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)

Parents Name: Mother ______________________________ **Father**______________________________

Adolescent's Name: ____
Street Address: ____
City: ____________________ County: ____________________ State: _____ ZIP: __________
Phone# ______________________________ 2ndary# ______________________________
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**	**MO D**	**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: ____

____

____

Embrace Counseling and Consulting, LLC

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Consent to Treatment

(Please initial each section!!!)

_______ I acknowledge that I have received and 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. **I know that I must call to cancel an appointment at least 24 hours before the time of the appointment**. 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. If you are a self-pay Client (Not using insurance), you will receive a good faith estimate from your therapist via in writing or email correspondence. 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 reserves the right to use an attorney or collection agency to secure payment. If you are utilizing your insurance, you will be responsible for any client balances not paid by insurance based on the contracted rate of reimbursement. (ie…copayments, deductibles and co-insurances) EAP services are billed however, if information received fails to deliver payment for insurance due to incorrect information from client, client is aware that payment for services will be charged to card on file and reimbursed once payment is received for services rendered.

_______ 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 $950.00 for one-half (1/2) day to be paid five (7) 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.

________ (**Clinical Intern Acknowledgment**) I acknowledge that I have received notification that I am receiving therapy services from a Master's Clinical Intern who is under the Direction and Supervision of Embrace Counseling and Consulting, LLC/Lyresa McGriff, LPC

________ (**Clinical Intern Acknowledgement**) I understand that I may be asked to have a session recorded (Audio or clinician facing Only) to assist in providing clinical training of assigned intern for treatment services. These recordings would only be for assessing the intern and their continued education to meet graduation and licensure requirements. Recordings will be disposed of at the end of each semester and/or quarter term.

______ 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/ Guardian/Parent attest that underaged clients can receive therapy services.

____ ______________________________

Signature of Therapist or (*Intern if applicable*) 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

Embrace Counseling and Consulting, LLC

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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

Number:____ Expiration Date: ________________________

CSV: _________________ Billing Zip Code: _____________________

(**Please initial**) _________ ? 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**) _________ ? I understand that my card will be billed for any balances due for self-pay or from insurance balances deemed client responsibility based on contracted rate.
(**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 (**<u>not the name of your therapist</u>**)

Embrace Counseling and Consulting, LLC
Where Grace, Love and Hope Greet You at the Door
Privacy Practices for your Review and Records

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The terms of this Notice of Privacy Practices (“Notice”) apply to [**Embrace Counseling and Consulting, LLC**], its affiliates and its employees/Contractors. [**Embrace Counseling and Consulting, LLC**] will only share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by [Practice Name]. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (“HIPAA”). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.
USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:
Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment, or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc. Uses and Disclosures for Payment: We will make use and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.
This is a document intended solely for general informational purposes. It does not constitute legal advice. The reader should consult with knowledgeable legal counsel to determine how applicable laws apply to the reader’s specific circumstances. Since it is possible that the laws or other circumstances may have changed since publication of this form, the reader should consult with knowledgeable legal counsel to discuss any action he or she may be considering as a result of reading this form.
Uses and Disclosures for Health Care Operations:
We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care. Individuals Involved in Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these

outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information. Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other

health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such a request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below. Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional.

Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information. Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such a request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:
• Any purpose required by law
• If we suspect child abuse or neglect to children/minors, elderly and disabled individuals protected by ADA/ the law
• To your employer when we have provided health care to you at the request of your employer (eg. EAP)
• Court or administrative ordered subpoena or discovery request
• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law

DISCLOSURES REQUIRING AUTHORIZATION:
Psychotherapy Notes:
We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following:
(1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you)
(2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law
(3) as required by law
(4) for health oversight activities authorized by law
(5) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
You do, however, have the right to restrict disclosure of our protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Embrace Counseling and Consulting, LLC] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records. Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Privacy Practices for your Review and Records cont'd…

You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints:

If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer.

Lyresa McGriff, LPC
(678) 664-4311