COMPASSION COVE
COUNSELING, LLC

Informed Consent for Treatment

CLIENT'S RIGHTS & RESPONSIBILITIES

Confidentiality

Confidentiality is an important part of the mental health/ substance use disorder treatment/therapy process. It means that unless you give us written permission, we may not give any information about you to anyone outside of Compassion Cove Counseling, LLC. If you and another adult (someone 18 years of age or older) are seen together, BOTH of you must agree in writing before any information can be released. There are specific times however, when the law requires us to give information about you with or without your consent:

1. When required by subpoena or court order
2. To report known or suspected instances of abuse, exploitation, or neglect of children and elders.
3. To warn another person that you have threatened his or her life.
4. When you are a danger to your own life.

Risks and Benefits of Therapy

While mental health/substance use disorder therapy can be an effective mode of treatment for a variety of life problems, positive results cannot be guaranteed. One major benefit that can be gained from participating in treatment/therapy includes a better ability to handle or cope with family and other interpersonal relationships. Other benefits relate to the potential to resolve specific concerns brought to treatment/therapy. Seeking to resolve issues between family members and other person can similarly lead to discomfort, frustration and relationship changes not originally intended. Compassion Cove Counseling, LLC therapists focus on the relational nature of therapeutic problems. At any time, you may ask your therapist to explain more about how they work, why they are gathering information, or why they are prescribing a particular approach.

Supervision

Lisa Hedden is currently licensed as an Associate Professional Counselor and is a National Certified Counselor. Lisa is under the licensed supervision of Dr. David Lane and the direction of Compassion Cove Counseling Practice Manager, Melanie Gulley.

Safety Protocol

If you have suicidal or homicidal thoughts during the course of completing the initial assessment, we will stop the assessment, I will contact my supervisor immediately, and you will simultaneously contact the Georgia Mental Health Access line at 800-715-4225 for professional assistance immediately.

Appointments

Ongoing appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with fewer than 24 hours' notice, my policy is to collect the standard session fee [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. If and when you make the decision to end therapy, I ask that you allow for a final session to allow us time to terminate our relationship with care. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Legal Services & Court Testimony

If your involvement in any legal matter that leads to any Compassion Cove Counseling, LLC. therapist being subpoenaed or court ordered to appear in court on your behalf, you will be charged $250.00 per hour for the time that the therapist spends preparing to testify, travel to and from court, waiting to appear, testifying, depositions, attorney correspondence/communication affidavits, etc. You are responsible for and agree to pay these charges whether or not the therapist ultimately testifies. An initial five-hour retainer is required to be paid prior to the court date.

Emergency Procedures

If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department or call the Georgia Crisis and Access Line for any mental health emergency 1-800-715-4225.

Complaint Resolution Procedures

The staff of Compassion Cove Counseling, LLC wants to know that you are satisfied with your individualized program. We also understand that with any ongoing relationship there may be times of conflict. It is important to all of us that you feel any of your complaints or concerns are heard. The following is a guideline and timeframe for filing complaints. The first person to call should you have any problem is your therapist. You should expect to have he/she help you resolve the conflict within two (2) business days. Should you feel uncomfortable bringing your concerns to your therapist or feel that the situation has not been resolved to your satisfaction; you can contact your therapist's supervisor at the Compassion Cove Counseling, LLC's office at (770) 810-5789. You can expect this situation to be resolved within five (5) business days. Again, we believe that in working together to address conflict and

concerns can only serve to help you reach your goals through the services that are provided by Compassion Cove Counseling, LLC.

Mandated Reporting Statement

As required by our regulatory agencies, the following information is provided:
Compassion Cove Counseling, LLC does not support nor condone the use of corporal punishment at any time. Under state law, all supervisors, therapist, employees, and affiliates of Compassion Cove Counseling, LLC are mandated reporters of child and elderly abuse and neglect. That is, we are required to make a report to the appropriate county office of the Department of Family and Children Services or related department when there is reasonable cause to believe that an elderly person or a child under the age of 18 years old has had physical injury inflicted upon him or her by a parent/caretaker by other than accidental means, has been neglected or exploited by a parent/caretaker or has been sexually assaulted or sexually exploited.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my voice mail and your call will be returned as soon as possible, but it may take a day or two 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 my practice.

Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. If and when you make the decision to end therapy, I ask that you allow for a final session to allow us time to terminate our relationship with care. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Acknowledgement of Consent to Treat

I have read Compassion Cove Counseling, LLC's Policies and Practices regarding care and treatment, and I both understand and agree to proceed as outlined above.

Signature of Client/Legal Guardian or Legally Authorized Representative	Date
Client/Legal Guardian (Print Name)	
Therapist Signature	Date
Therapist Name (Printed)	

Protecting Your Privacy

NOTICE OF COMPASSION COVE COUNSELING, LLC'S 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

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

II. Uses and Disclosures Requiring Authorization

We 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 we asked for information for purposes outside of treatment or health care operations, we will obtain an authorization from you before releasing this information. We will also obtain authorization from you before using or disclosing PHI in a way that is not described in this Notice. We will also need to obtain an authorization before releasing your Psychotherapy Notes.

"Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we 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.

III. Uses and Disclosures with Neither Consent nor Authorization

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

Child Abuse

If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

Adult and Domestic Abuse

If we have 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, we must report that belief to the appropriate authority.

Health Oversight Activities

If we are the subject of an inquiry by the Georgia Composite Board, Georgia Board of Psychological Examiners, or other applicable Georgia Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
Judicial and Administrative Proceedings—If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such

information is privileged under state law, and we will not release information without your written consent 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

If we determine, or pursuant to the standards of the mental health profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

Worker's Compensation

we 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.

Exceptions

When the use and disclosure without your consent or authorization is allowed under other sections of Section164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease of FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Therapist'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, we are 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 therapists. At your request, we 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 your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.

Right to Amend

You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we 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, we 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 us upon request, even if you have agreed to receive the notice electronically.

Right to a Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

Right to Be Notified if There is a Breach of Your Unsecured PHI

You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessments fails to determine that there is a low probability that your PHI has been compromised.

Therapist's Duties

We are required by law to maintain the privacy of PHI and to provide you with a notice of your therapist's legal duties and privacy practices with respect to PHI. We reserve the right to modify the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. In the event of a modification, we will provide you with a revised notice by mail or by a posting in the waiting room, which you will see on your next visit.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Managing Partner of Compassion Cove Counseling, LLC. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Financial Responsibility

Client maintains full responsibility for paying all charges for services rendered. Payment for services rendered is due before or on the date services are rendered. Compassion Cove Counseling, LLC accepts payment by credit card only. Client agrees to keep a valid credit card on file throughout the duration of treatment.

Acknowledgement of Policies and Practices to Protect the Privacy of Your Health Information

I have read Compassion Cove Counseling, LLC's Policies and Practices to Protect the Privacy of Your Health Information, and I both understand and approve of its content. I also have been offered a copy of the above policy.

Signature of Client/Legal Guardian or Legally Authorized Representative	Date
Client/Legal Guardian (Print Name)	
Therapist Signature	Date
Therapist Name (Printed)	

Please read, initial and sign below:

_____I have read and understand the above statement concerning the limits of confidentiality, the risks and benefits of therapy, payment and cancellation policy, and emergency procedures. I do hereby seek and consent to take part in treatment provided by Compassion Cove Counseling, LLC. I understand that if payment for the services I receive is not made, the therapist may stop treatment. My signature below indicates my informed consent to receive services and reflects that I understand and agree with all of the above statements. I have been given the opportunity to ask questions regarding this information.

____I understand that the fees for services are payable at the time of service. I understand that I am financially responsible for all charges.

____I understand that at no point shall a person under the age of 14 be left unattended in any waiting areas. Compassion Cove Counseling's staff is not responsible or liable for any person left in the waiting areas.

____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, I will be charged the session fee for that appointment.

____ I acknowledge I have been given the option to receive a copy of Client's Rights & Responsibilities, received an orientation of services, and give my voluntary consent for treatment.

____ I acknowledge I have received the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I acknowledge that I was given the option to receive a copy of the "Notice of Compassion Cove Counseling LLC's Policies and Practices to Protect the Privacy of your Health Information" and that I have read (or have the opportunity to read, if I so choose, again).

____ Informed Consent: By affixing my signature to this form, I acknowledge that I have read, understood, and agreed to all of the polices detailed above and in the notice of Compassion Cove Counseling LLC's Policies and Practices to Protect the Privacy of your Health Information. A staff member of Compassion Cove Counseling, LLC has reviewed the forms with me and I have been given the option to receive a copy of each form. I have had the opportunity to ask questions regarding these forms/ policies.

Signature of Client/Legal Guardian or Legally Authorized Representative	Date
Client/Legal Guardian (Print Name)	
Therapist Signature	Date
Therapist Name (Printed)	

Compassion Cove
Counseling, LLC

Consent to Correspond Electronically

Name: _____
Date of Birth: _____

While the therapists that practice at Compassion Cove Counseling, LLC take reasonable precautions to protect my confidential information, I understand that email, text messages and other sources of electronic communication are not completely secure methods of communication.

I understand that electronic communication (emails and/or texts) is not a way of communicating new information regarding care or of communicating emergency needs. I further understand I must speak with my therapist directly regarding all important information pertaining to my (or my child's) treatment. Although my therapist will attempt to reply in a timely fashion, I further understand that if I (or my child) am experiencing an emergency situation and need to contact someone immediately to help me, then I will call any of the emergency numbers that have been provided to me. I grant my therapist and/or staff of Compassion Cove Counseling, LLC permission to communicate with me via email, text message and any other electronic means.

I further affirm that my therapist has a social media policy, and pursuant to that policy assert that I will not attempt to connect with my therapist, without my therapist's prior written consent, on any social media platform that includes, but is not limited to: Facebook, Twitter, Instagram, Snapchat, or any other current or future social media platforms where my therapist maintains a presence. I acknowledge that if I use an electronic means of communication to initiate with my therapist regarding my care (or my child's care), the therapist, and/or staff of Compassion Cove Counseling, LLC has my permission to correspond via that email address, text message, or other forms of electronic communications.

I acknowledge that I have the choice for my therapist or staff to include identifying information when e-mailing me.

_____By initialing here, I allow my therapist and/or staff to send e-mails and/or text messages to me with identifying information without encryption.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative | Date

_____

Client/Legal Guardian (Print Name)

_____ _____

Therapist Signature | Date

_____

Therapist Name (Printed)

Authorization for Release of Information *(Optional)*

Name: _____

Date of Birth: _____

Client/Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

____ I hereby authorize Compassion Cove Counseling, LLC to RELEASE my protected health information (PHI) to (List names of persons to whom you would like us to release your records):

_____

_____

_____

____ I hereby authorize Compassion Cove Counseling, LLC to OBTAIN my protected health information (PHI) from (List names of person(s) from whom you would like us to obtain your records):

_____

_____

_____

1. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization conforming to all

requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for **(CHECK ONE)**:

_____The period necessary to complete all transactions on accounts related to services provided to me.

_____One (1) year

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

Signature of Client/Legal Guardian or Legally Authorized Representative	Date
Therapist Signature	Date
Therapist Name (Printed)	

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

Date this authorization is revoked by Individual Signature of Individual or legally authorized Representative

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me at 3754 Lavista Road, Suite 200, Tucker, Georgia 30084.

Signature of Client/Legal Guardian or Legally Authorized Representative	Date authorization is revoked
Therapist Signature	Date
Therapist Name (Printed)	