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

Spouse's Name: _____ **Phone #:** _____

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 # _____ **Relation:** _____

Emergency Contact: _____

Phone #: _____ **Relation:** _____

What is your occupation: _____ **Employer:** _____

If Student; Name of School: _____ **Phone #:** _____

Type of Insurance: _____ **Secondary Insurance:** _____

Policy Holder's Name: _____

Primary Care Physician: _____ **Phone #:** _____

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

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

Client Clinical Intake

Office use only

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

Presenting Problem by Age/Disability: ☐ AMH ☐ CMH ☐ ADD ☐ CDD ☐ ASA ☐ CSA

Brief Description of Presenting Problem: _____

_____

Competency: ☐ Competent ☐ Incompetent ☐ Minor **Need Severity:** ☐ EMERGENT ☐ URGENT ☐ ROUTINE

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

What medical conditions do you have? ☐ **None**

☐ Diabetes ☐ High Blood Pressure/Hypertension ☐ High Cholesterol ☐ Heart Disease ☐ History of Stroke ☐ History of Heart Attack ☐ Hepatitis ☐ Liver Disease ☐ Thyroid Disease ☐ Migraines ☐ Asthma ☐ Chronic Pain _____ ☐ Arthritis ☐ Osteoporosis ☐ Sleep Apnea ☐ Allergies ☐ COPD or Emphysema ☐HIV or AIDS ☐ Other medical conditions not listed:

_____

What mental health conditions do you have? ☐ **None**

☐ Depression ☐ Anxiety ☐ PTSD ☐ Bipolar I ☐ Bipolar II ☐ Obsessive Compulsive Disorder ☐ ADD/ADHD ☐ Schizoaffective Disorder ☐ Autism Spectrum Disorder ☐ Eating Disorder ☐ Substance ☐ Use Disorder (sober or currently using) ☐ Alcoholism (sober or currently using) ☐ Cancer ☐ Other mental health conditions not listed:

_____

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

_____

_____

_____

_____

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 you a risk to yourself or others? ☐ Yes ☐ No If Yes, explain: _____

Are you in need of Detox? ☐ Yes ☐ No If yes, explain: _____

Are you Aggressive or Self-Injurious? ☐ Yes ☐ No If yes, explain: _____

Are your living arrangements stable? ☐ Yes ☐ No If no, explain: _____

Do you feel safe in your living situation? ☐ Yes ☐ No If no, explain: _____

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

PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Welcome to Greater Vision Counseling & Consulting Agency, PLLC. We appreciate your giving us the opportunity to be of help to you. This document answers some questions regarding the practice of psychotherapy. At Greater Vision Counseling & Consulting Agency, PLLC, it is important to us that you know how we will work together. After you read this, we will discuss in person how these issues apply to your own situation.

WHAT YOU CAN EXPECT FROM PSYCHOTHERAPY

Psychotherapy requires your very active involvement. It will be important for you to be honest with me about your feelings, emotions, and experiences. Therapy is most effective when you feel trust in our therapeutic partnership and are open to change and the uncomfortable feelings that may be associated with stepping outside your typical way of viewing life, yourself, and others.

We will plan our work together. I expect us to agree on a plan that we will both work hard to follow. In our treatment plan, we will list the areas to work on, our goals and the methods we will use. From time to time, we will look together at our progress and goals and if we think we need to, we can make changes.

Many different techniques will be utilized in order to work towards increasing your self-awareness and personal growth. Techniques may include dialogue, education, relaxation strategies, reframing negative thoughts, art and writing exercises, or role-playing positive communication techniques. An important part of your therapy will be practicing the new skills you learn. I will ask you to practice outside our meetings, and we will work together to set up homework assignments for you. You can expect the unfamiliar feelings often associated with change to dissipate as you begin to incorporate the various techniques into your life.

Change will sometimes be easy and quick, or it may be slow and frustrating. There are no instant cures and no "magic pills." However, you can learn new ways of looking at your problems that will be very helpful in developing more positive ways of coping with your current situation.

I may refer you to other professionals, such as doctors, nutritionists, or other supportive services if I feel that you would benefit from additional resources. I believe in a collaborative approach and would request you to fill out a release of information form, so that I may talk with these other professionals. You may, as with all aspects of your treatment, decline such recommendations.

The process of ending therapy, called "termination, " can be a very valuable part of your work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy, I ask that you agree now to meet then for at least one session to review our work together. We will review our goals, the work we have done, and future work that needs to be sone, as well as our choices.

The following are two expectations to our joint decision to end therapy. **(1)** If I am, in my judgment, not able to help you because of the nature of your presenting concerns/diagnosis/medical illness or because my training and skills are, in my judgment, not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. **(2)** Verbal or physical threats, harassment, and violence towards me, my family, or my co-workers may result in an immediate and unilateral termination of treatment. If I terminate you from therapy, I will offer you referrals to other sources of care but cannot guarantee that they will accept you for therapy.

THE BENEFITS AND RISKS OF THERAPY

As with any treatment, psychotherapy involves some potential risks. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

While you consider these risks, you should know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. For example, people who are depressed may find their mood lifting. In this therapeutic partnership, you will have a chance to talk things out fully. You may find that your relationships and coping skills improve greatly. You may experience more satisfaction out of social and family relationships, work, school or a renewed sense of hope.

ABOUT CONFIDENTIALITY

In all but a few rare situations, you have the absolute right to the confidentiality (that is, the privacy) of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. Under the provisions of the Health Care Information Act of 1992, I will always act so as to protect your privacy even if you do release me in writing to share information about you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). This law insures the confidentiality of all electronic transmission of information about you. You will be given a copy of my Notice of Privacy Practices and you will be asked to sign a client consent for the use and disclosure of protected health information.

In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional or a family member some information to protect your life.

The following are legal expectations to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect. In any of these situations, I would reveal only the information that is needed to protect you or the other person.

- **a.** If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services.
- **b.** If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I am not obligated to do this and would explore all other options with you before I take this step. However, if at that point you were unwilling to take steps to guarantee your safety, I would call the police.
- **c.** If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- **d.** If your records are subpoenaed by court order, I may be required to disclose confidential information.

The next is not a legal exception to your confidentiality, However, it is a policy you should be aware of if you are in couples therapy with me.

If you and your partner decide to have some individual sessions as part of the couple's therapy, what you say in those individual sessions will be a part of these couples therapy and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Children and families create some special confidentiality questions.

- **a.** Confidentiality also extends to parents. Other than the exceptions listed above, I will not share with you the specifics of what your child said or did during a session unless your child gives me permission to do so. I will, however, talk with you on a regular basis about your child's therapeutic progress, treatment goals, your expectations for therapy and your concerns and hopes for your child.
- **b.** In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes, any limits on confidentiality that may exist and my role.
- **c.** We also request that you respect the right of confidentiality of others that you may see at this practice. We ask our clients not to disclose the identity of those they may see coming or going, as everyone has the right to decide with whom they share this information.

RECORDS

All of our communication becomes part of the clinical record. Diagnoses are technical terms that describe the nature of the client's problems and whether they are short-term or long-term. All diagnosis will be discussed with the client prior to placing it in the client's record. Client diagnoses are from the book entitled DSM-V; I have a copy in my office. Records are the property of my agency, but you have the right to the information with your record. Clients have the right to receive a copy of their file/record upon a written request. I will maintain your records in a secure location that cannot be accessed by anyone else.

WHAT YOU SHOULD KNOW ABOUT MANAGED MENTAL HEALTH CARE

If your therapy is being paid for in full or in part by a managed care organization (MCO, there are usually further limitations to your rights as a client imposed by the contract of the managed care organization. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me or require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me if I am not on their list. If you use your health insurance to help pay for psychotherapy, you must allow me to tell the MCO about your problem (give it a diagnosis). I am required to give a diagnosis in order to be paid for the services provided.

MY ROLE IN OUR THERAPEUTIC PARTNERSHIP

I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients other than the therapy relationship.

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: **(1)** My statements will be seen as biased in our favor because we have a therapy relationship; and **(2)** the testimony might affect our therapy relationship, and I must put this relationship first.

ABOUT OUR APPOINTMENTS

Initially, we will meet once a week, then less often. The frequency of our sessions will be a joint decision. An appointment is a commitment to our work. If you are late, we will be unable to meet for the full-time.

If you miss a session without canceling, or cancel with less than **24-hour notice**, for non-emergency reasons, you will be charged **$75.00**. We cannot bill these charges to your 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 request that you do not being children that are young and need babysitting or supervision, as it would be difficult for you to fully devote your attention while also attending to a small child.

ACKNOWLEDGEMENT OF PROVIDER CHOICE

I understand Greater Vision Counseling & Consulting Agency, PLLC is required to ensure that services provided are deemed medically necessary. I have been informed of my right to choose a provider from a list of service providers who provide services within my area of residence. I have been additionally informed of my right to change providers at a later date during my treatment if I so desire.

I have made the decision for Greater Vision Counseling & Consulting Agency, PLLC to render medically necessary mental health and/or substance abuse services for me. My decision was not in any way influenced by personnel from Greater Vision Counseling & Consulting Agency, PLLC, nor was payment offered.

FEES AND PAYMENT

I agree to provide psychotherapy services in return for a fee of **$160.00** for an initial session and intake. Each subsequent session fee is **$100.00**, or my insurance provider's contracted rate. Payment or co-payment for each session will be collected at the start of each session. Cash, personal checks, debit or credit cards are acceptable methods of payment. Please make out your check or have payment available before each session begins. I will provide you with a receipt for all fees paid.

If there is any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. Such problems can interfere greatly with our work. If you think you may have trouble paying your bills on time, please discuss this with me. I am not willing to have clients run a bill with me or have any overdue payments. Payment is expected at the time of service. There will be a **$35.00** charge for all returned or bounced checks. Please be aware that following the second returned or bounced check, you will be required to pay all fees in cash. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency and must end therapy at that time.

CONSULTATION

During the course of treatment, consultation may be a required and/or necessary part of your care. Payment for such will be required on the date of service. Time spent on phone consultation or attendance at school conferences, such as IEP meetings will be billed at **$150.00** an hour. Any requested administrative work, beyond what is provided at the end of each session, will be charged an administrative fee of **$35.00** for 1-20 minutes. Each additional 20-minute increment will be billed at **$35.00**.

If a court appearance is required by a court ordered subpoena, rate of **$1500.00** will be retained. This retainer must be received prior to any action being taken by your therapist. Each subsequent hour, including such actions as time spent in travel, preparations, document preparation, and consultation with attorneys or other professionals will be billed at a rate of **$150.00** per hour. In the event the client's lawyer continues to subpoena the therapist for court it will cost **$500.00** per day.

YOU HAVE THE RIGHT TO PRIVACY

You have the right to be free from any unwarranted search of your person or property. At the time of admission to a 24-hour facility, staff may search you and your belongings to prevent dangerous or illegal substances from being brought into the facility.

The facility itself may be searched if dangerous or illegal substances are reasonably believed to be present, and staff may search consumers who are minors. *Should search and seizure apply to a program from which you are receiving treatment, the specific procedures will be explained when you enter the program.*

YOU HAVE THE RIGHT TO MAKE A COMPLAINT

If you are dissatisfied with a Mental Health, Intellectual Developmental Disabilities or Substance Abuse service delivered through **Greater Vision Counseling & Consulting Agency PLLC** you have the right to state a complaint or file a grievance at any time. Before stating a written complaint, we urge you to first discuss the matter with staff of the program providing the service and allow them an opportunity to help resolve it.

YOU HAVE CERTAIN APPEAL RIGHTS

If you have Medicaid, you have the right to request an appeal hearing if you are denied a requested service, or if current services are reduced, suspended, or terminated.

If you have questions or problems, contact:

Greater Vision Counseling & Consulting Agency PLLC, 402 Harris Ave, Raeford NC 28376, 910-336-3554 or 910-875-5590 or you may contact. Disability Rights of NC or the NC Social Work Board at the following address and/or phone number.

Disability Rights NC or NC Social Work Board

This statewide agency is designated under federal and state law to protect and advocate for the rights of persons who have disabilities.

Disability Rights of NC
3724 National Drive, Ste. 199
Raleigh, NC 27612
877-235-4210 Local 919-856-2195

NC Social Work Licensure and Certification Board
Post Office Box 1043
Asheboro, NC 27204
Complaints: 336-625-1679 or Toll Free 800-550-7009

CLIENT CONSENT TO PSYCHOTHERAPY

I acknowledge that I, the client (or his or her parent or guardian), have received, have read (or have had read to me), and understand the "Informed Consent". I have discussed those points I did not understand, and have had my questions, if any, fully answered. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. Furthermore, I am aware that an agent of my insurance company or other third-party payer may be given information the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I, or as the legal guardian of _____, do hereby consent for assessment, treatment and/or other services. I consent to take part in psychotherapy services provided by Greater Vision Counseling & Consulting Agency, PLLC. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all modalities are refused, the voluntarily admitted consumer may be discharged.

A minor may seek and receive periodic services from a physician without parental consent for the prevention, diagnosis and treatment of (1) venereal disease and other diseases reportable under G.S. 130A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance.

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

My signature below shows that I understand and agree with all of the statements contained in this document. This document is a part of the Standards of Practice of the North Carolina Board of Licensed Clinical Social Workers (LCSW) and North Carolina Board of Licensed Clinical Mental Health Counselors (LCMHC).

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

Greater Vision Counseling & Consulting Agency, PLLC

Consumer Acknowledgement

24 Hour Behavioral Health Crisis Coverage

In the event of a behavioral health crisis after business hours please call Greater Vision Counseling & Consulting Agency PLLC 910-638-8299. Crisis calls will be returned within **15** minutes. In the event of a medical emergency please call 911 or have someone take you to your nearest emergency room.

Should your provider not be available after business hours, you will be instructed to call **910-638-8299**; the person/agency with whom there is a written agreement to provide coverage in your provider's absence.

I acknowledge that I have received a copy of my provider's 24 hour/ after-hours behavioral health crisis coverage number/information. I understand that this information indicates how to access support for after-hours behavioral health crises only.

The provider will be available to the client for urgent services within 48 hours as needed.

_____ _____ _____

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 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** 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 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** 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*

Greater Vision Counseling & Consulting Agency, PLLC

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
- HIPAA Security 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.

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*

NOTICE OF PRIVACY PRACTICES
OF

Greater Vision Counseling & Consulting Agency, PLLC

Greater Vision Counseling and 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 and 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 and Consulting Agency, PLLC. This document explains how the agency keeps my health information private while providing me with care.

_____ / _____

Client or Legally Responsible Representative Date

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

Greater Vision Counseling & Consulting Agency, PLLC

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:

- 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 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.

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 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*

Greater Vision Counseling & Consulting Agency, PLLC

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 areas.

2. Setup Instructions

For Face-to-Face Visits:

- Arrive 10–15 minutes early.
- Bring necessary documents (ID, insurance, list of medications).
- 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.
- Notify staff of any changes in health, medications, or emergency contacts.

Telehealth:

- Regularly update your software or app.
- Maintain internet connectivity.
- 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 experiencing symptoms (fever, cough, etc.).
- Rooms are sanitized regularly.
- Social distancing may be required as per current public health guidelines.

_____ _____ _____

Client or Legal Guardian Signature *Relationship* *Date*

_____ _____

Witness Signature *Date*

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*

Greater Vision Counseling & Consulting, PLLC
Disclosure of Information

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

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)