

Ray of Hope Counseling Service, Inc.

Welcome, thank you for choosing Ray of Hope Counseling Services, Inc. This document is designed to answer some frequently asked questions about myself, the counseling process, our professional relationship, confidentiality, and your financial obligations. As you read this feel free to mark any places which are not clear to you or write in any questions which come to mind, so we can discuss them. Both of us need to be clear as to what your needs are and how I can best serve those needs. This will allow us to work most productively and comfortably together. So, in order to accomplish this, we will enter the necessary information in the provided spaces, as well as sign and date the appropriate pages. You will have the original for your periodic review. If our work together uncovers a problem area beyond my expertise, I will help you obtain services from an appropriate specialist.

This document (the agreement) also contains important information about my professional and business policies. You also have the right to obtain or review summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have given you the opportunity to review HIPAA regulations. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The therapists at Ray of Hope Counseling Services are trained and specialize in a wide variety of areas. The therapists at Ray of Hope Counseling Services are licensed by the state of Georgia and at a minimal have obtained a Masters degree from a fully accredited school. In addition, the therapists at Ray of hope Counseling Services have a diverse background in training. Please feel free to ask me any specific questions that pertain to my clinical background, approach, and training.

The ultimate goals of counseling would be to gain self-awareness into what is disturbing you; explore and understand your thoughts, feelings, and behaviors; to seek a greater sense of happiness and contentment; and for you to choose and maintain behavioral changes. To achieve these goals, some persons need only a few sessions, whereas others may require months or even years. Each therapy session will be fifty minutes in length.

I expect and encourage you to obtain knowledge of the procedures, goals and possible side effects of therapy. I will try to make our professional relationship one where you will receive the maximum benefits. I will also keep you informed about alternatives to counseling. Counseling may be tremendously beneficial for some individuals. At the

same time, there are some risks. These may include the experience of intense and unwanted feelings including sadness, anger, fear, guilt, or anxiety. These feelings may be natural and normal and can be an important part of the counseling process. Other risks of therapy might include recalling unpleasant events, facing unpleasant thoughts/beliefs, increased awareness of feelings, and or alteration of your ability or desire to deal effectively with others in a relationship. In counseling, major life decisions are sometimes made. As your counselor, I will be available to discuss any of your assumptions, problems, or possible negative side effects of our work together. Although there may be negative side effects to counseling, benefits of counseling have been scientifically demonstrated. Benefits might include the lifting of depression, fear, anxiety, or helplessness. You may be better able to cope with social or family relationships and find them more satisfying. You may better understand yourself, your goals, values, and grow and mature personally.

To achieve the ultimate goals of counseling, you need to have information and understanding of how counseling works. Counseling requires a large commitment of your time, energy, and money, so it is important that you be comfortable and optimistic with me. However, if you are dissatisfied with me for any reason, I would greatly appreciate you discussing your feelings or thoughts with me. If at any time, you wish to consult with another therapist or get another opinion, I will help you find a suitable professional. Therapy is not like visiting a medical doctor, in that therapy requires your active involvement and efforts to change your thoughts, feelings, and behaviors. You will have to make an active effort both in our meetings and between our meetings. There are no instant, painless, or passive cures – “no magic pills.” Instead, there will be serious exploration of your history, feelings, thoughts, behaviors, and how you interact with others. There may be “homework” where you will have to think and feel, observe yourself and how you interact, and even complete assignments, exercises, keep diaries, or other projects. Change sometimes is easy and swift. However, for the most part, change is slow, frustrating, and requires hard work and dedication on your part. I will assist and help you in all of your struggles along the way.

I do not take on a client whom, in my professional opinion, I cannot help using the knowledge and techniques I have available. If I do not feel that I can be of help, I will refer you to others or agencies which would be better able to serve your needs. If necessary, I will make these referrals at our initial conversation on the telephone or in our initial meetings. In some cases it takes multiple meetings to assess one’s needs or we may come to a point where I feel that I can no longer meet your needs. If that occurs, we will talk about the issues and I will direct you to the person or services, which will be better able to serve your needs.

Contacting Me

Due to my schedule, I am often not immediately available by phone. I am usually with clients. Therefore, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exceptions of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, call 911 or go to the closest

emergency room. If you are unable to reach me and feel that you can't wait for me to return you call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for extended time, I will provide you with the name of a colleague to contact, if necessary.

Confidentiality

I regard the information and feelings you have expressed with me, with the greatest respect. In general, I will tell no one what you tell me. The privacy and confidentiality of our conversations and records are a privilege of yours and is legally protected by state law and my ethical principles. However, Insurance companies, but more likely, managed care companies (HMO, PPO, etc.) may ask for my progress notes for more detailed information on your symptoms, diagnosis, issue or my treatment plans or methods. For managed care, after a certain number of visits or an amount of time, I have to submit a treatment plan. The treatment plan consists of all identifying information, diagnosis, treatment goals and approach, and other information. I will review these treatment plans with you at any time. However, after submitting a treatment plan or billing to managed care company or insurance company. In today's world, everything is entered into a computer. Your name, diagnosis, and information/issues could be obtained by someone else. I try to enter on a treatment plan or claim form the minimum information necessary. You will always have the choice of using or not using your insurance.

In addition, there are certain situations where what you say and who you are may be discussed or heard by another person. I may consult with another colleague regarding some aspect of your situation. I may at times talk with other persons, such as your physician, attorney, social service worker, or another mental health professional. However, if I need to speak with one of these professionals I will obtain a signed release of information form from you.

Secondly, upon occasion, I am away from the office. I have a trusted fellow therapist to "cover" for me at all times. He or she will be available for emergencies or anything urgent. If I feel that you may call while I am away, I will let him or her know in order to enable him or her to be better able to respond.

Thirdly, by law, I am required to report any evidence of child abuse or strong suspicions of child abuse or neglect. I am also mandated to report abuse of handicapped or elderly persons.

Fourth, if subpoenaed to provide information in a court of law, I will first assert client-therapist privilege, if it applies. However, I can be ordered by a judge to disclose that information.

Fifth, parents have the right to any and all information regarding you dependent. Because the presence of trust is important in the therapeutic relationship between your dependant and myself it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and

understand the nature of your dependants' treatment and the progress being made. If your dependant is able to understand the issues of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have any objections to the manner in which information is shared with you regarding your dependant, we will need to resolve those differences before therapy begins.

Finally, if in my judgment, I feel any person is a serious and immediate risk of harming him/herself or another person, or will engage in criminal behavior, I will break confidentiality. I will notify other family members, the person to who harm is intended or the police in order to maintain safety.

To repeat, confidentiality will be maintained. It is only under the above situations that information will be imparted to others. Thus, you and your records have the privilege of privacy and confidentiality, but there are limits and boundaries. Please feel free to discuss your confidential exceptions with me at any time. This is particularly important from the onset of our meetings.

Termination

Termination is inevitable and it should not be done casually. Either of us may terminate our work together if we believe it is in your best interest. I will suggest a tentative termination date and plan, after at least three sessions. If you agree, then we will follow this plan. You can terminate at any time. I ask that we discuss the termination before we actually stop in order to review goals and accomplishments, and any future issues to resolve later. Finally termination means we have met our goals, but we can always work together again in the future. Termination is never final and the door will always be open for you at any time.

Associates

Please be advised that there are various persons who work in the same office as me. Knowing there are other people in the office that may become aware of you being a client, you agree to hold any other professional in the office as harmless and/or not liable for any legal or civil action.

Patient Rights

HIPPA provides you with several new or expanded rights with regard to your clinical record and disclosure of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information in your clinical record is disclosed to others; requesting an accounting of most disclosures of protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to paper copy of this agreement, the attached Notice Form, and privacy policies and procedure. I am happy to discuss any of these rights with you.

Billing and Payment

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another agreement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Due to the rising cost of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care Plans as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Your signature allows me to submit a treatment plan to request further time or number of visits. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that your contact with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share information with a national medical information databank. I will provide you with a copy of any treatment plan I submit, if you request it. By signing this Agreement, you

agree that I can provide requested information to your carrier. However, it is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CLIENT INFORMATION

Clients Name: _____

Date of Birth: _____ **Age:** _____

Client's SS# _____

Insurance Information:

Policy holder's Name: _____ DOB: _____ SS# _____

Married__ Divorced__ Single__ Remarried__ other__

Address _____ City, State, Zip: _____

Home Phone _____ Work Phone _____

Employer _____ JobTitle _____

Referred By _____

Previous Counseling:

__no __yes Clinician's Name _____

Issues Addressed _____

Spouse's Name _____ (1st __ 2nd __ marriage)

Spouse's Address _____ Home phone _____

Spouse's Employer _____ work Phone _____

Children: Please provide name(s) and age(s) _____

IF CLIENT IS A MINOR OR LEGAL DEPENDANT

Parent/Guardian Name: _____

Address: _____ City, State, Zip _____

Home# or cell# _____ Work #: _____

Nearest Relative in case of Emergency:

Name: _____ Address: _____

City, State, Zip: _____ Phone (HM) and (Cell) _____ (Wk
Phone) _____

THIS INFORMATION IS FOR ASSESSMENT PURPOSES

Physical Health/ Symptoms

- Headache Vomiting
- Diarrhea Dizziness
- Chestpain Shortness of Breath

Function/Activity

- Fatigue Little/No Sleep
- Weight Loss Weight Gain
- Academic/Work Inhibition
- Loss of Interest or Pleasure

Duration of Symptoms:

- Excessive Worry
- Self-Injury
- Substance use/Abuse
 - Alcohol__
 - Drugs__
 - Other__

Emotional Symptoms

- Hopelessness Anxiety
 - Anger Tearful
 - Panic/Anxiety Suicidal Thoughts
 - Indecisive Fearful
- Other: _____
-
-
-

Current Medications:

Medication	Strength	How Often	Prescribed By	Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Past Medications (if applicable)

Individual/Family History

Physical Abuse Sexual Abuse
 Domestic Violence Rape
 Arrests Hospitalization

The three biggest problems in my life right now are:

1. _____

2. _____

3. _____

Patient Communication Preferences

Our office will need to contact you to schedule and/or reschedule appointments, to schedule follow-up visits and other such administrative issues.

To ensure that your privacy is maintained to the fullest extent possible, please select the method by which our office can contact you.

Home phone _____

Leave message? Yes _____ No _____

Cell Phone _____

Leave message? Yes ___ No _____

Home email _____

Work phone _____

Leave message? Yes _____ No _____

Work e-mail _____

US Mail _____

Your signature and date below indicate that you have been given the opportunity to review or obtain a copy of the HIPPA Notice and that it is your responsibility to ask any questions.

Name _____ Date _____

Witness _____ Date _____

Your signature and date below indicate that you have read the treatment agreement and agree to abide by its terms during our professional relationship.

Name _____ Date _____

Witness _____ Date _____