minimizes risk.
- Freedom from threat or fear of unwarranted suspension or expulsion from the facility.

Client Name:
DOB:
Insurance #:

Emergency/Crisis Response Protocol

Counsel For Hope provides 24/7 crisis response to our clients and their families. If it is an emergency the family or client will be directed to call 911 or to go immediately to the nearest emergency room.

If the emergency does not require hospitalization a counselor will provide support by phone if it is after business hours. A Counsel For Hope staff member or contactor we will work with local hospitals to assist the client with receiving whatever service is needed to meet their needs in the least restrictive environment when possible.

Crisis Support Numbers

1. **John Adriatico** (704) 201-9063
2. **Suicide Prevention Hotline** 1-800-273-8255
3. **Atrium Health Lincoln Emergency Department** at 980-212-2200 or the **Police** at 911
4. **Crisis Text Line** serves anyone, in any type of crisis, providing access to free, 24/7 support via a medium people already use and trust: text. Text **HOME** to **741741** to connect to a crisis counselor.
5. **National Disaster Distress Helpline** (call or text 1-**800-985-5990**; for Spanish, press “2”) is dedicated to providing crisis counseling and support 24/7/365 for anyone in the U.S./territories experiencing emotional distress or other mental health concerns related to any natural or human-caused disaster.

Counsel For Hope
119 Fuchia Lane ~ Lincolnton, NC 28092 ~ (704) 201-9063
125 N Tradd Street ~ Statesville, NC 28687 ~ (704) 201-9063

Client Name:
DOB:
Insurance #:

Authorization to Obtain or Disclose Protected Health Information

Client name: ___________________________________ DOB: ____

I, ____, hereby authorize

Client or legally responsible person/personal representative's name

____

Name of agency/Persons which possess information to be released

To release/exchange information noted below to Counsel For Hope

I understand that this information will be used for: To coordinate crisis services and/or treatment for the client above.

Once information is disclosed pursuant to this signed authorization, I understand that the HIPPA privacy law (45 C.F.R) protecting health information may not apply to the recipient of the information, and, therefore, may not prohibit the recipient from disclosing it. When this agency discloses information protected by federal law (42 C.F.R.) we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these laws. I understand that HIV/AIDS, STD (sexually transmitted diseases), and TB (tuberculosis) related information is protected by state law (GS 130 A-143) and cannot be disclosed unless the disclosure is authorized by the State communicable disease laws or with your consent.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign a revocation. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility of benefits.

Information to be disclosed: (check approved information that can be obtained or disclosed)

Evaluations O	Progress Notes O	Admission Assessments O
Treatment Plans O	HIV Information O	Substance Abuse Information O
Medical Records O	Educational Records O	Other ____

If not revoked earlier, this authorization expires automatically on ______________ or one year from the date it is signed, whichever is earlier

_________________________________ ______________________ _____________

Revised 11.4..22

Client/Legally Responsible Person Signature Relationship to Client Date

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Professional Disclosure