CONSENTS/RIGHTS INFORMATION

#### Consent for Treatment

I hereby give my consent for **Global Counseling Solutions** to provide mental health and/or substance abuse services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: Date:

#### Financial Release

I understand that **Global Counseling Solutions** may use confidential information about me to bill and be paid for services. I hereby consent for **Global Counseling Solutions** to release information to the billing agent, Integrity Support Services and/or to the funding source, and for the funding source to release information to **Global Counseling Solutions** and **Integrity Support Services** for this purpose.

Client/Parent/Guardian: Date:

#### Permission to Seek Emergency Medical Care

I hereby give consent for **Global Counseling Solutions** to seek and sign consent for emergency medical care in the event that I am in their care and become incapacitated or unable to do so for myself.

Client/Parent/Guardian: Date:

#### Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights information. A representative of Global Counseling Solutions gave me this information and verbally explained my rights as a client.

Client/Parent/Guardian: Date:

1. **Privacy Rights (See Handout)**

###### I have received and had explained to me the Privacy Rights. A representative of Global Counseling Solutions gave me this information and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: Date:

I understand that one of my rights is to be able to choose how I am contacted.

I ***do/do not*** *(please circle one)* give permission for **Global Counseling Solutions’** representative to contact by home or mobile phone.

Furthermore, I ***do/do not*** *(please circle one)* give permission for **Global Counseling Solutions’** presentative to leave voice-mail messages for me on my home or mobile phone.

I ***do/do not*** *(please circle one)* give permission for **Global Counseling Solutions’** representative to contact by email.

Client/Parent/Guardian: Date:

I, a representative of **Global Counseling Solutions,** have explained and provided copies of the following: Client Rights/Grievance Procedure and the Privacy Rights to the Client/Parent/Guardian of the client to be served.

Signature: Date:

Disclosure and Informed Consent for Treatment

Our Services and What to Expect from Us

We provide individual, couples and family counseling to assist people in finding solutions to their problems. We seek to provide an environment that is accommodating to your needs. Our goal is to help you explore options and choices that work in your best interest. Counseling can help you gain greater understanding, evaluate options and find the strength that to make positive changes. Such change requires you to be actively involved in the treatment process to include ongoing discussions of your treatment planning and progress.

Our ability to assess your needs effectively and deliver appropriate assistance is based on your willingness openly provide information. To effectively serve you we will need to inquire about many aspects of your life. Our inquiries include but are not limited to: family and social history, relationships, past treatment, substance use and abuse, trauma, physical and sexual abuse, current life circumstances and issues that brought you to treatment.

If you present with concerns that put you or others at imminent risk or harm, then we will make a referral for a higher level of care or other appropriate interventions. This may also include if substance use is impairing your ability to be safe or benefit from treatment. Provided that we are the appropriate level of care we will explore a variety of treatment interventions to assist you in meeting your needs to include: Cognitive Behavioral Therapy/interventions, Person-Centered Therapy/interventions, Motivational Interviewing, and Family Systems approaches.

If we think it is clinically appropriate, we may refer you to other professionals such as doctors and/or psychiatrist. In an attempt to work collaboratively on your behalf, we may request a release of information so we can talk to these professionals. As with other aspects of treatment, you can decline any request.

Risks of Therapy

Therapy can be accompanied by some risks. Change can be an uncomfortable process and can cause disruptions in existing relationships. This discomfort is often temporary but does occur this the process of change. Our goal is to assist you in working through difficult feelings and ultimate enhance the quality of existing relationships. However, there is no predictable time table in which change occurs and the process of change may be slow and frustrating.

Treatment does not guarantee elimination of presenting symptoms. Please note that symptoms may even worsen to include the continuation of behaviors that originally lead to the need for therapy. Some clients may not see the progress he or she is hoping for due to internal conflicts that are difficult to move past or external influences outside of the therapeutic process impeding the progress of change. Additionally, clients with a lack of commitment to explore options and try alternatives or not ready for change may not see the progress hoped for. Clients are responsible for taking the necessary steps towards change and we will provide the tools needed to facilitate change.

Appointments

Our normal business hours are Monday through Thursday from 9am-8pm, Fridays 9am to 3pm and Saturdays from 9am to 1pm. Sessions are normally 45-60 minutes however your first session will take 75-90 minutes. Because the therapeutic relationship and development of treatment goals are an important aspect of therapy, we recommend that clients have weekly appointments for the first few months of treatment. During your first session we will discuss the best plan for you.

**If you are unable to keep an appointment, please notify us immediately at 919-771-3128. For cancelations, please call within 24 hours before your scheduled appointment on Monday through Saturday (for appointments on Monday cancelations calls must be made by 12pm Saturday.) Non-adherence to our cancelation policy will result in you being charged an appropriate fee ($60.00). Missed appointment charges will be due on or before you next scheduled session.** Multiple missed appointments may result in cancelation of services. In such instances, we will attempt to refer you for other services. Additionally, we will do our best to ensure your appointment starts at its scheduled time and assure you your full session time. We also ask that you try to be on time for your appointments. We are not able to extend sessions time and you will be charged the full session fee. **If you are more than 30 minutes late, your session will be cancelled and you will be responsible for paying an appropriate fee.**

Telephone Availability During and After Hours

We are not always immediately available to you by phone. If you need to reach us but receive our VM message, please leave your message. We check our voice mails regularly and calls made by 4pm will receive a return call within the same day. Calls made after 4pm will receive a return call within 24 hours, except on weekends and holidays.

Clients in therapy may occasionally have the need for crisis intervention by phone. Please see our fee schedule below for phone consultations. **If you are having a medical emergency and you are not able to reach us by phone, please call 911 or go to your nearest emergency room.**

Insurance, Fees and Out of Network Services

Global Counseling Solutions has chosen to be out of network with some insurance companies. This means that full payment is due at the time of service. We are able to provide you with a receipt for you to submit to your insurance company or we may be able to negotiate a rate with the insurance company as an out of network provider. If you are paying the full payment at the time of service your insurance reimbursement will come directly to you. We recommend that you communicate in advance with your insurance company regarding deductibles and percentage to be refunded back to you.

There are advantages to not using insurance. When working with insurance companies and seeking reimbursement both in network and out of network, decisions about care are ultimately up to the insurance company as it relates to whether or not services are to be reimbursed. For example, insurance companies require that you meet criteria for a diagnosis in order to receive treatment and for treatment to be paid by the insurance company. This diagnosis and your treatment becomes a part of your medical record and will likely be accessible to insurers in the future. As a result, this can be considered a “pre-existing condition” and can be used to determine your insurability and the cost of various insurance policies as you seek insurance in the future.

Typically, insurance will not cover marital and couples counseling. Therefore, couple’s therapy is often paid for outside of insurance benefits. This has many advantages to include:

* We can see you as often and as long as you need without insurance restrictions.
* We can decide together on the length of sessions, focus of therapy and who can be a part of your therapy sessions.
* We do not have to give you a diagnosis that becomes a permanent part of your medical and insurance record.
* Your treatment is completely private as there are HIPAA laws that protects your confidentiality from insurance companies when you pay out of pocket.
* Out of pocket pay also gives us the flexibility to provide unlimited phone consultations, and some email correspondences without the restrictions imposed by insurance companies.

Paying for services outside of insurance assures you by law that treatment received does not need to be shared with insurance companies. There are special provisions in HIPAA regulations that allows for those who pay for medical services out of pocket to deny third parties access to their medical records. In paying out of pocket, you can choose to seek out of network insurance reimbursement.

Our fees vary depending on the services provided. Please see services and fee chart below:

Comprehensive Clinical Assessment……………… ………………………$150.00

1-hour Session………………………………………………………………$120.00

45-minute Session…………………………………………………………... $ 90.00

Brief 30 min. Session………………………………………………………...$60.00

Extended 75 min. Session……………………………………………………$135.00

Extended 90 min. Session……………………………………………………$150.00

* Respectfully, some counseling practices may charge additional fees for couples and family work however our fees for clients paying out of pocket remain as outlined above. We typically identified one individual as the identified client although in some cases we may address the symptoms of multiple individuals during a session.

Late cancellation charges (If less the 24 hours of scheduled session…100% of service scheduled.

Telephone Consultations……………………………………………$30.00 per 15mins.

Prepared Treatment Reports and Summaries………………………. $150.00 hour

Legal Proceedings to include: preparation, consultations, participation and attendance at legal proceedings and transportation………………………………………$300.00 per hour.

* Please note that the above administrative related activities are typically not reimbursable by insurance however we will provide you with a receipt per your request.

We accept checks, cash, Visa, Master Card, Discover and American Express.

* There is a $25.00 service charge for returned checks.
* Note: For our merchant services we incur a charge of up to 2.75% of each transaction however we do not pass this cost on to you, our client.

Given the current economic climate and the financial difficulties many people are facing, for clients paying out of pocket we offer reduced fees to individuals demonstrating financial hardships. Our approach is to work with you on a negotiated fee that will not incur additional hardships or stressors that could impede treatment progress.

Confidentiality & Privacy Notice

Federal and state laws are in place to protect the information that is shared between a therapists and clients. Any information you disclose to us during treatment or any information we obtain while providing care will be held confidential in compliance with HIPAA and other state PHI laws; unless you permit us to disclose such information or where we are required to disclosed information by law. This means we will not share any information about you to anyone, verbally or written unless you give us specific written consent to do so by submitting a release of information. In order to disclose any information about you we must have a release of information signed by you prior to any disclosures. Please know that privacy will not prevent others from calling to request or provide information; in such cases we will not acknowledge your status as a client unless the request is accompanied by a release signed by you.

By signing this consent for treatment and insurance authorization you are agreeing to the following:

* Allowing us to leave brief messages on your voice mail, answering machine or by email confirming, changing or cancelling an appointment.
* In order to ensure we are delivering the highest quality of care and services, we may consult with other professionals about our work with clients. We do not share any identifying information and will not disclose these consultations to you, unless you feel it would benefit treatment. These professionals must also adhere to federal confidentiality laws.
* If you are requesting out of network insurance reimbursement, we will only be able to give you the limited information needed to get reimbursement. Since we do not have contracts with all insurance companies, we will give this information directly to you and will not be able to provide it directly to the insurance company.
* In the event that contractual relationships are developed with insurance companies, your billing insurance and demographic information may be disclosed as needed to the different contractors that may be hired to do billing, collections and accounting for Global Counseling Solutions. In compliance with HIPAA, these contractors will enter into binding contracts requiring that they comply with confidentiality laws.

We also ask that you respect the privacy of others you see at this practice. Therefore, we ask that you do not disclose this identity of those you see coming and going, and to respect their right to decide with whom to share this information.

Our practice also offers group therapy sessions whereas the same rule of confidentiality applies. Group participants are to hold the disclosers of peer group member in the strictest of confidence and not disclose the personal matters of others to individuals or entities outside of group.

Confidentiality of couples: It is important to recognize that when a family or couple comes to our office for therapy, the family or couple and not just the identified individual are the client. The confidentiality of all will be upheld and will be kept private from the general public. However, when serving families and couples we have a no secrets clause which means that treatment within the context of the family and couples is open to those involve in the therapy; unless it is deemed by the therapist that such disclosure would cause more harm to the treatment process. We reserve the right to use our professional judgment about whether to maintain individual confidences from the other family members who are attending therapy sessions. Therefore, it is recommended that you do not share anything in therapy that you wish to be kept secret from your partner or family member. We will encourage any secret disclosures to during therapy to be shared by the individual making the discloser. If you are participating in family or couple’s therapy and feel it necessary to share information that you absolutely do not want shared with other members participating in the therapy, then we will recommend you seek out an individual therapist who can treat you individually. We are able to make a referral to appropriate individual therapist.

In couples and family counseling, in order to provide the safest environment possible, it is our policy not to release information requested in the future for divorce proceedings that may ensue. When you sign this disclosure and agree to the no secrets clause, you are agreeing not to subpoena my records in order to defame the character of your spouse in the process of a divorce. The exception to this is when we are treating issues of reported domestic abuse. Being that the couple or family is the client, release of PHI must be authorized in writing by both parties.

Confidentiality of Children & Families: All children and adolescents receiving therapy through Global Counseling Solutions is considered the client and the medical record will be in their name. Parents and guardians are considered the personal representatives for decisions, use and disclosure about protected health information disclosed to others. However, it is important to know that in NC minors can seek mental health and substance abuse treatment without parental consent and therefore their PHI is protected by law. Our purpose in the provision of therapy services to children and adolescents is for treatment purposes only and not to make custody decisions or assessments for such reasons. Individuals must seek out other professionals who provide this service. By signing you are agreeing not to request our assistances or records for custody issues or proceedings. The exception to this is when during treatment we observe or highly suspect abuse in which case we will discuss this with you and the appropriate authorities as we are mandated by law to report suspected abuse and neglect.

Exceptions to Confidentiality

We may be allowed or required by law to disclose confidential information without our consent in certain cases. The following are examples:

* If we assess that you are a clear and imminent danger to yourself or others the appropriate others will be notified to prevent that occurrence, including family members, police, 911, or emergency services.
* If we believe you may harm another person, we are legally obligated to attempt to warn them of this possibility and to inform the police to protect you and the intended victim.
* In case of your death your personal representative may request information if allowed by state law.
* If you communicate the contemplation or commission of a terrorist, harmful or criminal act.
* If there is reason to suspect that child or elder abuse has occurred. The law requires that we report such suspicious to protective services within 24 hrs.
* If a government or public agency is requesting medical records for auditing or healthcare oversight activities.

Your Rights

In compliance with HIPPA you have the right to: have any complaints or concerns you raise about Global Counseling Solution’s practices or procedures documented in your record. You also have a right to review your medical record. If you have any concerns regarding disclosure of your protected medical information, you may file a complaint verbally or in writing to the owner of Global Counseling Solutions, James Robinson, LCSW.

Professional Boundaries

We have an ethical responsibility to not develop personal friendships or business relationships with clients. If interactions with clients or their families is unavoidable we will take appropriate steps to maintain professional boundaries and confidentiality.

Please Note: If you are or later become involved in a divorce or custody dispute you are agreeing that, unless in cases of child and/or elder abuse, Global Counseling Solutions will not provide evaluations or give testimony in court regarding custody related issues. We are not trained to make custody recommendations. There are other professionals you can hire for custody related services.

Termination of Services

You are under no obligation to continue services and have the right to terminate services at any time. However, we strongly recommend that you talk with your therapist in person in order that termination is discussed openly. Please know that maintaining therapy is your right and responsibility. You are ultimately responsible for keeping your appointments and communicating your treatment needs with us. If treatment with us needs to be terminated, we can make appropriate referrals per your request.

Signatures and Agreements

This information is designed to help you understand our approach, philosophies and policies as well as your rights and responsibilities as a client. If you have any questions about this information, please discuss them with your therapist. I, James E. Robinson, thank you for allowing Global Counseling Solutions to assist you in your journey.

Please sign on this final page below to show that you have read, understand and agree to the terms described in this document.

* I/we have read and understand the background, philosophy and approach Global Counseling Solutions, PLLC has disclosed in this document.
* I/we agree to pay the therapist in full at the time of service or for any late, cancelled or missed appointments as specified in this document.
* I/we also understand and accept the terms as outlined in this statement regarding confidentiality, limits to confidentiality, fees, client rights and responsibilities.
* I/we understand that services can terminated at any time and that treatment is voluntary unless client was referred and mandated by the courts.
* I/we understand that if we wish to file a complaint or grievance we can do so with owner, James Robinson and the following licensing board:

Licensed Clinical Social Worker Board

[www.ncswboard.org](http://www.ncswboard.org)

336- 625-1679

Print Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Legal Guardian (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Other Family Member (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Therapist providing Service (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date