Coastal Samaritan Counseling Center

Instilling hope and healing

Therapy Information and Disclosure Form

WELCOME:
The Coastal Samaritan Counseling Center (CSCC) welcomes you as a potential client. We believe it is important for you to be informed about the nature of counseling or psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. Signing this form signifies your general consent to therapy.

COUNSELING AND PSYCHOTHERAPY IN THIS CENTER:
The words counseling and psychotherapy (referred to below as "therapy") are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work and with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life change based on acquiring a better understanding of one's personal, interpersonal, and social circumstances.

CSCC's methods of treatment are based on standard practices common to the training and experience of psychotherapists, marriage and family therapists, psychologists, social workers, and pastoral counselors. Practitioners in this Center work within the standards and ethical guidelines of state licensing laws, of professional associations, and of the Solihten Institute. [A statement of Professional and Clinical Standards is available on request.] CSCC therapist also function in a training capacity for student interns. From time to time interns may sit in on your sessions to observe the therapist. Interns are held to the same ethical and confidential standards as therapist. CSCC therapists also respond to the spiritual and theological needs of clients who recognize that values, beliefs, and religious affiliations make a difference in the process of changing and growing, and who want these factors to be considered in their therapy.

VIDEO THERAPY SERVICES:
CSCC offers Video Therapy Services (VTS) to delivery health care services using electronic communications to connect with individuals using interactive video and audio communications. The laws that protect confidentially of your personal information also apply to Video Therapy Services. Please be aware that there are risk in using VTS, including, but limited to the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of personal information could be disrupted or distorted by technical failure, the transmission of personal information could be interrupted by unauthorized persons. We take privacy and security very seriously. As a result, the VTS platform used by CSCC complies with HIPAA requirements. CSCC utilizes secure, encrypted audio/video transmission platforms to deliver VTS. Please see "Confidentiality" below for more information. Informed consent to Video Therapy Services must be giving before engaging in VTS. Please ask for more information.

THERAPY PROCESS:
Therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the therapist decide about engaging in therapy. This may take one interview or a series of interviews. If becoming a client here does not seem feasible, you will be helped to select a more appropriate place for the help you need. The *therapy process* itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Treatment is guided by a *treatment plan* that you and your therapist both agree to pursue. Therapy ends when the work is done, or at the point you decide to end it. Clients are entitled to receive information from therapists about the credentials, education, methods of therapy, the possible duration of therapy, and fees. Your therapist will disclose these facts and opinions in the initial interviews.

THERAPY POLICIES AND PROCEDURES:
YOUR RIGHTS AS A CLIENT: You have all the rights established by the state of South Carolina governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about

his or her qualifications, or requesting a different therapist, or ending treatment at any time, or accessing the client grievance procedures, and of having the records of your treatment kept in confidence (see confidentiality statement below).

CONFIDENTIALITY: What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, as a part of the professional practice of this Center. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child, elder or other vulnerable adult abuse; and c) if ordered by a court of law. If your therapy is court ordered, the results of treatment or test must be revealed to the court. Also, in keeping with standard profession practice, your case records may be viewed by Samaritan Center staff, consultants, and accreditation reviewers for purposes of diagnosis, treatment, and quality control. In all other instances, your written permission is required before your therapist or the Center can reveal information about your treatment.

RELEASE OF CONFIDENTIAL RECORDS POLICY

In compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, CSCC has developed policies and procedures to ensure that your confidential records are handled in a manner meeting necessary guidelines. Records will be release directly to third party entities (e.g. Lawyers, Doctors, etc.) only upon written request from the patient. Confidential records may take up to 10 days to be completed once all forms are received by CSCC. CSCC will only release records that were created and maintained by our counselors and center. We will not release records received from other clinics or providers. Except for authorizations to provide information to third-party payers, authorizations are valid for 1 year. Revocation must be in writing. Also, in keeping with standard profession practices, both parties must provide written permission to release records for marital counseling.

APPOINTMENTS AND CANCELLATIONS: All appointments are made with your counselor unless the counselor specifically asks the office to make the appointment. In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the hour reserved for you may be offered to someone else needing profession counseling services. The counselor reserves the right to terminate clients after two (2) no-shows or late cancelations.

INSURANCE AND OTHER THIRD-PARTY PAYMENTS: If you have insurance or some other third-party coverage (e.g., a managed care organization or employee assistance program) that pays for therapy, you are responsible for giving the Center this information on the Insurance Information Form. The Center will file your claims if the information you give us is accurate and complete. The Center does not guarantee that your insurance or other coverage will pay your claim.

ENDING THERAPY: Although you may end therapy at any time, it is preferred that you have a least one face-to-face concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up. In general, your file will be closed after three (3) months of no appointments, unless other arrangements have been made with your counselor or office administration. At the time of discharge, clients may be given or sent a Client Satisfaction Form that is used to elicit feedback on the therapy process. This is a valuable tool to increase the Centers' awareness of the strengths and weaknesses of our services.

________________________________ ____________

Client Signature Date

Coastal Samaritan Counseling Center

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901 N. Kings Hwy., Myrtle Beach, S.C. 29577
Telephone: (843) 448-4820 / Fax: (843) 448-9875
E-mail: csccinfo@coastalsamaritan.org
Website: www.coastalsamaritan.org

HIPAA Notice of Privacy Practices

This notice tells you how **Coastal Samaritan Counseling Center** makes use of your health information, how this information might be disclosed to others, and how you may get access to the same information. You will be asked to sign the Client Intake Signature Form, signifying that you were offered a copy of our Notice of Privacy Practices.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of South Carolina to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on **04-14-2003** and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at **Coastal Samaritan Counseling Center**. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations.
   Examples: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information sent to, for any reason you want. You may revoke this authorization in writing any time you want. When you revoke an authorization it will only affect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in

your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

8. The Center's Confidentiality Agreement contains information applicable to special disclosures required by South Carolina law regarding special circumstances in which confidentiality may be or must be waived (i.e. abuse of a child). Please refer to the pink Confidentiality agreement that has been or will be given to you at the time of your first appointment.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization.
We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of **Coastal Samaritan Counseling Center, Inc.**, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. We will charge you **$ .00** per page for making these photocopies.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

Compliance Officer: **Clinical Director**
Telephone: **843-448-4820**
Fax: **843-448-9875**
E-mail: **clinicaldirector@coastalsamaritan.org**

Alternate Compliance Officer: **Office Administrator**
Telephone: **843-448-4820**
Fax: **843-448-9875**
E-mail: **officeadmin@coastalsamaritan.org**

Address: **Coastal Samaritan Counseling Center**
901 N. Kings Highway
Myrtle Beach, SC 29577

M. You may also submit a written complaint to the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D. C. 20201

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Video Therapy Services Disclosure

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I understand that I have the rights with respect to Video Therapy Services:

1. The laws that protect the confidentiality of my personal information also apply to VTS. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the VTS interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of online therapy in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from VTS, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a face-to-face intervention if available with my counselor or referred to mental health professional that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through VTS as they have been explained to me, and in choosing to participate in VTS, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of online therapy in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that the VTS provided by Coastal Samaritan Counseling Center falls under the policies and procedures already in place which was provided as part of this intake process including, the therapy process, your rights as a client, confidentiality, fees and payment, appointments and cancellation, insurance and other third-party party payment and ending therapy.

8. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

PATIENT CONSENT TO THE USE VIDEO THEAPY SERVICES: I have read and understand the information provided above regarding VTS, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of online therapy services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of online therapy services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

____

Print Client Name

____

Client Signature

____

Date

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Client Intake Information Form

The information requested in this form will be kept confidential, and will help your counselor assist you.

Please fill out the form as completely as you can.

GENERAL INFORMATION

Last ______________________ First ______________________ Middle ____________________

Age _____ Date of Birth ____________ Social Security# ______________________ ☐ Male ☐ Female

Street Address ____ City ______________________

State ______ Zip __________ Phone ________________ ☐ Cell ☐ Home E-mail ____________________

May we leave a message on your phone? ☐ Yes ☐ No May we contact you by e-mail? ☐ Yes ☐ No

May we contact you by text message? ☐ Yes ☐ No

Referred By ____________________________ Reason for Referral ______________________

Religious preference/ Congregation Name ____________________________ Reason for choosing CSCC ______________________

RACIAL/ETHNIC IDENTITY
☐ African-American ☐ Asian-American ☐ Hispanic
☐ Native-American ☐ White/Caucasian ☐ Other

EMPLOYMENT ☐ Full-Time ☐ Part-Time
☐ Unemployed ☐ Stay At Home

Place of employment ______________________

Type of work/position ______________________

EDUCATION Highest Level of Education Completed
☐ High School ☐ Graduate Degree ☐ Other
☐ College Degree ☐ Professional Training

PAYMENT METHOD Do you plan to file insurance ☐ Yes ☐ No Employee Assistance Program ☐ Yes ☐ No

Do you wish to apply for fee assistance ☐ Yes ☐ No

Name of person responsible for payment ____

FAMILY INFORMATION ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabiting

prior marriages? ☐ Mother: age ☐ ☐ Deceased Father: age ☐ ☐ Deceased

CHILDREN				SIBLINGS			
First Name	Age	First Name	Age	First Name	Age	First Name	Age

PROBLEM DEFINITION

Reason for seeking help now?

Are any of the following conditions a problem for you at this time? (check all that apply)

- ☐ Anxiety
- ☐ Grief
- ☐ Depression
- ☐ Irrational Fears
- ☐ Nervousness
- ☐ Loneliness
- ☐ Anger
- ☐ Marriage Problems
- ☐ Sexual Problems
- ☐ Loss of Work/Job
- ☐ Self Esteem
- ☐ Stress
- ☐ Substance Abuse
- ☐ Chronic Fear
- ☐ Guilt Feelings
- ☐ Suicidal Feelings
- ☐ Loss of Hope
- ☐ Rage
- ☐ Relationship to Parents
- ☐ Relationship to Children
- ☐ Loss of Meaning in Life
- ☐ Loss of Faith in God
- ☐ Conflict at Work
- ☐ Religious Doubts
- ☐ Other (List)

What would you like to see happen as a result of psychotherapy or counseling?

____

MEDICAL/PSYCHOLOGICAL HISTORY

General Practitioner/Medical Doctor   Date of Last Medical Examination? ____________

Last Name ______________________ First Name ______________

Address ____

Any major surgeries, physical illnesses or mental illnesses in the last five years? ☐ Yes ☐ No If Yes, please list

Are you suffering any physical illnesses or symptoms at this time? ☐ Yes ☐ No If Yes, please list

LIST CURRENT MEDICATIONS

Medication Name	MG	Per Day	Medication Name	MG	Per Day

Have you received help for drug or alcohol dependency?	☐ Yes	☐ No
Have you received psychotherapy or counseling in the past?	☐ Yes	☐ No
Do you have thoughts of harming yourself or others?	☐ Yes	☐ No
Are thoughts of harming yourself or others a frequent occurrence?	☐ Yes	☐ No
Do you dwell on these thoughts and wonder if you can control them?	☐ Yes	☐ No
Have you sought professional help because of these thoughts and feelings?	☐ Yes	☐ No

Emergency Contact ______________________ Contact Phone # ______________

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

Signature ______________________ Date ____________

Print

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Client Insurance Information Form

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

Clients's Name: ______________________________

Name of Insured: ______________________________

Insured's Date of Birth: ______________ Relationship to Client: ______________

Employer: ______________ Insurance Card ID#: ______________

Check one of the following: ☐ Insurance ☐ Managed Care ☐ EAP

Insurance Company Name: ______________________________

Address: ______________________________

Phone Number: ______________ Group Number: ______________

Is there another health benefit plan or insurance company providing coverage? ☐ Yes ☐ No If yes complete the following:

Name of Insured: ______________ Insured's Date of Birth: ______________

Insurance Company Name: ______________________________

Address: ______________________________

Phone Number: ______________ Group Number: ______________

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize The Coastal Samaritan Counseling Center, Inc. and any member of the clinical staff of the Center to provide a summary of care and assessment information regarding evaluation and/or treatment for the purpose of evaluating and processing claims for benefits. Furthermore, I authorize payment of mental health benefits directly to The Coastal Samaritan Counseling Center, Inc. for services rendered. The Coastal Samaritan Counseling Center, Inc. will file my claim for me and re-file if necessary. I will make all co-payments in accordance with the adjusted fee scale if my insurance company delays or refuses to pay claims. The Coastal Samaritan Counseling Center, Inc. will make any necessary adjustments to my account when insurance payments are received. I understand the payment for services render is ultimately my responsibility.

Signature: ______________ Date: ______________