Safe Harbor
CHRISTIAN COUNSELING

www.safeharbor1.com

Administrative Office:
1208 E. Churchville Road, Suite 300
Bel Air, Maryland 21014
TOLL FREE: 800-305-2089 / FAX: 443-640-4358

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.

_____ _____ _____

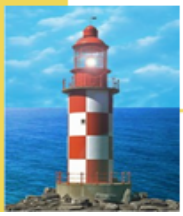
Client Name (Print) Client Signature Date

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



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CONFIDENTIAL CLIENT INTAKE FORM – FOR CHILD

Child's Name: _____ Today's Date: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____ Check here if you want Christian counseling: ☐

Any known mental illness:_____

Please list any siblings (including step, adopted, foster) below:

Siblings' Name	Sex	DOB	Relationship to Child	Any known mental illnesses? *(please specify)*

EMERGENCY CONTACTS

Please provide two emergency contacts if parent can't be reached:

Emergency Contact Name:_____ Relationship to Child: _____

Primary Phone: _____ Alternate Phone: _____

Emergency Contact Name:_____ Relationship to Child: _____

Primary Phone: _____ Alternate Phone: _____

FAMILY HISTORY

1. **Mother's Name:** _____ Date of Birth: _____

   Sex: ☐ Male ☐ Female Marital Status: _____ Occupation: _____

   Address:_____

   Preferred Phone:_____ Alt. Phone:_____ May I leave a message? ☐ Yes ☐ No

   Any known mental illness? ☐ Yes ☐ No *If yes, please specify*: _____

2. **Father's Name:** _____ Date of Birth: _____

   Sex: ☐ Male ☐ Female Marital Status: _____ Occupation: _____

   Address:_____

   Preferred Phone:_____ Alt. Phone:_____ May I leave a message? ☐ Yes ☐ No

   Any known mental illness? ☐ Yes ☐ No *If yes, please specify*: _____

3. Step-parent/Guardian's Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Marital Status: _____

Address:_____

Preferred Phone:_____ Alternate Phone:_____

Any known mental illness? ☐ Yes ☐ No *If yes, please specify*: _____

4. Step-parent/Guardians's: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Marital Status: _____

Address:_____

Preferred Phone:_____ Alternate Phone:_____

Any known mental illness? ☐ Yes ☐ No *If yes, please specify*: _____

CUSTODY ARRANGEMENTS (may be required to produce documentation)

Primary Guardian: _____

Are there any arrangements that may affect the schedule of sessions?

_____

_____

_____

How long has the child's parents been separated? _____

How has the child responded to the change?

_____

_____

_____

Please name all significant changes within the family occurring within the past several years
(i.e. moves/homelessness, significant financial changes, births/deaths, major illness, marriages/divorces, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

ISSUES OF CONCERN

What issues are bringing the child in for counseling? _____

_____

_____

_____

_____

What measures have been taken to help the child with these issues *(by the child, parents, family, other counselors, school staff, legal system, etc.)*? _____

_____

_____

_____

Please check all of the child's behaviors and symptoms that you consider related to the issue above or otherwise problematic.

☐ Compulsive behaviors	☐ Developmental Milestones *(e.g. speech impediment, delay in walking, etc.)*	☐ Worry/anxiety	☐ Low self-worth
☐ Hyperactivity	☐ Running away	☐ Panic attacks	☐ Feelings of hopelessness
☐ Drastic change in appetite	☐ Destruction of property	☐ Sadness/Depression	☐ Social discomfort
☐ Drastic change in weight	☐ Headaches	☐ Mood swings	☐ Strange thoughts
☐ Stomach aches	☐ Stealing	☐ Boredom	☐ Hallucinations
☐ Fatigue	☐ Bedwetting	☐ Lack of motivation	☐ Hearing voices
☐ Insomnia	☐ Toileting problems	☐ Social withdrawal/isolation	☐ Paranoia
☐ Aggression/Fighting	☐ Sexual problems	☐ Loneliness	☐ Phobias
☐ Violence toward self	☐ Computer addiction	☐ Anger/Irritability	☐ Nightmares
☐ Violence toward others	☐ Lying	☐ Defiance	☐ Poor memory/ Confusion
☐ Substance abuse	☐ Swearing/Obscene language	☐ Inability to concentrate	

Add any additional notes/comments to expand upon the behaviors and symptoms checked above *(e.g. frequency, duration, severity)*:

_____

_____

_____

_____

HISTORY OF TREATMENT

Has the child ever been admitted to an inpatient treatment program for psychiatric issues?

If yes, please give the date, issues, diagnosis, and duration of treatment: _____

_____

_____

_____

_____

Has the child been seen by a mental health professional on an outpatient basis? If yes, please describe the issues, any diagnoses, and duration of treatment: _____

_____

_____

_____

_____

_____

Please list all current medications the child is taking *(even if seldom used, or take only as needed)*:

Name of medication	Taking Currently?	Dose	Reason for taking
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

How important is spirituality to the child? _____

_____

_____

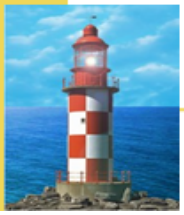
_____

_____

I certify that the preceding information is honest and truthful to the best of my knowledge.

_____ _____

Client's Signature Date



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POLICIES AND PROCEDURES

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.

_____ (Initial)

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.

_____ (Initial)

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.

_____ (Initial)

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.

_____ (Initial)

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.

_____ (Initial)

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.

_____ (Initial)

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.

_____ (Initial)

7. INCLEMENT WEATHER POLICY

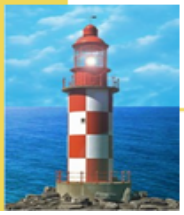
The counselor is responsible for determining if the weather is too hazardous to commute to your practice location. If your counselor decides to hold the session as originally scheduled, you are expected to show and will be charged a cancellation fee for missed appointments. If your counselor decides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

_____ _____

Client's Signature Date



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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*.

Purposes 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

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- *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*.

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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.

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- 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
www.safeharbor1.com
Administrative Office:
1208 E. Churchville Road, Suite 300
Bel Air, Maryland 21014
TOLL FREE: 800-305-2089 / FAX: 443-640-4358

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

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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_____

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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.