ISLANDS COUNSELING SERVICES

The Haven @ ISLANDS COUNSELING SERVICES

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Male ___ Female ___

Address: _____ PO BOX: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email Address: _____

SSN: _____Employer or School: _____ Marital Status: _____

Spouse Name and Phone: _____

Hospital of Preference: _____

Emergency Contact Name and Phone: _____

Do we have your permission to provide information to your spouse:	Y	N
Do we have your permission to provide information to your physician:	Y	N

(If you answered "yes" to any of the questions above, please see the therapist to sign a Release of Information.)

Do we have your permission to leave a message on the numbers you listed:	Y	N
Do we have permission to provide information via email:	Y	N
Do we have permission to provide information via text:	Y	N
Do we have your permission to add you to our informational mailing list?	Y	N

PARENT/GUARDIAN INFORMATION (IF THE CLIENT IS LESS THAN 18 YEARS OF AGE):

Parent 1 Name: _____ Date of Birth: _____ Male___ Female___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

SSN: _____ Employer or School: _____ Marital Status: _____

Parent 2 Name: _____ Date of Birth: _____Male___Female___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

SSN: _____ Employer or School: _____ Marital Status: _____

Insurance Verification Request

❑ **I am using Insurance**

❑ **I am not using Insurance (Please skip this form and request a Good Faith Estimate for our Self Pay options)**

Please call your insurance company and request the information to the questions below. On the back of your card (typically) locate the telephone number provided for Mental Health/Substance Abuse and /or behavioral Health.

PRIMARY INSURANCE COMPANY: _____

ID/Member Number of the Insured (Client): _____

Policy Effective Date: _____ Customer Service Phone # _____

SECONDARY INSURANCE COMPANY: _____

ID/Member Number of the Insured (Client): _____

Policy Effective Date: _____ Customer Service Phone # _____

NOTE: IF YOU FAIL TO PROVIDE SECONDARY INSURANCE INFORMATION, ALL CLAIMS MAY BE DENIED AND YOU WILL BE LIABLE FOR THE FULL AMOUNT.

Please make sure to request outpatient mental/behavioral health benefits when calling. Ask and Complete the following:

Are these providers in-network with your plan? (Please verify all as we cannot promise you will be able to see your first choice)

- ❑ KELLI LITTLEFIELD – NPI 1497085385
- ❑ KIMBERLEY SIMON – NPI 1396046777
- ❑ KARI BARRETT – NPI 1689884744
- ❑ KEVIN TOMBERLIN – NPI 1235567025
- ❑ MARIA IRWIN – NPI 1700302403

If no providers above are in-network, ask if your plan allows for out of network benefits? (Usually a percentage if OON coverage is available) _____%

If providers above are in-network:*

What is the Payor ID for Mental Health services? (This is not always the same as what's shown on the back of the card)_____

What is the Claims Address for Mental Health services? (This is not always the same as what's shown on the back of the card- Provide if different from back of card.) _____

Are there any mental health diagnoses excluded from your mental health plan, related to your presenting concerns? (e.g. depression, ADHD, Autism Spectrum disorder, etc.) Please name diagnoses, if so. _____

Is there a deductible? Yes_____No_____ If it has not been met, how much remains?_____

What is the copay/coinsurance for CPT codes 90791 (intake) and 90837(std 60 min session)? _____

Is there a limit on how many visits per year? If so, how many? _____

Prior Authorization:

Do outpatient mental health services require preauthorization? Yes____ No_____

If authorization is required, and you are planning on therapy or if the patient is a minor, please inform the insurance company that you are requesting individual and/or family visits. If authorization is required, please obtain the authorization number and list it here: _____

Authorization Effective Dates: (from_____to_____)

Authorization for how many sessions? _____

Name of Call Representative you spoke with:_____

Call Reference # _____

Patient/Guardian Signature_____ Date_____

Credit Card Authorization and Payment Consent

**In order to establish and continue services at Islands Counseling Services and The Haven at Islands Counseling INC, we require that a valid credit/debit card be kept on file at all times.

Client Name:

_____

Card holder Name on card (if different than client):

_____

Card holder Address (Street, City, State and ZIP):

_____

Card holder phone number: _____

Card holder email: _____

Card Type: _____

Debit/Credit card number: _____

CVC: _____ Expiration Date: _____

I authorize Islands Counseling Services or The Haven at Islands Counseling, Inc. to charge my credit/debit/health account card for professional services after our scheduled appointment. If I do not cancel before 24 hours, I recognize that Islands Counseling Services or The Haven at Islands Counseling, Inc. reserves the right to charge my card $75 as a missed appointment fee before I am able to schedule any future appointments.

I verify that my credit card information is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

_____ _____

Client or Legal Guardian Signature Date

_____ _____

Cardholder Signature Date

Practice Policies

Welcome to Islands Counseling Services and The Haven at Islands Counseling Services! Thank you for trusting us with your care. Below, you will find our practice policies. Please review them and direct any questions you may have to your therapist at your first session.

Appointments and Cancellations
Please remember to cancel or reschedule 48+ hours in advance. Starting January 1, 2024, we enacted a Late Cancellation/ No Show Fee of $75. If you cancel or miss an appointment with less than 24-hour notice. We will use the credit card on file and email you a receipt of the charge(s). Health insurance does not cover this charge. You are given 1 free "late/no show" per year to account for last minute emergencies. Reminders are sent out 48 hours before your appointment, please email or call if you need to reschedule at that time. We attempt to fill all open slots from our waiting list in order to increase the frequency with which clients can be seen.

More than three cancelled appointments with less than 24 hours' notice may result in future appointments being removed from our schedule. If this occurs, you will be notified via phone, email and/or in writing. If you are more than 15 minutes late for your scheduled appointment, it may be necessary to reschedule for a later date.

When scheduling minors and in the instance of divorce, we require that we have a copy of the official custody agreement on file in order to establish care for the adolescent/child. In the case of dual custody, we must have the consent of both parents on file in order to establish care for the adolescent/child.

We only accept payment from one custodial parent/guardian. It is up to both parents to work out reimbursement between themselves. Invoices and statements are available through our client portal.

Sliding Scale Fees: Our insurance contracts set your rate and do not allow us to offer additional discounts. If you are a self-paying patient and need to access our sliding scale, please reach out to our scheduling department at info@islandscounseling.org.

***If your insurance is Medicaid or a Medicaid CMO, we are unable to charge a missed appointment fee, per our contracts with those organizations. Instead, we will provide you 1 missed appointment per year and will discharge you from our services upon the 2nd missed appointment.

A $30.00 service charge will be charged for any checks returned for any reason for special handling.

Court Policy
If your therapist is subpoenaed to attend court for a case in which you are involved, a fee of $1500/per day will be charged to you and payment will be required 24 hours in advance of court appearance. Standard reports and records requests will be provided at no charge. Non-standard reports will be provided at the standard hourly rate of $200/hour. An estimate of the cost of the non-standard report will be provided and the report will not be released until payment is received. An invoice will be sent to you via Square to be documented in your client portal upon receipt of payment.

Fees for court related services are as follows:
Evaluations (60 minutes): $250.00
Court Attendance and/or Testimony: $1500/day to be paid 24 hours prior to court date
Electronic Records and Standard Reports: Records copying: $10.00 for the first 20 pages, .25 per addl. page.
Non-Standard Reports: $200/hour (estimates will be provided at time of request)

***Court Preparation, Documentation and Non-Standard Reports, Emails and Responses, Phone Calls, and Collateral Contact are billed $200 per hour to be pro-rated for actual time spent.

Social Media

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Electronic and Telecommunication

We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Access to telecommunications (therapist's personal cell phone and text) are at the discretion of the therapist. We highly encourage you to use the Secure Messaging in our client portal through Simple Practice. Please be sure to utilize all forms of the business's communication (office phone, email, office emergency number, and Simple Practice messaging) before accessing the therapist's personal cell phone, if you need to contact your therapist.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

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

Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

Notice of Security Camera in Lobby:

Please know that there are two active security cameras in our Lobby at all times. The cameras are for the safety of both therapists and clients and can be accessed only through a secure portal by the President and CEO of the Company. The information will only be accessed by law enforcement in the event of a crime being committed or an injury.

Training Facility

Islands Counseling Services and The Haven at Islands Counseling are training facilities. We train clinicians both in their masters program and after they have graduated through Supervised practice of mental health counseling. Listed below are the supervised clinicians and their supervisors with their contact information should you have any comments, questions, or concerns.

Supervisees: Zhane Richardson, MA
Kaitlin Atkins, MA
Kayla Capeles, MA
Grace Hallenbeck, Intern
Whitney Lowery, Intern

Supervisors: Kelli Littlefield, EdS, LPC, CPCS – kelli@islandscounseling.org 770-342-8692
Kari Barret, MA, LPC, CPCS, RPT/S – kari@islandscounseling.org 912-713-2117

By Signing this document, you are agreeing to possibly be seen by a supervised clinician unless you designate otherwise to the scheduling office. Any issues or concerns can be directed to the supervisors listed above.

Research Activities

Islands Counseling Services does not conduct research. Treatment data may be anonymously aggregated for internal quality control and improvement efforts only. Your information will never be shared or sold.

I have read and agree to the information contained within the Islands Counseling Services Practice Policies.

_____ _____

Client or Legal Guardian Signature Date

Informed Consent for Psychotherapy

Counseling is a cooperative venture between the therapist and client and if the client is a minor, the legal guardian. All have responsibilities in the change process. Due to the cooperative nature of psychotherapy and counseling, no guarantee of a cure or positive resolution can be given. The therapists at Tybee Counseling Services, LLC d/b/a Islands Counseling Services (Hereafter referred to as "Islands Counseling Services") and at The Haven at Islands Counseling Inc. are Licensed Professional Counselors and Licensed Clinical Social Workers who adhere to the Code of Ethics and Standards of Practice of the National Association of Social Workers (NASW), American Counselors Association (ACA), the National Board for Certified Counselors (NBCC), the Commission for Certified Rehabilitation Counselors (CRCC) and the Georgia Composite Board of Social Workers and Professional Counselors. As licensed therapists, we are required to participate in extensive ongoing training. This is to maintain our licenses and continue to grow professionally for the benefit of our clients.

Confidentiality and privacy are maintained on all communication between the client and therapist. We will not release clinical information about your treatment unless you give us written permission. However, there are circumstances where, by law, information must be revealed as they are outside of the scope of privileged communication. Those instances are:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Duty to Warn: If a therapist believes that a client is in a physical or emotional danger to themselves or another human being, the therapist will contact any person who is in a position to prevent harm to me or another including, but not limited to, the person in danger.

Informed Consent for Care of Minors

When counseling a minor, we ask that the legal guardian grant us permission to maintain confidentiality with the child. We request that the legal guardian be present for the first session to provide clinical information to the therapist and discuss the legal aspects of counseling with minors. During the therapeutic process, we will consult with the parent on themes of the session and information we deem in the best interest of the child and healthy overall functioning of the family. Maintaining confidentiality with the child helps to build a trusting relationship, which is the foundation of successful therapy. Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name or any identifying information.

In the instance of divorce, we require that we have a copy of the official custody agreement on file in order to establish care for the adolescent/child. In the case of dual custody, we must have the consent of both parents on file in order to establish care for the adolescent/child.

Please be aware that the documentation resulting from consultations with either parent are accessible to both custodial parents. No parent has confidentiality from the other parent when the child is the identified patient.

We only accept payment from one custodial parent/guardian. It is up to both parents to work out reimbursement between themselves. Invoices and statements are available through our client portal.

Contact Outside of Office

If we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge us first, we will be more than happy to speak briefly with you, but feel it is appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Therapist Availability and Emergency Procedures

Your therapist will not always be immediately available to take your calls. However, you may leave a voicemail on the private phone line at (912) 373-6789 and your therapist will return your call as soon as possible. Except for weekends, we will generally return the call within 24 hours. Included in the office voicemail is an emergency phone number to be utilized in emergencies.

If you have an emergency and cannot immediately reach us by telephone, you or a family member should immediately call 911 or proceed to the nearest emergency room to access care.
If your therapist is to be absent for a period of time, such as for a vacation, we will provide you information of a back-up therapist who can be available for emergency consultation.

Termination

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

Insurance Reimbursement

Islands Counseling Services and The Haven at Islands Counseling Inc. are considered "in network" with many insurance companies. This means that the insurance companies that we are "in network" with have negotiated a lower contracted rate for you in order to give you the best value for the services we provide. As such we ask that you agree to the following conditions of using your insurance benefits at Islands Counseling Services and The Haven at Islands Counseling, Inc:

- I am aware that I am responsible for providing a copy of my insurance card and notifying Islands Counseling Services of any changes to my insurance policy.
- I authorize the release of treatment information necessary to process all insurance claims.
- I authorize payments of benefits to Islands Counseling Services or The Haven at Islands Counseling Inc. for all services provided.
- I understand it is my responsibility to ensure that the provider is in my insurance network.
- Claims denied or reduced due to the provider being considered out of network are my responsibility. I agree to pay all co-pays, co-insurance, deductibles, and/or any other costs not covered by my insurance at the time of service.

Credit Card Consent

**In order to establish and continue services at Islands Counseling Services and The Haven at Islands Counseling Inc, we require that a valid credit/debit card be kept on file at all times.

I authorize Islands Counseling Services or The Haven at Islands Counseling, Inc. to charge my credit/debit/health account card for professional services after our scheduled appointment. If I do not cancel before 24 hours, I recognize that Islands Counseling Services or The Haven at Islands Counseling, Inc. reserves the right to charge my card $75 as a missed appointment fee before I am able to schedule any future appointments.

I verify that my credit card information is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

I have read and agree to the information contained within the Informed Consent for Psychotherapy.

_____ _____

Client or Legal Guardian Signature Date

HIPAA PRIVACY NOTICE

Georgia Notice Form
Notice of Policies and Practices to Protect the Privacy of Your Health Information
THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.
To help clarify these terms, here are some definitions:
· "PHI" refers to information in your health record that could identify you.
· "Treatment, Payment and Health Care Operations": *"Treatment"* is when a therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when we consult with another healthcare provider such as your family physician or another therapist. *"Payment"* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *"Health Care Operations"* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, supervision of mental health practitioners to help them improve their counseling skills, and case management and care coordination.
· "Use" applies only to activities within my practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
· "Disclosure" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes the therapist has made about your conversation during a private, group, joint, or family counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:
· Child Abuse – If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
· Adult and Domestic Abuse – If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
· Health Oversight Activities – If we are the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers and Marriage and Family Therapists, the Secretary of Health and Human Services, your insurance company, or are defendants to legal proceedings instituted by you, we may be required to disclose protected health information regarding you in those proceedings.
· Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services provided or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
· Serious Threat to Health or Safety – If we determine, or pursuant to the standards of our profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
· Worker's Compensation – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

· Law Enforcement- We may release medical information if asked to do so by a law enforcement official:
• In response to Court Order, subpoena, warrant, summons or similar process
• To identify or locate a subject, fugitive, material witness, or missing person
• About the victim of a crime, under certain limited circumstances, if we are unable to obtain the person's agreement
• About a death we believe may be the result of criminal conduct
• About criminal conduct at the Islands Counseling office or in the presence of a therapist working with Islands Counseling
• In emergency circumstances to report a crime; the location of the crime or victims, or the identify, description or location of the person who committed the crime.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:
· Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternate means and at alternate locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, we will send your bills to another address.)
· Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
· Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
· Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, your therapist will discuss with you the details of the accounting process.
· Right to a Paper Copy – You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.
Therapist's Duties:
· We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
· Islands Counseling Services reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
· If these policies and procedures are revised, Islands Counseling Services or The Haven at Islands Counseling Inc. will provide you with the revision at your next appointment.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact your treating therapist. If you believe that your privacy rights have been violated and wish to file a complaint with this office, you may send a written complaint via e-mail to kelli@islandscounseling.org. Or you may also file a complaint with the Secretary of Health and Human Services. You have specific rights under the Privacy Rule. Islands Counseling Services or The Haven at Islands Counseling Inc. and its associated therapists will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy-This notice will go into effect on May 16, 2013.

I have read and agree to the information contained within the Notice of Privacy Policies.

Printed Name: _____ Signature: _____ Date: _____

ISLANDS COUNSELING SERVICES

The Haven @ ISLANDS COUNSELING SERVICES

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

1. I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.
2. I understand that none of the telemental health sessions will be recorded or photographed.
3. I agree not to make or allow audio or video recordings of any portion of the sessions.
4. I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
5. I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.
6. I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
7. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
8. I understand that I or my therapist may discontinue the telemental health sessions at any time if it is felt that the video technology is not adequate for the situation.
9. I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.
10. I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.
11. I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.
12. I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

How to join the telehealth session:
https://support.simplepractice.com/hc/en-us/articles/360003183011-Telehealth-FAQs-for-clients
We prefer that you log in to your Simple Practice client account to join a session.
However, a link will be provided to you via text and email 24 hours before your session as an alternate means to access your online session.

I have read and agree to the information contained within the Informed Consent for Telemental Health Treatment and give my informed consent for the use of telemental health in my care.

_____ _____

Client or Legal Guardian Signature Date

Intake Questionnaire

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

How did you hear about us?

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Describe your current living situation. Do you live alone, with others. With family, etc…

If you are in a relationship, please describe the nature of the relationship and months or years together.

Is there a history of mental illness in your family?

Have you ever been hospitalized for a psychiatric issue?

Do you have suicidal thoughts?

Have you ever attempted suicide?

Do you have thoughts or urges to harm others?

Have you experienced any of the following symptoms in the past six months?

Low motivation
Low self esteem
Depressed mood
Tearful or crying spells
Fear
Hopelessness
Issues with concentration, attention or focus
Hyperactivity
Racing thoughts
Hallucinations
Impulsivity
Other:

Have you seen a mental health professional before?

Do you drink alcohol?

Do you use recreational drugs?

Do you have any current medical conditions?

Have you had any recent changes in your physical health within the past 6 months? If so, please provide as much detail as you can.

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

What are your goals for counseling?

What else would you like me to know?