INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

Welcome to Safe Harbor Christian Counseling (SHCC). We hope that your counseling experience with us will be positive and that our assistance will be beneficial to your mental health. Your counselor is __________________ and has the following credentials: ______________

The purpose of SHCC mental health treatment is for our counselors to help you achieve your goals and overcome any obstacles that led you to seek counseling with SHCC. This treatment will include various mental health treatment modalities. You are encouraged to work with your counselor in the development of your treatment plan and you should be informed of the process of any new modes used within your treatment process. The associated risks of mental health counseling are limited; you may experience some emotional difficulty, which your counselor will do their best to help you work through. The benefits to be gained from counseling are vast; some potential benefits of counseling are an improved outlook on life, more effective coping skills, greater understanding of yourself, and better communication tools that will not only have positive effects on your relationships, but through many spheres of your life.

As a client of SHCC, you are not required to accept treatment from SHCC at any time, and you have the right to decline part or all of your treatment, including withdrawal from our services should you not be willing to participate.

______________________________ ______________________________ ____________
Client Name (Print)     Client Signature     Date

INFORMED CONSENT FOR ONE MEDICAL RECORD

I understand and consent to Safe Harbor Christian Counseling (SHCC) having one medical record for me. I understand that every counselor that provides treatment for me at SHCC will have access to all clinical notes in my clinical record.

______________________________ ______________________________ ____________
Client Name (Print)     Client Signature     Date

INFORMED CONSENT FOR RESEARCH

There may be opportunity in the course of your treatment to participate in research or outcome-based metrics. You are not required to participate and there will be no direct or implied deprivation or penalty for refusal to participate.

______________________________ ______________________________ ____________
Client Name (Print)     Client Signature     Date
CONSENT FOR TREATMENT OF A MINOR

I, _______________________, give Safe Harbor Christian Counseling and _______________________
Parent/Guardian
Counselor
permission to provide treatment for ________________________________________.

CONFIDENTIALITY STATEMENT

I, ___________________ and __________________ understand limits to confidentiality and have been
Parent/Guardian Child
provided with a copy of this statement.

For the Parent/Guardian: The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.

2. The professional has reason to believe that you will harm others, including your child.

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.

2. The professional has reason to believe that you will harm others.

3. The professional has reason to believe that someone or something is harming you, including your parents.

Additional Disclosures at the Parent’s Request:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_________________________________  ______________________________________  __________
Counselor Parent/Guardian Date

_____________________________________
Child
CONFIDENTIAL CLIENT INTAKE FORM

Name: ___________________________________________   Today’s Date: __________________

Sex: □ Male  □ Female  Date of Birth: ______________ Age: ______

Home phone: _______________________  Work phone: _________________________

Cell phone: _________________________  Email: ______________________________

Any number you do not want to be contacted at: ________________________________

Check here if you want Christian counseling: □

Do you regularly attend a church, synagogue, or other religious institution?  □ Yes  □ No

If yes, which one? ____________________________________________________________

RELATIONAL INFORMATION

Current marital status: □ Single  □ Engaged  □ Married  □ Separated  □ Divorced  □ Widowed

If engaged, married, separated, divorced, or widowed, for how long? ______

Number of previous marriages for you: _______  For your spouse: _______

If married, spouse’s name: _____________________ Age: ______

Is your spouse supportive of you seeking counseling? □ Yes  □ No  □ Unsure  □ Spouse doesn’t know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive):
_________________________________________________________________________________________________________

What is your current occupation? ____________________________________________

What is your level of satisfaction with your occupation? ____________________________

Please list your children (including step, adopted, foster) below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age or Yr of death</th>
<th>Relationship to you</th>
<th>Living with whom?</th>
</tr>
</thead>
<tbody>
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</table>

Who else lives with you? ______________________________
Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative):

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age or Yr of death</th>
<th>Relationship to you</th>
<th>Describe him/her (e.g. angry, outgoing, supportive, controlling)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

COUNSELING HISTORY
If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs:

<table>
<thead>
<tr>
<th>Therapist's Name or Program</th>
<th>Major Issue</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?

☐ Yes  ☐ No  If yes, please describe: _______________________________________________

Have any of your family members or friends ever attempted or committed suicide?

☐ Yes  ☐ No  If yes, who and when: _______________________________________________

MEDICAL HISTORY
Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Are you currently receiving any medical treatment?  ☐ Yes  ☐ No  If yes, please describe: ___________________________
________________________________________________________________________________________________________

Please list all current medications you are taking and the reasons for taking them (even if you seldom use, or take only as needed):

<table>
<thead>
<tr>
<th>Name of medications</th>
<th>Dose</th>
<th>Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Are you taking these medications according to the doctor’s recommendations?

☐ Yes  ☐ No  If no, please explain: _______________________________________________________________

Date and outcome of last physical exam: _______________________________________________________________
PRESENT ISSUES AND GOALS
Please describe why you are coming to counseling. (i.e. What are your issues, problems, symptoms, how long, etc.):

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Check any of the following symptoms or problems that you currently are, or recently have, experienced:

<table>
<thead>
<tr>
<th>List 1</th>
<th>List 2</th>
<th>List 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Marital Problems</td>
<td>Compulsive Behaviors</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Other Relational Problems</td>
<td>Seeing Things Others Don’t</td>
</tr>
<tr>
<td>Panic</td>
<td>Physical Abuse</td>
<td>Hearing Voices</td>
</tr>
<tr>
<td>Depression</td>
<td>Emotional Abuse</td>
<td>Racing Thoughts</td>
</tr>
<tr>
<td>Apathy</td>
<td>Verbal Abuse</td>
<td>Eating Problems</td>
</tr>
<tr>
<td>Fatigue/Lack of Energy</td>
<td>Sexual Abuse</td>
<td>Drug Use</td>
</tr>
<tr>
<td>Loss of Appetite/Overeating</td>
<td>Sexual Problems</td>
<td>Alcohol Use</td>
</tr>
<tr>
<td>Trouble Sleeping</td>
<td>Gender Identity Issues</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Poor Concentration</td>
<td>Anger</td>
<td>Abortion</td>
</tr>
<tr>
<td>Feeling Worthless</td>
<td>Aggressive Behavior</td>
<td>Legal Matters</td>
</tr>
<tr>
<td>Recent Death</td>
<td>Bad Dreams</td>
<td>Work Stress</td>
</tr>
<tr>
<td>Grief</td>
<td>Unwanted Memories</td>
<td>Career Choices</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Loss of Control</td>
<td>Indecisiveness</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Impulsive Behavior</td>
<td>Parenting Problems</td>
</tr>
<tr>
<td>Fears</td>
<td>Controlling</td>
<td>Financial Problems</td>
</tr>
<tr>
<td>Shyness</td>
<td>Controlled by Others</td>
<td>Spiritual Problems</td>
</tr>
<tr>
<td>Low Self-Esteem</td>
<td>Obsessive Thoughts</td>
<td>Other</td>
</tr>
</tbody>
</table>

Place an “X” on the scale below to indicate how distressing your problem(s) are to you.

[---------------------------------------------------------------] [---------------------------------------------------------------] [---------------------------------------------------------------]
Very                           Moderately                           Very
Minimally Distressed           Distressed                         Extremely
Distressed

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Have you experienced suicidal thoughts in the past? ☐ Yes ☐ No

Have you attempted suicide in the past? ☐ Yes ☐ No

Are you currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

What do you hope to gain from this counseling experience?

____________________________________________________________________________________________________________

I certify that the preceding information (personal information, relational information, counseling history, medical history, present issues and goals) is honest and truthful to the best of my knowledge.

_________________________________________________             _________________
Client’s Signature  Date
Welcome to Safe Harbor Christian Counseling. Please read all documents thoroughly and complete them where necessary, so that you are prepared to discuss any questions with your counselor during your first session.

1. CONFIDENTIALITY

All information obtained/derived by the course of treatment is fully confidential. Exceptions to this guideline include instances when (a) the patient is a clear danger to themselves or others; (b) the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical or sexual abuse; and (c) there is any suspected abuse to a child or elder abuse.

If you desire Safe Harbor to release or obtain information from a specific individual or agency, ask your counselor for an “Authorization to Release Information” form.

I understand that cases are occasionally discussed between Safe Harbor counselors and supervisors to provide the best clinical treatment possible.

2. TELEPHONE CALLS

Occasions may arise when you need to talk to your counselor in between normally scheduled sessions. If you leave a message with your counselor, they will make every effort to respond in a timely manner. Any consultation by telephone made between scheduled sessions will incur a charge to the patient. If there is a life-threatening emergency, call 911 or go immediately to your local Emergency Room.

3. LENGTH OF SESSION

Depending on what your insurance allows and authorizes, the psychotherapy session is 38 minutes in length or 53 minutes in length, beginning at your appointed time and concluding about 38 minutes or 53 minutes after. Therefore, it is to your benefit to arrive a few minutes in advance of the appointment time. Since your counselor has sessions scheduled after yours, the sessions must end 38/53 minutes after the appointment time regardless of your arrival time. If client’s lateness precludes the scheduled session length, a late fee may be assessed in addition to the copay.

4. FEES AND PAYMENT*

*Does not apply to Medicaid clients

All payment is due at the time services are rendered. Payment may be made in the form of cash, check, or credit. If you choose to pay by check, please be prepared to supply a form of ID (e.g. driver’s license) and make the check payable to Safe Harbor Christian Counseling. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. If you choose to pay by credit card, please use the “Credit Card Authorization” form contained in this packet.

Our current fee per session is $100-$150 depending on the Current Procedural Terminology (CPT) code. If any or all outstanding balances are not paid, Safe Harbor reserves the right to release a
client’s name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full.

5. INSURANCE

Safe Harbor Christian Counseling will bill your insurance company for all sessions unless otherwise agreed upon. You are responsible for any balance that insurance does not cover and agree to pay any unpaid balance on your account in a prompt manner. *This does not apply to active Medicaid clients.

All balances on accounts will be collected from clients 90 days after insurance has been billed. This means that Safe Harbor Christian Counseling is giving your insurance company 90 days to pay the claim. The law states that it must be processed within 30 days of receipt. After 90 days, you are responsible to pay Safe Harbor Christian Counseling directly. We will give you a receipt, which you can use to try to get your insurance company to reimburse you.

If your insurance changes or is terminated, please call the Safe Harbor administrative office as soon as possible to provide the office staff with your new information. Check the benefits as your coverage has likely changed from your old policy. If the insurance changes and you fail to notify us, this will result in the claim being denied from the insurance company and you will be held responsible for the entire fee.

6. CANCELLATIONS AND MISSED APPOINTMENTS

When your appointment is scheduled, a particular time slot is reserved for you on either a weekly or bi-weekly basis. It is your responsibility to give at least 24 hours’ notice if you must miss or cancel an appointment so that the counselor can make use of that time slot. Therefore, a cancellation fee of $60 will be assigned every time an appointment is missed or cancelled with less than 24 hours’ notice (does not apply to Medicaid clients). This fee is assessed regardless of the reason for missing or cancelling the originally scheduled appointment. *This does not apply to active Medicaid clients.

Repeated cancellations or missed appointments may affect the retention of your allotted time slot. There is a limit of one cancellation every three months in order to keep your allotted time slot in place. Therefore, if a second cancellation occurs within the three month time frame, the counselor may be unable to reserve your allotted time slot for you. However, your counselor will likely be able to keep you on their caseload via a floating time slot.

7. INCLEMENT WEATHER POLICY

The counselor is responsible for determining if the weather is too hazardous to commute to your practice location. If your counselor decides to hold the session as originally scheduled, you are expected to show and will be charged a cancellation fee for missed appointments. If your counselor decides to cancel your session, they will contact you to inform you of the change.

We trust that your experience with Safe Harbor Christian Counseling will be helpful and profitable to you. If you have any questions regarding these policies or other aspects of your relationship with us, please discuss them with your counselor or his/her clinical supervisor.

My signature certifies that I have read, understand, and have been given a copy of the Policies and Procedures document.

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Client’s Signature ___________________________ Date ___________________________
PRIVACY NOTICE OF
SAFE HARBOR CHRISTIAN COUNSELING (SHCC)

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy
practices to protect the privacy of your individual identifiable health information; this is, Protected Health
Information (PHI), as that term is defined in the HIPAA under Information.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. SHCC is required to follow the terms of this
Notice until it is replaced. SHCC may make changes to the terms of this Notice at any time. Upon your
request, we will provide you with a copy of the current Notice. SHCC reserves the right to make the changes
apply to your Information maintained in our files before, and after, the effective date of the new Notice. The
following is a general description of how Federal and State law permits us to use and disclose your Information.

Purpose for which SHCC May Use or Disclose Your Mental Health Information with your Consent to
Treatment

SHCC may request your consent for the use and/or disclosure of your Information for treatment, payment, or
health care operations as described below:

- **Treatment.** SHCC will use and disclose your Information to provide, coordinate, or manage your mental
  health care and any related services. SHCC may disclose your Information to physicians, therapists,
  other mental health providers, or other health care providers who are treating you or assisting in your
  diagnosis, treatment, or recovery.

- **Payment.** Your Information will be used and disclosed, as needed, to obtain payment for your mental
  health care services. This may include certain activities that your health insurance plan undertakes
  before it approves or pays for the mental health care services we recommend for you; such as making a
  determination of eligibility or coverage for insurance benefits, reviewing services provided to you for
  medical necessity, and utilization review activities. If more than one third-party payer is responsible for
  payment for your health care, SHCC may disclose your Information to more than one health plan and
  those health plans may share your Information with each other. Your Information may also be used and
  disclosed as needed to obtain payment for mental health care services rendered to you by other
  providers.

- **Mental Health Care Operations.** SHCC may use or disclose, as needed, your Information in order to
  support delivery of mental health care services. SHCC may call you by name in the waiting room area.
  SHCC may use or disclose your Information, as necessary, to contact you to schedule an appointment or
  remind you of your appointment.
• SHCC may share your Information with third party Business Associates who perform various
administrative services; for example, those within SHCC, or with whom SHCC contracts, who perform
billing services, transcription services, record retention, or other professional consultants. Whenever an
arrangement between a Business Associate and us involves the use or disclosure of your Information, we
will have a written contract that contains terms that will protect the privacy of your Information.

• Health Care Services. Your Information may be used and disclosed to contact you and to give you
information about treatment alternatives or other health benefits and services that may be of interest to
you.

Uses and Disclosures With Your Verbal Consent
Your Information may be disclosed to a family member, friend, or other person selected by you or as designated
by the law, if you verbally agree.

Uses and Disclosures With Your Written Authorization
Except as provided below, your Information will not be used for any non-routine purposes unless you give your
written authorization to do so. If you give written authorization to use or disclose your Information for a
purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any
time. Your revocation will be effective for the Information SHCC maintains, unless SHCC has taken action in
reliance on your authorization.

Uses and Disclosures Without Your Consent
• As required by law;
• To comply with legal proceedings, such as a court or administrative order or subpoena;
• To law enforcement officials for limited law enforcement purposes;
• To a coroner, medical examiner, or funeral director about a deceased person;
• To avert a serious threat to your health or safety or the health or safety of others;
• To a governmental agency authorized to oversee the mental health care system or government programs;
• To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
• To public mental health authorities for public health purposes.

Your Rights
You may make a written request to us to do one or more of the following concerning your Information:
• Put additional restrictions on use and disclosure of your Information.
• Communicate with you in confidence about your Information by a different means than SHCC is
currently doing.
• See and get copies of your Information.
• Receive a list of disclosures of your Information that SHCC has made for certain purposes for six (6)
years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which
includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact
us at the address below. In certain instances, SHCC is not required to agree to your request. SHCC will give
you necessary information and forms for you to complete and return to request your Information. SHCC is
permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as
listed above. (Fee $1.00 per page.)
Complaints
If you believe that SHCC violated your privacy rights, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with us at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. SHCC will not retaliate against you if you choose to file a complaint.

Contact Address:
Safe Harbor Christian Counseling
1208 E. Churchville Road
Suite 300
Bel Air, MD 21014
PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Safe Harbor Christian Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Safe Harbor Christian Counseling.

Client Name or Guardian (Print): __________________________________________________

_________________________________________________             _________________

Client’s Signature   Date
PRIVACY NOTICE OF
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THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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SHCC may request your consent for the use and/or disclosure of your Information for treatment, payment, or health care operations as described below:

- **Treatment.** SHCC will use and disclose your Information to provide, coordinate, or manage your mental health care and any related services. SHCC may disclose your Information to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

- **Payment.** Your Information will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you; such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one third-party payer is responsible for payment for your health care, SHCC may disclose your Information to more than one health plan and those health plans may share your Information with each other. Your Information may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- **Mental Health Care Operations.** SHCC may use or disclose, as needed, your Information in order to support delivery of mental health care services. SHCC may call you by name in the waiting room area. SHCC may use or disclose your Information, as necessary, to contact you to schedule an appointment or remind you of your appointment.
• SHCC may share your Information with third party Business Associates who perform various administrative services; for example, those within SHCC, or with whom SHCC contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and us involves the use or disclosure of your Information, we will have a written contract that contains terms that will protect the privacy of your Information.

• Health Care Services. Your Information may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent
Your Information may be disclosed to a family member, friend, or other person selected by you, or as designated by the law, if you verbally agree.

Uses and Disclosures With Your Written Authorization
Except as provided below, your Information will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your Information for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the Information SHCC maintains, unless SHCC has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent
• As required by law;
• To comply with legal proceedings, such as a court or administrative order or subpoena;
• To law enforcement officials for limited law enforcement purposes;
• To a coroner, medical examiner, or funeral director about a deceased person;
• To avert a serious threat to your health or safety or the health or safety of others;
• To a governmental agency authorized to oversee the mental health care system or government programs;
• To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
• To public mental health authorities for public health purposes.

Your Rights
You may make a written request to us to do one or more of the following concerning your Information:
• Put additional restrictions on use and disclosure of your Information.
• Communicate with you in confidence about your Information by a different means than SHCC is currently doing.
• See and get copies of your Information.
• Receive a list of disclosures of your Information that SHCC has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact us at the address below. In certain instances, SHCC is not required to agree to your request. SHCC will give you necessary information and forms for you to complete and return to request your Information. SHCC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)
Complaints
If you believe that SHCC violated your privacy rights, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with us at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. SHCC will not retaliate against you if you choose to file a complaint.

Contact Address:
Safe Harbor Christian Counseling
1208 E. Churchville Road
Suite 300
Bel Air, MD  21014
SAFE HARBOR CHRISTIAN COUNSELING
COUNSELOR DISCLOSURE
(to be completed at the first session with your counselor)

I, _________________________, am glad that you have chosen to begin a counseling relationship with me. I am committed to providing the best possible care to promote your well-being and growth. My credentials are ____________________________.

To contact me, please call ____________________. Messages received after 6 p.m. may not be heard until the next day. Messages received over the weekend may not be heard until the next working day. While your call is very important to me, I am often in session and may not immediately return your call. However, I will make every attempt to return it within 24 hours. If you have a clinical emergency, please do not call me first. Instead, please call 911 or go to the nearest emergency room while you attempt to reach me.

Sincerely,

Counselor’s Signature___________________________________ Date ______________

This is to certify that I have read, understand, and have received a copy of this disclosure form:

Client’s Signature__________________________________  Date______________
CREDIT CARD AUTHORIZATION

Client Name: __________________________________________________

Name on Card: _________________________________________________

Cardholder’s Phone Number: _____________________________________

Specify Type of Credit Card:

- Credit Card
- Debit Card
- Flex Spending/HSA Card

Card Number: _________________________________________________

Expiration Date: ____/____

Counselor: ____________________________________________________

Date of Service: ____/____/_______

Charge Amount: $ __________

I, ____________________________, authorize Safe Harbor Christian Counseling to bill my credit card for the amount indicated above and/or for any ongoing balances on my account.

Note: There will be a time delay in the processing of charges to your credit card due to the nature of our billing system.