Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

Welcome to Embrace Counseling and Consulting, LLC. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-7

CLIENT INFORMATION

Name:____

Street Address: ____

City: ________________ County: ________________ State: _____ ZIP: _________

Email Address: ________________________ OK to email confidential messages? ___Y ___N

Date of Birth:________________________Age:__________ ❐ Male ❐ Female

Phone (Cell):________________________Messages okay?____Text reminder okay?________

School:________________________________Grade:____________

Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

____

Do your parents have access to your electronic communication? (Y/N)___________Do they have any issues with your use of phone, text, electronic communication? (Y/N) ___________

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? ________________________

____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) ____

____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? ____________________

____

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

____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❐ Yes ❐ No

If yes, what did you find **most helpful** in therapy?____________________________

____

If yes, what did you find **least helpful** in therapy?____________________________

____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, ____ No
If yes, how often do you drink?_____ Daily, ______Weekly, _____Occasionally, _____Rarely
If yes, how much do you drink? ___________ (#) per time.
Do you currently use Tobacco? ______Yes, ____ No
If yes, how much do you smoke/chew? ________________________
Do you currently use any other drugs? ________Yes, ______ No
If yes, what drugs do you use? ____
If yes, how often do you use? ____ Daily, ______Weekly, ______Occasionally, _____Rarely
Have you received any previous treatment for chemical use? Y/N _________
If so, where did you go?____
____Inpatient_________Outpatient

Adolescents (*please answer the following with* **Y/N**)

1. Have you ever used more than 1 chemical at the same time to get high? _________
2. Do you avoid family activities so you can use? _______
3. Do you have a group of friends who also use? _______
4. Do you use to improve your emotions such as when you feel sad or depressed?? _______

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.____

FAMILY HISTORY

1. Are your parents married or divorced? ________________________
2. Do you think their relationship **is** good? (Y/N/Unsure)________________
3. If your parents are divorced, whom do you primarily live with? ______________
4. How often do you see each parent? Mom_________% Dad___________%.
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above ____

PEER RELATIONS

1. How do you consider yourself socially:____outgoing____shy____depends on the situation.
2. Are you happy with the amount of friends you have? (Y/N)______________
3. Have you ever been bullied? (Y/N) __________
4. Are your parents happy with your friends? (Y/N)_______________
5. Are involved in any organized social activities (e.g. sports, scouts, music)? ______________

SCHOOL HISTORY

1. Do you like school? (Y/N)______________
2. Do you attend regularly? (Y/N)______________
3. What are your current grades? ______________________
4. Do you feel you are doing the best you can at School? (Y/N) ________________________

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTURBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
PHOBIAS						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (UNPLANNED CHANGES)						OTHER				

*We would like you to know that we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing.

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Welcome to Embrace Counseling and Consulting, LLC. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: ______________________________

Street Address: ______________________________

City: ______________ County: ______________ State: _____ ZIP: __________

Email Address: ______________________ OK to email confidential messages? ___Y ___N

Date of Birth: ______________________ Age ❒ Male ❒ Female

Race/Ethnic Origin: ______________________________

Religious Preference: ______________________________

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

____

____

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

____

What is most concerning right now? ______________________________

____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes____No____If yes, describe:
   ____
2. Did your child have health problems at birth? Yes______No _______
   If yes, describe: ____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
   Yes____No____Not sure______
   If yes, describe: ____
4. Did your child have any unusual behaviors or problems prior to age 3? Yes____No ____
   Not sure_____If yes, describe: ____
5. Has your child experienced emotional, physical, or sexual abuse?
   Yes_____No_____Not sure______If yes, describe: ____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ☐ Yes ☐ No

If Yes, where: ____

Approximate Dates of Counseling: ____

For what reason did your son or daughter go to counseling? ____

Does your son or daughter have a previous mental health diagnosis? ____

What did you find **most helpful** in therapy? ____

____

What did you find **least helpful** in therapy? ____

____

Has your son or daughter used psychiatric services? Yes_____No_____

If yes, who did they see? ____

If yes, was it helpful? N/A____Yes_____No_______

Has your son or daughter taken medication for a mental health concern? Yes______No __________

Name of medication	Dates taken	Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _______

If so, please describe. ____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _________

If yes, please explain your concern: ____

____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _________

If yes, please explain your concern: ____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past. ____

____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? ______________________

____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. ______________________

____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? ______________________

____

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ___Other

Length of marriage/relationship:______________________If divorced, how old was your child at time of divorce? _______

If divorced, How much time does your child spend with each parent? Mother______%, Father______%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: ______________________________**Birth Date:**_________ **Age:**_____

Ethnic Origin: ______________________________

Total years of education completed:______________Occupation:______________________

Place of Employment: ______________________________

Military experience? Y/N____________ Combat experience? Y/N ______________

Current Status______Single,_____Married,_____Divorced,_____Separated,______Widowed,______Other

Please answer if you are no longer with your child's bio-mother **OR check here if you are still with bio-mother*___________

Assessment of current relationship if applicable: Poor_____Fair________Good_________

Biological Mother's Name:______________________________**Birth Date:**_________ **Age:** _____

Ethnic Origin: ______________________________

Total years of education completed:______________Occupation:______________________

Place of Employment: ______________________________

Military experience? Y/N____________ Combat experience? Y/N ______________

Current Status______Single,_____Married,_____Divorced,_____Separated,______Widowed,______Other

Please answer if you are no longer with your child's bio-father **OR check here if you are still with bio-father*___________

Assessment of current relationship if applicable: Poor_____Fair________Good_________

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try? ______________________________

What personal qualities would you say your son or daughter has? ______________________________

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) ______________________________

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTURBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF MUTALATION					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					DECREASED CREATIVITY				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

Is there anything else you would like to share: ______________________________

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Consent to Treatment

(Please initial each section!!!)

_______ I acknowledge that I have received, have read (or have had read to me), and understand the "Counseling Information and Agreement" document. I understand that I am free to discuss any aspect of my treatment with my therapist at any time. I consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand the benefits and risks of therapy and that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I understand the provisions and limits of confidentiality established by Federal (HIPAA) and Georgia laws. I understand that my therapist operates under the professional and ethical standards of the American Counseling Association (ACA), the American Association for Marriage and Family Therapy (AAMFT), and/or the National Association of Social Workers (NASW), as appropriate to my therapist's specialization, and to the Ethics Standards of the Christian Association for Psychological Studies (CAPS). I am aware that I may stop my treatment with this therapist at any time. My only remaining responsibility will be to pay for the services I have already received. <u>I know that I must call to cancel an appointment at least 24 hours before the time of the appointment</u>. If I do not cancel or do not show up, my account will be charged the full session fee for that appointment, and any credit card on file for my account will be used to collect payment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, my therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements.

______ Your therapist will discuss the amount of your fee .You are responsible for paying at the time of your session unless prior arrangements have been made. Payment will be collected at the beginning of your session using your credit card on file or cash. We are unable to accept checks or insurance at this time. If you refuse to pay your debt, your therapist reserve the right to use an attorney or collection agency to secure payment.

_______ In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me.

_______ I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Lidums, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I would be responsible for his or her expert witness fees in the amount of $850.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time spent over one half (1/2) day would be billed at the rate of $150.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

______ I am required to keep appropriate records of the counseling services that I provide. Your records are maintained within a secure Electronic Medical Record (EMR) or Paper Chart. These records will include your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself or others, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

______ Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

______ I am often not immediately available by telephone. I do not answer the phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, however, it may take 24 – 48 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the **Georgia Crisis and Access line at 1-800-715-4225**, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering your care if applicable.

______ Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

____ ____________________

Signature of client (or parent/guarding acting for client) Date

____ ____________________

Printed name Relationship to client (if necessary)

I, the therapist undersigned below, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to treatment.

____ ____________________

Signature of Therapist Date

____

Printed name

Embrace Counseling and Consulting, LLC

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Notice of Privacy Practices Confirmation The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients with notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

Please read our Notice of Privacy Practices, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, we make every effort to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification. Please read the following paragraph and sign your agreement below. By Law, Embrace Counseling and Consulting is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights Document.

HIPPA Compliance Officer: Lyresa McGriff, LPC

I have read and understand Embrace Counseling and Consulting, LLC Notice of Privacy Practices, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may, at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document.

____

Printed name of client

____

Printed name of parent/guardian, if applicable

____ ____________________

Signature of client (Or parent/guardian for clients under age 18) Date

848 Hiram Acworth Highway Bldg 100 Terrace Level Hiram Georgia 30141
2480 Windy Hill Road, Ste 105 Marietta Georgia 30067
(678) 664-4311

Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

Financial Responsibilities Form

Your Name: ________________________________ ***Date:*** ______________

For the financial health of the practice, it is our policy to collect all amounts owed on the day services are rendered prior to your session. Please provide complete payment information for billing which will occur on the day of each session. DEBIT/CREDIT CARDS and CASH are accepted. ***Checks will not be accepted.***

Full Name as seen on Card: ____

Client's Name if different from Cardholder: ________________________________

Type of Card: (*please circle*) VISA ~ MASTERCARD ~ AMEX ~ DISCOVER ~ HSA Card

Card Number: ______________________________

Expiration Date: ______________CSV: ______________ Billing Zip Code: __________

_________ ☐ I confirm that the information provided above is true and accurate (***Please initial***)

_________ ☐ My signature below gives authorization to bill my credit card for services on the day of each session. (***Please initial***)

_________ ☐ I understand that my card will be billed if I fail to cancel within 24 hours of my scheduled appointment or no-show the appointment at a full session fee. (***Please initial***)

If payment is taken over the phone due to card information update or payment being made on behalf of a client that is not the cardholder, I authorize information obtained to be used to make payment for therapy sessions with my consented therapist.

Signature of Card Holder: ________________________ Today's Date ______________

*Your completed form will be placed on file for authorization records. Your receipt and/or bank statement will show Embrace, Embrace Square, or IPID or IPID Square as billing services (**not the name of your therapist**)*

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

Your counselor 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within this clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of this clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your counselor 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 the counselor is asked for information for purposes outside of treatment, payment or health care operations, he/she will obtain an authorization from you before releasing this information. He/she will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes your counselor has made about your conversations during a private, group, joint, or family counseling session, which have 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) the counselor or his/her representatives has 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

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If your counselor has reasonable cause to believe that a child has been abused, he/she must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If your counselor has 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, he/she must report that belief to the appropriate authority.

- *Health Oversight Activities* – If your therapist is the subject of an inquiry by the Georgia State Board of Examiners of Psychologists, protected health information regarding you may be disclosed in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the counseling services provided to you by an intern or the records thereof, such information is not privileged under state law, and may be released subject to a court order. An effort will be made to inform you in advance if this is the case.

- *Serious Threat to Health or Safety* – If your counselor determines, or pursuant to the standards of his/her intended profession should determine, that you present a serious danger of violence to yourself or another, he/she may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – Your counselor 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.

IV. Patient's Rights and Counselor'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, your counselor 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 alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor. On your request, the counseling center 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 the mental health and billing records used by your counselor to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor or a designated agent of the counseling center 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. Your counselor or a designated agent may deny your request. On your request, your counselor or a designated agent 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 counselor or a designated agent 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.

Duties:

- The counseling center is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

- The administration of the counseling center reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, it is required that the center abides by the terms currently in effect.

- If these policies and procedures are revised, you will be notified by mail at your last known address.

V. Complaints:

If you are concerned that your counselor or this counseling office has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact:

Director: Lyresa McGriff, LPC @ (678) 664-4311

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

Embrace Counseling and Consulting reserves the right to change the terms of this notice and make new notice provisions effective for all PHI that it maintains. You will be provided with a revised notice by electronic delivery and/or by your therapist. An updated copy is available for review in the waiting room of Embrace Counseling and Consulting, LLC.