Client Name: _____ **DOB:** _____ **Insurance:** _____ **MR#** _____

Greater Vision Counseling & Consulting Agency, PLLC

Client Intake Information Sheet

Date: _____ **Referral Source:** _____ **MR#:** _____

Client Name: _____ **If Female, Maiden Name:** _____

Preferred Name: _____ **Other Names Used:** _____

DOB: _____ **Age:** _____ **Social Security #:** _____

Address: _____ **City**_____ **State**_____ **Zip**_____

Preferred Phone #: _____ **Primary Language:** _____

What type of communication do you prefer? ☐ Email ☐ Text ☐ Phone **Can message be left:** ☐ Yes ☐ No

Email Address (if applicable): _____

Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow
Race:	☐ American Indian ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Multiracial
Gender:	☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Prefer not to say ☐ Other: _____
Ethnicity:	☐ Cuban ☐ Puerto Rican ☐ Hispanic or Latino ☐ Not Hispanic/Latino ☐ Mexican ☐ Other _____
Education Level:	☐ High School Diploma ☐ GED ☐ Some College ☐ Type of Degree_____ Grade Level: _____
Employment:	☐ Employed FT ☐ Employed PT ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed
Military Status:	☐ Active Duty ☐ Retired ☐ Reservists/National Guard ☐ Type of Discharge: _____

Legal Guardian:	**Phone:**	**Relationship:**
Emergency Contact:	**Phone:**	**Relationship:**
Place of Employment:	**School: (name and grade)**	

Primary Care Physician: _____**Name of Agency:**_____ **Phone:** _____

What medical conditions do you have? ☐ None ☐ **Other:** _____

_____

Other Physicians/Psychiatric: _____ **Phone #:** _____

Any current diagnosis: _____

Are you currently taking medications? ☐ Yes ☐ No If yes, please list or specify below:

_____

_____

_____

Number in Household: _____ **Annual Household Income:** _____ **Sliding Fee:** _____

Client Name: _____ **DOB:** _____ **Insurance:** _____ **MR#** _____

Client Clinical Intake

Office use only

Presenting Problem by Age/Disability:	☐ AMH ☐ CMH ☐ ADD ☐ CDD ☐ ASA ☐ CSA
Competency:	☐ Competent ☐ Incompetent ☐ Minor **Need Severity:** ☐ EMERGENT ☐ URGENT ☐ ROUTINE

Brief Description of Presenting Problem: _____

_____

Have you ever been convicted of a crime: ☐ Yes ☐ No If yes, explain: _____

Allergies: ☐ Yes ☐ No If yes, please list with reaction: _____	**Have you been hospitalized in the past?** ☐ Yes ☐ No If yes, explain: _____
Are you Pregnant ☐ Yes ☐ No ☐ N/A	**Are your living arrangements stable?** ☐ Yes ☐ No If no, explain: _____
Substance Use (DSM-5: Substance Use Disorders) ☐ Alcohol use concerns ☐ Drug use concerns ☐ Misuse of prescription medications ☐ Cravings or loss of control over use	**Safety Concerns (DSM-5: Risk Indicators)** ☐ Thoughts of self-harm ☐ Suicidal thoughts ☐ Thoughts of harming others ⚠ **If checked, immediate clinical follow-up is required**
Mood & Emotional Symptoms (DSM-5: Depressive Disorders, Bipolar Disorders) ☐ Sadness / depressed mood ☐ Loss of interest or pleasure (anhedonia) ☐ Mood swings / elevated mood ☐ Irritability / anger ☐ Feelings of hopelessness or worthlessness ☐ Excessive guilt	**Behavioral & Functional Concerns (DSM-5: ADHD, Disruptive/Impulse-Control Disorders)** ☐ Difficulty concentrating ☐ Poor motivation ☐ Withdrawal from others ☐ Difficulty completing tasks ☐ Impulsive or risky behaviors ☐ Defiance / oppositional behavior.
Thought-Related Symptoms (DSM-5: Psychotic Disorders, OCD) ☐ Racing thoughts ☐ Intrusive or unwanted thoughts ☐ Obsessive thoughts ☐ Compulsive behaviors ☐ Confusion / disorganized thinking ☐ Suspiciousness / paranoia	**Sleep & Physical Symptoms (Cross-cutting DSM-5 symptoms)** ☐ Trouble falling or staying asleep ☐ Sleeping too much ☐ Fatigue / low energy ☐ Changes in appetite or weight
Trauma & Stress-Related Symptoms ☐ Nightmares / Flashbacks ☐ Easily startled / Hypervigilance ☐ Avoidance of reminders of trauma ☐ Feeling emotionally numb	**Behavioral & Functional Concerns** ☐ Difficulty concentrating ☐ Poor motivation ☐ Withdrawal from others ☐ Difficulty completing daily tasks ☐ Impulsive or risky behaviors

What services are you most interested in?	☐ Therapy ☐ TCM ☐ Intensive In-Home ☐ Peer Support ☐ Other _____

Name of Person Completing Form: _____ ***Date:*** _____

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Consumer Acknowledgement

24-Hour Behavioral Health Crisis Coverage

Greater Vision Counseling & Consulting Agency PLLC is committed to ensuring that all clients have access to behavioral health crisis support 24 **hours per day, 7 days per week.**

After-Hours Crisis Support:

If you are experiencing a **behavioral health crisis outside of normal business hours**, please contact:

Greater Vision Counseling & Consulting Agency PLLC Crisis Line
Phone: 910-638-8299

- Calls will be **returned within 15 minutes**
- This line is intended for **urgent behavioral health needs requiring immediate attention**

Emergency Situations: If you are experiencing a **medical emergency or are in immediate danger**, please: **Call 911 immediately**, or Go to the **nearest emergency room**

Coverage in Provider Absence: If your assigned provider is unavailable after business hours:

- You will be directed to contact **910-638-8299**
- Crisis support may be provided by:
  - An on-call licensed clinician, or
  - A contracted agency with a formal coverage agreement to ensure continuity of care

Response Expectations

- Crisis support is available 24/7
- Urgent needs will be addressed promptly (within 15 minutes for crisis calls)
- Non-emergent concerns will be addressed within 24 hours

Client Acknowledgment

I acknowledge that I have received information regarding Greater Vision Counseling & Consulting Agency PLLC's 24-hour / after-hours behavioral health crisis coverage.

I understand:

- **This contact information is for behavioral health crises occurring outside of regular business hours**
- **I may access support by calling the number provided above**
- **In the event of a life-threatening emergency, I should call 911 or go to the nearest emergency room**
- **The agency ensures 24-hour access to crisis support, including coverage when my assigned provider is unavailable**

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

PSYCHOTHERAPY DISCLOSURE STATEMENT & INFORMED CONSENT

Welcome to **Greater Vision Counseling & Consulting Agency, PLLC**. This document outlines your rights, expectations, and important information regarding psychotherapy services. Please review carefully and discuss any questions with your provider.

1. NATURE OF PSYCHOTHERAPY

Psychotherapy is a collaborative process that requires your active participation, honesty, and openness to change. Together, we will:

- Develop an individualized treatment plan
- Establish goals and interventions
- Review progress regularly and adjust as needed

You may be referred to additional services (e.g., medical, psychiatric, or supportive services) when clinically appropriate. You have the right to accept or decline any recommendation.

Termination of services may occur:

- At your request
- If services are no longer clinically appropriate
- In cases of threats, harassment, or unsafe behavior

Referrals will be provided when possible.

2. RISKS AND BENEFITS

Therapy may involve emotional discomfort, increased awareness, or temporary worsening of symptoms. However, benefits may include:

- Improved mood and functioning
- Enhanced relationships and coping skills
- Increased insight and emotional regulation

No specific outcomes can be guaranteed.

3. CONFIDENTIALITY & PRIVACY (HIPAA COMPLIANT)

Your information is confidential and protected under HIPAA and applicable state laws.

Information will not be disclosed without your written consent except when required by law, including:

- Suspected abuse or neglect of a child or vulnerable adult
- Risk of harm to yourself or others
- Court orders or subpoenas
- Medical emergencies

Special Considerations:

- **Couples Therapy:** Information shared individually may be disclosed in joint sessions
- **Minors:** Parents receive general updates; session details remain confidential when clinically appropriate
- **Family Therapy:** Confidentiality will be clarified at the start of services

You will receive a Notice of Privacy Practices.

4. RECORDS

- Clinical records are maintained securely in compliance with HIPAA
- Diagnoses are based on DSM-5 criteria
- You may request access to your records in writing (subject to clinical review)

5. CLIENT RIGHTS

You have the right to:

- Right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation.
- Right to live as normally as possible while receiving care and treatment.
- The right for protection from abuse, financial, retaliation, humiliation, and neglect.
- Right to receive age-appropriate treatment, access to medical care and habilitation, and the right to written person-centered treatment plan that reflects an individual's desired goals and outcomes.
- Right to be informed in advance of the potential risks and alleged benefits of the treatment and program options
- Right to confidentiality.
- The right to access or referral to legal entities for appropriate representation.
- The right to access to self-help and advocacy support services.
- Right to be free from unnecessary or excessive medication. Medication shall not be used as punishment, discipline, or for staff convenience.
- All voluntary consumers have the right to consent to or refuse treatment offered; including valid opportunity to consent to or refuse planned interventions.
- Right to request notification after occurrence of any or specified interventions.
- Right to be informed of emergency procedures
- Right to exercise all civil right, to dispose of property, execute instruments, make purchases, enter into contractual relationships, register to vote, bring civil actions, marry and divorce – unless the consumer has been adjudicated incompetent.
- Right to certain safeguards and carefully controlled circumstances when interventions are used.
- Right to social integration, self-governance groups and treatment in the least restrictive, most appropriate environment.
- Right to be free from corporal punishment, neglect, abuse and exploitation.
- Right to be free from physical restraint and isolation time out except when there is imminent danger of abuse or injury to self or others or when substantial property damage is occurring.
- The right to investigation and resolution of alleged infringements of rights.

6. FEES & PAYMENT

- Initial Assessment: **$160.00**
- Individual Sessions: **$100** (or insurance contracted rate)
- Payment is due at time of service

Additional Fees:

- Returned checks: **$35**
- Administrative services: **$25 per 20 minutes**
- Consultations (e.g., IEP meetings): **$150/hour**
- Court-related services:
  - Retainer: **$1,500**
  - Ongoing: **$150/hour**
  - Court day fee: **$500/day**

Unpaid balances may result in service interruption or collections.

7. COMPLAINTS & GRIEVANCES

If you have concerns, you are encouraged to first discuss them with your provider.

You may also contact:

Greater Vision Counseling & Consulting Agency, PLLC
632 W. Prospect Avenue, Raeford, NC 28376
Phone: 910-638-8299/ 910-875-5590

Disability Rights NC Social Work
877-235-4210

NC Social Work Licensure Board
800-550-7009

8. CONSENT FOR SERVICES

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

By signing below, you acknowledge that:

- You have received and understand this document
- Your questions have been answered
- You voluntarily consent to assessment and treatment
- You understand you may withdraw consent at any time

No guarantees have been made regarding treatment outcomes.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Telehealth Informed Consent

Purpose

Telehealth uses secure, two-way audio and video technology to provide healthcare services when the consumer and provider are in different locations. Telehealth may be used for outpatient therapy, assessments, diagnosis, treatment, follow-up, education, and the secure exchange of health information. Telehealth systems will include appropriate security measures designed to protect the confidentiality, privacy, and integrity of consumer information.

Benefits and Risks

Potential benefits of telehealth include improved access to care, increased convenience, timely evaluation and treatment, and access to qualified providers who may be located in another geographic area.

Possible risks include technology or connection failures, service delays, limitations in the quality of transmitted information, and the unlikely possibility of a privacy or security breach. If a connection is interrupted and cannot be restored, the provider will make reasonable efforts to continue the service through an appropriate alternative or reschedule the appointment.

Consumer Rights and Acknowledgment

By signing this consent, I understand that:

1. Privacy and confidentiality protections that apply to in-person healthcare also apply to telehealth services.
2. My health information may be electronically communicated to healthcare professionals involved in my care when necessary and authorized.
3. I have the right to access information maintained in my medical record in accordance with applicable laws and agency policies.
4. I have the right to ask questions regarding telehealth services, including the technology being used, potential risks, benefits, and available alternatives.
5. I may withdraw my consent for telehealth services at any time, subject to applicable agency procedures, without affecting my right to future care or treatment.

Consumer Consent

I have read and understand the information provided regarding telehealth services. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily consent to receiving healthcare services through telehealth.

☐ **I authorize the agency to use telehealth** for assessment, treatment, therapy, follow-up, and other appropriate healthcare services.

Request for Alternative Communication

Clients have the right to request an **alternative method of communication** if they are unable or prefer not to participate in services through telehealth. Alternative communication methods may include telephone, in-person services, or another appropriate and available method approved by the agency.

Clients may request an alternative method of communication at any time by notifying their provider or agency staff. The agency will make reasonable efforts to accommodate the request based on the client's needs, preferences, clinical appropriateness, and available resources. Requesting an alternative method of communication will not negatively affect the client's access to care or services.

Communication Preference

☐ I am comfortable receiving services and communications through telehealth and **do not** require an alternative method at this time.

☐ I **request** an additional or alternative method of communication. **Preferred Method:** _____

Additional Communication Needs/Accommodations: _____

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Greater Vision Counseling & Consulting Agency, PLLC

Authorization for Use and Disclosure of Protected Health Information

I hereby request and authorize **Greater Vision Counseling & Consulting, PLLC** to ☐ release ☐ obtain and/or ☐ exchange information with:

Agency/Individual: _____
Address: _____
Telephone Number: _____

Dates of records to release: ☐ All Dates or ☐ From: _____ to _____

Method of Delivery: **(check all that apply, charges may apply)** ☐ US Mail ☐ Fax ☐ Email (encrypted) ☐ Pick-up at office ☐ Other: _____

Nature of records to be released: (***Client/Guardian must check beside each applicable document***)

- ☐ Admission Assessments/Screening
- ☐ Treatment Recommendations
- ☐ Needs Assessment
- ☐ Progress/Psychotherapy Notes
- ☐ Medications/Lab Results
- ☐ AIDS/HIV
- ☐ Other: _____
- ☐ Treatment Plans/Service Plan
- ☐ Psychiatric Evaluations/Psychological Evaluations
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Substance Abuse/Legal History
- ☐ School Attendance/Education Information

I understand the purpose of the disclosure/redisclosure will be used for: (***Client/Guardian must check beside each applicable document***)

- ☐ Insurance/Medicaid/Medicare determination of benefits
- ☐ To assist in the development of individual treatment/service plan
- ☐ Provide data to assist with evaluations/assessment
- ☐ To assist in securing benefits from entitlement programs
- ☐ Coordination of services between agencies

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions G.S. 130A-143 shall be strictly confidential.

I understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year **(364 days)** from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Greater Vision Counseling & Consulting Agency PLLC** will begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information indicated by initials will be disclosed.

I understand Substance Abuse records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Paragraph 2, and cannot be disclosed with written authorization unless otherwise provided for in the regulations.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Greater Vision Counseling & Consulting Agency, PLLC

Authorization for Use and Disclosure of Protected Health Information

I hereby request and authorize **Greater Vision Counseling & Consulting, PLLC** to ☐ release ☐ obtain and/or ☐ exchange information with:

Agency/Individual: _____
Address: _____
Telephone Number: _____

Dates of records to release: ☐ All Dates or ☐ From: _____ to _____

Method of Delivery: **(check all that apply, charges may apply)** ☐ US Mail ☐ Fax ☐ Email (encrypted) ☐ Pick-up at office ☐ Other: _____

Nature of records to be released: (***Client/Guardian must check beside each applicable document***)

- ☐ Admission Assessments/Screening
- ☐ Treatment Recommendations
- ☐ Needs Assessment
- ☐ Progress/Psychotherapy Notes
- ☐ Medications/Lab Results
- ☐ AIDS/HIV
- ☐ Other: _____
- ☐ Treatment Plans/Service Plan
- ☐ Psychiatric Evaluations/Psychological Evaluations
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Substance Abuse/Legal History
- ☐ School Attendance/Education Information

I understand the purpose of the disclosure/redisclosure will be used for: (***Client/Guardian must check beside each applicable document***)

- ☐ Insurance/Medicaid/Medicare determination of benefits
- ☐ To assist in the development of individual treatment/service plan
- ☐ Provide data to assist with evaluations/assessment
- ☐ To assist in securing benefits from entitlement programs
- ☐ Coordination of services between agencies

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions G.S. 130A-143 shall be strictly confidential.

I understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year **(364 days)** from signature date.

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I understand Substance Abuse records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Paragraph 2, and cannot be disclosed with written authorization unless otherwise provided for in the regulations.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Consent for Electronic Health Information Exchange (eHIE)

What is Electronic Health Information Exchange (eHIE)?

A Health Information Exchange (HIE) is a secure, electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway.

Benefits.

- A full "picture" of a person's health, including ambulatory visits, hospitalizations, and medications
- Reduction in valuable staff time spent phoning and faxing other providers involved in a client's care to track down health information
- Timely access to important health events as they happen to clients (near, real-time notifications)
- Improved, more accurate and timely medication reconciliation that reduces errors and avoids unnecessary tests
- Access to test results, reducing costly duplicative tests and gaps in treatment

Opt-Out or IN

☐ Request to Opt-In ☐ Request to Opt-Out

Privacy & Security.

The N.C. Health Information Exchange Authority's privacy and security safeguards meet or exceed federal, state and local requirements, including the:

- HIPAA Privacy Rule
- Health Information Technology for Economic and Clinical Health (HITECH) Act

Only participating health care providers and other HIPAA-covered entities that have signed contracts with the NC HIEA will be able to access clients' medical information through NC HealthConnex. Client data may also be provided to third parties who have entered into contracts with NC HIEA for limited purposes (e.g., the N.C. Department of Public Health for immunizations). These contracts ensure that all relevant privacy statutes and regulations are followed in how health information is viewed, used and shared. NC HIEA also has the power to audit the use of client information by each participating practice and each third party to ensure that the law is being followed.

NOTICE OF PRIVACY PRACTICES

Greater Vision Counseling & Consulting Agency, PLLC needs to collect accurate health information about you and share it with your healthcare team here so they can diagnose and treat you properly. Sometimes, we may need to send your health information to other providers outside our agency if they offer services we don't. It is our legal duty to protect your health information and make sure it's not shared without permission while we provide care, get payment, and handle other health-related services.

This Notice of Privacy Practices explains how your health information may be used by Greater Vision Counseling and Consulting Agency, PLLC and why it might be shared with other service providers outside our agency.

This Notice explains your rights to protect your health information and how you can use those rights. It also gives you the names of people to contact if you have questions or comments about how **Greater Vision Counseling & Consulting Agency, PLLC**, keeps your health information private.

Please read this document carefully and ask for help if there's anything you don't understand.

Client Acknowledgement

I have received the Notice of Privacy Practices from **Greater Vision Counseling & Consulting Agency, PLLC**. This document explains how the agency keeps my health information private while providing me with care. My signature below acknowledges that I understand all of the statements contained in this document. I understand that further education will be provided as needed or upon request.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Note: Greater Vision Counseling & Consulting Agency, PLLC retains the signed page. The client retains the Notice of Privacy Practices document.

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

CONSENT FORM FOR AUDIO/VIDEO RECORDING, PHOTOGRAPHY, AND USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES

Greater Vision Counseling and Consulting Agency PLLC is committed to providing quality services through various communication methods, including in-person and technology-based services. This consent form outlines your rights and responsibilities related to audio and video recording, photography, and the use of information and communication technologies (ICTs) for service delivery.

1. Consent for Audio and Video Recording and Photography: ***I understand and agree that:***
I understand and agree that:

- My sessions may be audio/video recorded or photographed for clinical, training, or documentation purposes if I provide specific consent.
- The purpose of such recordings will be explained, and I have the right to withdraw consent at any time.
- Any recordings or photographs will be securely stored and used in compliance with privacy laws and organizational policies.

☐ **I CONSENT** to the recording/photographing of my sessions.
☐ **I DO NOT CONSENT** to the recording/photographing of my sessions.

2. Consent for Decision-Making on ICT vs. In-Person Services: ***I acknowledge that:***

- At the beginning of services and throughout the course of services, my provider and I will discuss whether in-person or ICT-based service delivery is most appropriate.
- My provider will ensure that all necessary technology and equipment are available and functional before starting a session.
- Any transition between in-person and ICT services will be made with my informed consent, except in emergency situations.

☐ **I AGREE** to discuss and decide on service delivery methods with my provider as needed.

3. Technology and Equipment Functionality Verification: ***I acknowledge that:***

- My provider and I will confirm that all necessary technology and/or equipment is functional before each session.
- My provider will assist me in troubleshooting any issues that arise before or during service delivery.
- If technology failure prevents effective service delivery, alternative arrangements will be made.

☐ **I UNDERSTAND** that I must ensure the availability and functionality of my technology before a session.

4. Identity and Location Verification: ***I understand that:***

- At the start of each ICT-based session, my provider will verify my identity and physical location.
- I will provide accurate information about my location and any changes that may impact on service delivery.
- My provider's identity will also be verified at each encounter.

☐ **I CONSENT** to identity and location verification as part of ICT-based service delivery.

5. Privacy and Security During Service Delivery: ***I agree to:***

- Maintain a private and secure environment during ICT-based sessions.
- Avoid recording or sharing sessions without explicit consent from my provider.
- Notify my provider if my privacy is compromised during a session.

☐ **I AGREE** to maintain privacy and security during ICT-based sessions.

6. Response to Technology Disruptions: ***I acknowledge that:***

- If technology disruption impacts service delivery, my provider will work with me to restore the connection or reschedule the session.
- Alternative communication methods may be used if necessary (e.g., phone call, secure messaging, in-person session).

☐ **I UNDERSTAND and ACCEPT** the plan for responding to technology disruptions.

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

7. Emergency Procedures for ICT-Based Services: ***I acknowledge that:***

- My provider will identify an emergency contact and phone number before starting ICT-based services.
- My provider will ensure that I have access to local emergency resources, including phone numbers for crisis response teams, law enforcement, and medical services in my area.
- My provider will become familiar with emergency procedures at my location and discuss how to handle crises that arise during ICT-based sessions.
- If an emergency occurs during a session, my provider may contact emergency services or my designated emergency contact as necessary.

Emergency Contact Name: _____ **Emergency Contact Phone Number:** _____

Local Emergency Resources and Phone Numbers: _____

☐ **I UNDERSTAND and CONSENT** to the emergency procedures outlined above.

8. Right to Withdraw Consent

I understand that I have the right to withdraw or modify my consent at any time by providing written notice to my provider. My provider will discuss any changes to my service delivery options based on my decision.

CLIENT TRAINING SHEET: SERVICE DELIVERY USING INFORMATION TECHNOLOGIES

ACKNOWLEDGEMENT

I acknowledge that I received the Service Delivery Using Information Technology with the following:

1. Features of Service Delivery	2. Setup Instructions	3. Use of Services
4. Maintenance	5. Safety Considerations	6. Infection Control

Client Acknowledgment and Signature

I have read and understand this consent form. I have had the opportunity to ask questions, and my provider has explained this form to me. By signing below, I voluntarily consent to the terms outlined in this document.

_____	_____	_____
Client or Legal Guardian Signature	*Relationship*	*Date*
_____		_____
Witness Signature		*Date*

Client Name: _____ **DOB:** _____ **Insurance**: _____ **MR#** _____

Greater Vision Counseling & Consulting Agency, PLLC

Financial Agreement *(please print)*

CLIENT INFORMATION							
Client Name:			**MR#**		**Gender:** ☐ **Male** ☐ **Female**		
Date of Birth:	**SS#:**		**Phone Number:**		**County:**		
Current Address:		**City**		**State**	**Zip**		

INSURANCE INFORMATION							
Name of Primary Insurance:		Effective Date:		Name of Secondary Insurance:		Effective Date:	
ID#	Group #	Copay		ID#	Group #	Copay	
Subscriber's Name:		DOB:		Subscriber's Name:		DOB:	
SS #	Subscribers Phone Number:			SS#	Subscribers Phone Number:		
Relationship to Prescriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				Relationship to Prescriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

☐ I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff and **Greater Vision Counseling & Consulting Agency**. I therefore authorize the staff and personnel to release my or my child's information to the insurance company listed above for the purpose of determining and receiving benefits for bills.

☐ I understand payment is expected on the day of treatment. If a change of employment or other situations occurs which may affect my ability to pay in any way, I agree to notify my services provider and request a review of the above information. I have been informed of the provider's policy for patient fees and the fee schedule has been explained to me. I agree to pay all fees for treatment, which has been established based on my ability to pay.

☐ Insurance/Medicare Applicable – I understand my health insurance may cover a portion of treatment costs, and I hereby consent for services to be billed to my insurance company and agree for any benefits to be assigned to my service provider. By acceptance of this assignment of benefits, the service provider agrees to accept the approved charge as total cost for services. I further understand I am responsible for co-payments as determined by the insurance company. I have been informed and understand if I refuse to allow my insurance company to be billed, I will be required to pay the full charge for services.

☐ I understand that if I miss a session without canceling or cancel with less than **24 (twenty-four) hours' notice**, or no show, for non-emergency reasons, I will be charged **$75.00**. I understand that **Greater Vision Counseling & Consulting Agency** cannot bill these sessions to my insurance. Medicaid clients cannot be charged a no-show fee. After (3) no-shows for any client, the client will be discharged from services.

☐ I authorize **Greater Vision Counseling & Consulting Agency** or my insurance company to release any confidential information required to bill and be paid for services. Furthermore, I authorize payment directly to my therapist and hereby assign my right to reimbursement to **Greater Vision Counseling & Consulting Agency.**

I have read the above, understand, and accept the policies described herein. I certify that the above information is complete and accurate and understand all information is subject to verification by Greater Vision Counseling & Consulting Agency, PLLC.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Name: _____ DOB: _____ Insurance ID: _____ MR#: _____

Greater Vision Counseling & Consulting Agency, PLLC
Disclosure of Information

Date of Disclosure	Person/Entity to Whom Information is Sent	Address of Person/Entity Receiving Information	Brief Description of Information Disclosed	Purpose of Disclosure	Legible Signature of Person Sending Information (Method Used: Fax/Email/Mail)

GIVE THIS COPY TO CLIENT

CLIENT TRAINING SHEET: SERVICE DELIVERY USING INFORMATION TECHNOLOGIES

1. Features of Service Delivery: Face-to-Face Services:

- Delivered in-person at designated clinic or community-based settings.
- Provides direct interaction with providers for assessments, therapy, and support.
- Includes access to support services (e.g., group therapy, medication management).

Telehealth Services:

- Provided via secure video conferencing platforms.
- Real-time virtual access to therapists, case managers, or medical providers.
- Offers flexibility and access for clients in remote or underserved area

2. Setup Instructions: For Face-to-Face Visits: 1. Arrive 15 to 20 minutes early. 2. Bring necessary documents (ID, insurance, list of medications).
3. Check-in at front desk and follow posted signs or staff directions.

For Telehealth Visits:

- Ensure a private, quiet space with good lighting.
- Use a device with a camera and microphone (smartphone, tablet, laptop).
- Log into the designated platform (e.g., Zoom, Doxy.me, ICAN, etc.) 5–10 minutes before the session.
- Click the secure link sent to your email or phone.

3. Use of Services

- Participate actively in your treatment plan.
- Ask questions and express concerns freely.
- Follow up on recommendations or referrals.
- Maintain scheduled appointments; notify if you need to cancel or reschedule.

4. Maintenance: Face-to-Face: Keep contact info updated. And Notify staff of any changes in health, medications, or emergency contacts.

- Telehealth: Regularly update your software or app. 1. Maintain internet connectivity. 2. Charge your device before appointments.

5. Safety Considerations

- In case of emergency (medical or psychiatric), call 911 or go to the nearest emergency room.
- Inform staff of any safety concerns at home or during sessions.
- For Telehealth, do not join sessions while driving or in unsafe settings.
- Comply with all clinic safety protocols, including building security, PPE (if applicable), and emergency evacuation plans.

6. Infection Control (Face-to-Face)

- Masks and hand sanitizers are available.
- Please reschedule if you are experiencing symptoms (fever, cough, etc.).
- Rooms are sanitized regularly.
- Social distancing may be required as per current public health guidelines.
- Provided via secure video conferencing platforms.
- Real-time virtual access to therapists, case managers, or medical providers.
- Offers flexibility and access for clients in remote or underserved area

GIVE THIS COPY TO THE CLIENT

NOTICE OF PRIVACY PRACTICES (SHORT FORM)

Greater Vision Counseling & Consulting Agency, PLLC

Effective Date: August 23, 2024

Your Privacy Matters

Greater Vision Counseling & Consulting Agency, PLLC is required by law to protect your health information. This includes mental health, -substance use, and medical information.

We use your information to:

- Provide treatment and coordinate care
- Bill for services
- Improve the quality of care we provide

We will only share your information as allowed by law or with your written permission.

When Your Information May Be Shared Without Your Permission

We may share your information when required or permitted by law, including:

- Medical emergencies
- Risk of harm to yourself or others
- Suspected abuse or neglect
- Court orders or legal requirements
- Public health and safety concerns

Additional Protections for Substance Use Information (42 CFR Part 2)

If you receive substance use disorder services, your records are protected under federal law (42 CFR Part 2). This means:

- Your substance use information cannot be shared without your written consent, except in limited circumstances allowed by law
- Unauthorized disclosure is prohibited
- You may revoke your consent at any time

Federal law prohibits anyone receiving this information from redisclosing it without your written permission or as otherwise permitted by law. Violations may be reported to appropriate authorities.

Your Rights

You have the right to:

- Receive a copy of this notice
- Request to see or get a copy of your records
- Request corrections to your records
- Request limits on how your information is shared
- Request confidential communication (different address/phone)
- File a complaint without fear of retaliation

Communication

We may contact you by phone, text, email, or mail for:

- Appointment reminders
- Follow-up care
- Information about services

You may request how we contact you.

Authorization

We will not share your information for reasons not listed above without your written permission. You may revoke your authorization at any time.

Questions or Complaints

Corporate Compliance Officer
Greater Vision Counseling & Consulting Agency, PLLC
632 W Prospect Avenue, Raeford, NC 28376
Phone: (910) 875-5590

You may also contact the U.S. Department of Health and Human Services Office for Civil Rights.