PCAH Counseling Program
Office: 706-778-3100 Fax: 706-928-5183
122 North Laurel Drive, Clarkesville, GA 30523

"Helping adults and children that have had difficult life experiences during their childhood heal & lead a more fulfilling life"

NEW CLIENT WELCOME PACKET

Our counseling program has been created to serve a child or adult survivor of childhood adversities that would not otherwise be able to afford therapeutic counseling. Based on your assessment with your counselor you will be provided with 8-10 counseling sessions at no cost. These sessions are 50 minutes long unless otherwise specified.

Our Counseling Program Goals:

- To provide a safe, caring, and compassionate environment, with competent counselors trained in effective therapeutic interventions that assist and support children, adults, and families healing from childhood trauma and abuse.
- To provide support of victims through linking them to additional community resources as well as assist them with applying for victim compensation when appropriate.

Cancellation Policy:

This resource is being provided to you at no charge and we expect you to place the same value on our services and our time by *not* cancelling appointments with your therapist at the last minute. Please if you find you must cancel your appointment, out of courtesy to our therapists and other clients on our wait list, please provide as much notice as possible with a ***preferred 24 hour notice of cancellation***. Our phone system allows you to leave a message of your need to cancel 24 hours a day. If our agency finds that you regularly miss your appointments or reschedule them at the last moment it may be in the best interest of all parties for us to exit you from our counseling program and refer you to other counseling agencies.

Contacting Your Therapist:

Our therapists only offer their time for counseling at the Family Resource Center on particular days of the week, and each have private practices outside of their contracted work for our agency. For questions, rescheduling, or cancellations please call our main number 706-778-3100. Our counseling programs is an outpatient practice, and we are set up to accommodate individuals who are reasonably safe and resourceful. Our therapists do not carry a beeper nor are they available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he/she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, our therapists will return phone calls within 48 hours during normal business office hours.

In Case of an Emergency: If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call 911 or go to your nearest emergency room
- Call GCAL 1-800-715-4225 (for all mental health emergencies 24 hours a day)

Please initial that you have read this page: _____

APPLICATION FOR SERVICES

CLIENT INFO	STATUS & EMPLOYMENT
Date of Birth:____/_____/_____Last 4 SS#_____ Name:_____ Address:_____ City:_____Zip:_____ Home #_____Cell #_____ Work #_____Other #_____ On what number may we leave a confidential message: ❒Home ❒Cell ❒Other May we text you to confirm your appointment? ❒**Yes** ❒**No**	Gender:_____ Race:_____ I am: Single ❒Married ❒Divorced ❒ How many people live in household? _____ **EMPLOYMENT** Company:_____ Address:_____ City:_____Zip: _____ Annual Income: _____ Insurance:_____

EMERGENCY CONTACT INFO

Notify:_____ Phone:_____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician:_____Phone:_____

Psychiatrist:_____Phone: _____

Please list any medical problems: _____

Please list any current medications:

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (all availability)

50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
Mornings 8am-Noon						
Afternoons 1pm-4pm						
Late-Afternoons 4pm-6pm						

ADDITIONAL INFO

Has client ever been convicted of a crime against a minor child? ❒**Yes** ❒**No**

Have you obtained services from PCAH before? **Yes/ No** If yes, when? _____

Are you currently affiliated with any of PCAH's volunteer programs? **Yes/ No**

Are you interested in group therapy? **Yes/ No** If yes, what kind?

****COMPLETE THIS FOR CHILD/ADOLESCENT CLIENTS****

PARENT/GUARDIAN (1)
Name:_____ **Phone:**_____
Address:_____
Relationship: Parent ☐ Guardian ☐ Step-Parent ☐ Foster Parent ☐ Custody:❒Yes ❒No
PARENT/GUARDIAN (2)
Name:_____ **Phone:**_____
Address:_____
Relationship: Parent ☐ Guardian ☐ Step-Parent ☐ Foster Parent ☐ Custody:❒Yes ❒No
PARENT/GUARDIAN (3)
Name:_____ **Phone:**_____
Address:_____
Relationship: Parent ☐ Guardian ☐ Step-Parent ☐ Foster Parent ☐ Custody:❒Yes ❒No
PARENT/GUARDIAN (4)
Name:_____ **Phone:**_____
Address:_____
Relationship: Parent ☐ Guardian ☐ Step-Parent ☐ Foster Parent ☐ Custody:❒Yes ❒No

Please provide information for the agencies you give permission to PCAH & your counselor to release information on the client's behalf during the course of treatment.	
Agency	**Caseworker Name & Contact Information**
Law Enforcement	
DFCS	
Guardian Ad Litem	
Attorney	
Other:	
Other:	

I give permission to my counselor & PCAH to release information to the above listed agencies during my treatment. I also give these agencies permission to share information with PCAH and my counselor during my treatment. ❒Yes ❒No

Client/Guardian:_____Date:_____

Signature:_____

If for minor print child's name:_____

HIPAA Notice
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 for Treatment, Payment, and Health Care Operations

I may *use* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. The "consent" is given when you sign the Psychotherapist-Client Services Agreement.

II. Disclosures Requiring Authorization

I may disclose PHI for purposes of treatment, payment, or health care operations with your Authorization. I may also disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission for specific disclosures, above and beyond the general "consent." In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which I have 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) I have 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

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

- *Child Abuse* – If I know or suspect that child is a victim of child abuse or neglect, I am required to report the abuse or neglect to a duly constituted authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, I must report this belief to the appropriate authorities.

- *Health Oversight Activities* – If the California State Board of Psychology is conducting an investigation into my practice, then I am required to disclose PHI upon receipt of a subpoena from the Department.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization from

you or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case

- *Serious Threat to Health or Safety* – I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).

IV. Client's Rights and Counselor's Duties

Client's Rights

• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am 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 me. On your request, I will send your statements and communications to another address.

• Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless I make a clinical determination that access would be detrimental to your health. On your request, I 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. I may deny your request. On your request, I 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, I 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 from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

• I am required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will post the Notice on my website (www.pcahabersham.org).

- A copy of the Notice is available on request.

V. Complaints

- If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may discuss this with me at this office. You may file a written complaint to You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on February 5, 2017

I will limit the uses or disclosures to the minimum necessary.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting it on my website (www.pcahabersham.org). A copy is available on request.

Please acknowledge that you have read HIPAA Notice of Privacy Practices

Print Name Adult/Guardian:_____

Signature of Adult/Guardian:_____

If for minor print Child's Name:_____

Date:_____

Technology Statement

Cell Phones & Texting:

<u>Text messaging is only to be used for appointment confirmation if consent is given on application.</u>

Please never send a text message with dialogue that discusses your case to your counselor. We cannot guarantee receipt of a text message and they cannot provide you with the privacy that you are entitled to as our client. When needing to re-schedule or notify your therapist always use _____ and if no one answers leave a detailed message.

E-mail:
Though our email server is HIPAA compliant it is important for you to know that there are still risks associated with emailing private and confidential information. Emails will become part of your clinical record. Do NOT communicate urgent needs via email.

Social Media:
We do NOT communicate via any social media outlets with clients enrolled in our counseling program to ensure your privacy and confidentiality.

Technology is continuously changing and evolving and new ways of communicating emerge frequently. Please direct any questions or concerns you may have with your therapist for further clarification.

In Case of an Emergency

Our counseling program is an outpatient practice, and we are set up to accommodate individuals who are reasonably safe and resourceful. Our counselors do not have 24-hour availability and if at any time this does not feel like sufficient support, please inform your counselor. The two of you can discuss additional resources or transfer your case to a clinic with 24-hour availability. If you have a mental health emergency, we encourage you not to wait for your next appointment, but to do on or more of the following:

- Call Laurelwood Hospital at 770-531-3800 or Peachford Hospital at 770-454-5589
- Call the Suicide Prevention Hotline at 1-800-273-8255
- Call the Youth America Hotline (teens counseling teens) at 1-877-968-8454
- Call 911 or go to your nearest emergency room
- **Call GCAL 1-800-715-4225 (for all mental health emergencies 24 hours a day)**

Please initial that you have read this page: _____

PATIENT RIGHTS AND RESPONSIBILITIES
CONSENT FOR TREATMENT

Confidentiality, Limits of Confidentiality & Records: Your communications with our counselors will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet. Additionally, our counselors will always keep everything you say to them completely confidential, with the following exceptions: (1) you direct one of them to tell someone else and you sign a "Release of Information" form; (2) The counselor determines that you are a danger to yourself or others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) Your counselor is ordered by a judge to disclose information. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed, and our counselors and agency will do everything in their power to keep what you say confidential.

Professional Relationship:
Psychotherapy is a professional service your counselor will provide to you. Because of the nature of therapy, your relationship with he/she must be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your counselor were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you overall and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. To offer all our clients the best care, the counselor's judgment needs to be unselfish and purely focused on your needs. Therefore, your relationship with our counselors must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends may also need to have you do what they advise. A therapist offers you objective choices and empowers you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. Therapists are required to keep the identity of their clients a secret. As much as our counselors would like to, he/she will not address you in public unless you speak to him/her first. They also must decline any invitation to attend gatherings with your family or friends, or to accept "friend" requests on Facebook or any other social media. Lastly, when your therapy is completed, he/she will not be able to be a friend to you like your other friends, as you may want counseling from him/her sometime in the future. In sum, it is our counselor's duty to always maintain a professional role. Please note that these guidelines are not meant to be impolite in any way; they are strictly for your long-term protection.

Patient Rights: Confidentiality is a privilege protected by law and ethics of the counseling profession that allows for strict private discussion of issues that concern you. Exceptions include: Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself or others. Also, it is required by law to report any form of child neglect or abuse.

Respect and Non-Discrimination are part of your treatment regardless.

Telephone Consultations: refer to the occasional need to consult briefly by phone. For these necessary and brief consultations, there is no charge. However, if you desire further assistance, we can either schedule an earlier office appointment.

Child Care Release PCAH does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting rom. Minors must be picked up following their appointments on time. If you must be leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

Additional Rights and Responsibilities In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason. You have the right to question any aspect of your treatment with your counselor. PCAH reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of the expectations presented in this Client Welcome Packet, a change or reevaluation by your counselor of your therapeutic needs, our agency's ability to address those needs, or other circumstances that lead PCAH to conclude in its sole and absolute discretion that your counseling needs would be better served at another counseling facility. Under such circumstances, PCAH will suggest an appropriate counselor(s) or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this signed Client Welcome Packet and this consent form and give permission to PCAH to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

Print Name Adult/Guardian:_____

Signature of Adult/Guardian:_____

If for minor print Child's Name:_____

Date:_____

POLICIES ON DIVORCE AND/OR CUSTODY CASES

COUNSELOR'S ROLE as Child/Adolescent Therapist: Children benefit from having a place and a space to work through their emotions about their parents' divorce. Often, young children do not have the words to express what they are feeling but the feelings can be played out and worked through in play therapy. Older children benefit from talking about the divorce and gaining support and insight from the counseling relationship. This professional provides a safe and confidential space for children to express and work through their emotions and feelings. Parents are provided parenting recommendations as part of the therapy. The child therapist can provide an interview and/or a summary of treatment with the GAL or the Custody Evaluator but it is NOT in the child's best interest for a therapist to testify in court as it can destroy the therapeutic relationship and hurt the child causing the child to feel betrayed. Child therapists do NOT provide any opinion regarding custody. *Child therapists report suspected or disclosed abuse to proper authorities which may lead to a forensic investigation/interview but child therapists do not issue opinion on whether or not abuse has occurred.*

LITIGATION: POLICIES ON DIVORCE AND/OR CUSTODY CASES:

Our Counselors and agency is not custody evaluators and cannot make any recommendations on custody. We can refer you to a licensed professional who DOES provide custody evaluation if needed. Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you must agree before we enter a counseling relationship.

1. We require a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.

2. In most cases we need to have contact and written/signed consent with/from both legal guardians before we see the child for counseling. In the case there is a final-decision maker on health related issues who wants the child to be seen for counseling even in the case the other parent does not agree, it is to the discretion of your therapist as to whether the child will be seen.

3. We will provide an interview with any court-ordered Guardian ad Litem (GAL) and/or custody evaluator (CE) whom the court has ordered will have access to the child's records and any time spent speaking with the GAL or CE will be billed to and paid by you, the client at our court-related-fee hourly rate.

4. We will be in equal contact with both parent who share in the legal custody of the child being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

5. Family sessions may be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

6. We require all clients waive right to subpoena any of our therapists to court. By signing this Agreement, you are acknowledging and agreeing NOT to have us subpoenaed to court. This policy is set in order that we can preserve the integrity of the therapeutic progress and relationship with you and/or your child(ren). There are exceptions to this and we can discuss further should the issue arise and this policy needs to be waived.

7. In the case the above policy regarding subpoenas and court is waived (or disregarded) and one or our Counselors are subpoenaed to appear in court -- even with a waiver of this policy– you will be billed for the full standard fee for Court Related work of $400/hour for all professional time. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $400 per hour and must be paid in advance. Any reduced fee granted will not apply to court related work.

Client Name (Please print) _____ Client Signature: _____

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Parent or Legal Guardian Signature Date

Therapist Signature: _____ Date: _____