Insight COUNSELING CENTERS

File No._____

INFORMED CONSENT

Insight Counseling Centers recommends that you read and be certain that you understand the following information before proceeding with counseling services offered by INSIGHT.

THE COUNSELING PROCESS, BENEFITS, AND RISKS

All Insight therapists are clinically trained. Our mission is to provide spiritually informed therapy. Many of our therapists are also theologically trained. Our counselors are members of one or more professional organizations and follow the Codes of Ethics of those organizations. Your counselor will be glad to talk with you about his or her credentials and therapy approach, and to answer questions you may have about counseling. INSIGHT's counselors are not physicians and do not prescribe medications.

The counseling relationship requires cooperation between you and your counselor. Working with your counselor toward a treatment plan and goals and reviewing your work together is in your best interest. Counseling can increase self-awareness, improve communication, reduce interpersonal and internal conflict, and alter distressing moods. During the counseling process you may also experience unpleasant feelings. You may discover that some situations cannot be changed to your satisfaction, leaving you with difficult decisions to make. You should be aware that no guarantees of outcome can be made. It is usually best to have a closure session before termination or counselor changes. This needs to be discussed with your counselor. You have the right to stop counseling at any time; however, you will be responsible for the payment of services already received.

In a crisis, you can try to reach your counselor by phone. If your counselor is unavailable, call 911 or go to the nearest emergency room for help.

CONFIDENTIALITY:

Your counseling records are protected by INSIGHT's policy on confidentiality, the counselor's professional code of ethics, and state and federal law. However, there are some exceptions under which we can or must release information: (1) your written authorization; (2) suspicion of neglect or abuse of a child, disabled person, or elderly person; (3) in response to a judge's order; and (4) if we believe you intend to harm yourself or others.

To provide quality service to you, please be aware that our counselors will seek professional supervision or consultation with other professionals about your situation. We omit identifying data (such as names, workplaces) and each professional is bound by confidentiality when seeking supervision / consultation.

In sessions involving several persons, each person must sign a release of information form before any disclosure to a third party is made. Parents/legal guardians must sign for minor children, and a separate form about the treatment of children and adolescents may apply. Children are not seen without the consent of a parent or legal guardian.

When you participate in group counseling, you must abide by these confidentiality rules. It is important that a group provide a safe environment for all its members. What is discussed in group must not be discussed outside the group. It is a violation of others' confidentiality to identify other group members or to discuss information about them. However, you may discuss your own situation. Since each group member shares responsibility for maintaining the confidentiality of the group INSIGHT cannot be held accountable for individual violations of the confidentiality agreement on part of group members.

All staff at INSIGHT, including administrative, and volunteers abide by our confidentiality policy. We will file insurance claims but cannot be held accountable for confidentiality procedures within your insurance company. At times it may be necessary to transmit your information by facsimile or to file insurance information electronically. We will treat your information responsibly, but cannot insure complete confidentiality under those conditions.

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FEES, APPOINTMENTS, CANCELLATIONS, AND COLLECTIONS:
The regular fee for a 45-50 minute session is $140.00 for individuals, couples, or families. Sessions involving more than one counselor may last longer and the fees are adjusted accordingly. Group fees are considered separately. The fees for services are discussed in the initial session and the responsible parties sign a Financial Agreement form at that time. To access the income-based fee scale, your total household income must be entered on the Financial Agreement form. This form will be reviewed periodically by your counselor. If your financial situation changes you are responsible for letting him/her know immediately.

If you are using insurance, you must review and sign the Agreement of Financial Responsibility form.

Fees are due at time of services and all persons, including those applying for third-party payments, are expected to pay their fees as services are received. Checks should be made payable to Insight Counseling Centers. We also accept Master Card, Visa, Discover, and debit cards.

When you must cancel a session, please note that **it is our policy to charge for appointments not canceled 48 hours before the scheduled meeting time.** Should you need to cancel, please contact your counselor. It is your responsibility to reschedule future appointments; however, we will reschedule a session with you during the same calendar week (at no additional charge) if you request it and time with your counselor is available. Insurance companies do not reimburse for missed appointments and you are responsible for these sessions. Insight Counseling Centers reserves the right to make collection efforts, including the right to contact an attorney and to employ a collection agency when late cancellation or no-show fees have not been paid. In the event that Insight Counseling Centers must use the services of a collection agency and/or an attorney to collect outstanding fees, the client will be responsible for all fees incurred to collect the outstanding balance.

COMMUNICATION, EMAIL, AND SOCIAL MEDIA
The best way to contact our office is by telephone. You will need to discuss the use of email or text with your therapist. We prefer to use e-mail or text only to arrange or modify appointments. If you send an e-mail or text regarding an appointment and do not hear from your therapist within 24 hours, please call and leave a voice message for your therapist. Please do not e-mail or text content related to your therapy sessions, as neither are completely secure nor confidential. **E-mail, text messaging, and other forms of electronic communication are not effective means for communicating with your therapist in a clinical emergency.** Any electronic communication we receive from you and any responses your therapist makes to you become part of your client file.

We are committed to maintaining proper boundaries that include, but are not limited to, protecting the privacy and confidentiality of the therapeutic relationship between counselor and client.Therefore, we do not accept “friend” or contact requests from current or former clients on any social networking site. **Never attempt to contact your therapist by messaging on social networking sites such as Twitter, Facebook, and LinkedIn. It is our policy not to respond to such contacts from clients.**

By signing below, I agree that I have read and understand this information and that I am agreeing to work with my counselor in the counseling process. I understand that if I choose to use my insurance, INSIGHT can supply the necessary information to my insurance company, including diagnosis and treatment information. I understand that I am responsible for any outstanding payments for services received and that I am aware of the 48-hour cancellation policy. I am giving my consent to the above terms.

Client's signature:_____Date: _____

Counselor's signature:_____Date: _____

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INTAKE FACE SHEET

1. Date of Initial Visit_____Date of Birth_____Social Sec. No._____
2. First Name_____Middle Initial(s)____Last Name_____
3. Address_____City_____State____Zip_____
4. Home Phone:_____Work Phone:_____Cell:_____
5. I agree to have mail sent to the above address: ☐Yes ☐No please initial _____
6. Email:_____I would like to receive INSIGHT's email newsletter ☐Yes ☐No
7. ☐Married ☐Single Number of Persons Participating in Counseling_____
8. Number of Dependents and Names_____
9. Person Responsible for Payment_____
10. If filing Insurance: Insured is ☐ Self ☐ Spouse ☐ Parent ☐Other_____

    Name of Insured_____Social Security No._____

    Insured's Employer_____

    Insured's Employment Address_____

    Insured's ID No._____Insured's Group No._____

    Name and Address of Insurance Co._____

    Phone Number of Insurance Co. (Claims Dept.) ( )_____
11. Type of Counseling: ☐Individual ☐Couple ☐Family ☐Group Sex:☐Male ☐Female
12. Schooling Completed:☐Grade School☐High School☐Trade School☐College☐Graduate School
13. Racial/Ethnic Identity: ☐ African-American ☐ Asian ☐ Caucasian ☐Hispanic

    ☐ Native American ☐ Other_____
14. Religious Preference_____Local Congregation_____
15. Who referred you to our Insight?_____

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CONFIDENTIAL INFORMATION FORM

Note: Please complete this form as carefully and thoroughly as possible. This information will be used confidentially by your counselor to assist you.

FAMILY DATA

Relationship Status (Circle One): Single Committed Engaged Married Separated Divorced Widowed

Years Married_____Years/Months Separated or Divorced_____Previous Marriages? ☐Yes ☐No

Date(s) of Former Marriages: From_____To_____; From_____To_____; From_____To_____

If married, what is your spouse's name and age? Name_____Age_____

Names/Ages of children_____

If single, are you in a significant relationship? ☐Yes ☐No How Long?_____

Significance_____
(Boyfriend/Girlfriend, Fiancée, Roommate, Committed Partner, Special Friend, etc.)

Names/Ages of siblings_____

_____

Recent deaths of family/friends (Relation/dates)_____

_____

Emergency Contact_____Phone number_____Relation_____

EDUCATION

Grades Completed (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 High School Diploma? ☐Yes ☐No

College 1 2 3 4 Degree(s)_____Name of College_____

Graduate School 1 2 3 4 Name of School_____

Area of Study_____

Business or Technical School_____

Course of Study_____Certificate? ☐Yes ☐No

OCCUPATIONAL DATA

Employer_____Length of Employment_____

Type of Work You Do_____

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PHYSICAL AND EMOTIONAL DATA

List current illness(es) or symptoms:_____

List any major surgeries, serious crises, losses, or disabilities (with dates):_____

_____

_____

Last Medical Exam_____Reason_____

Name and Address of
Physician_____

_____

_____

Have you ever received psychotherapy, counseling, or other treatment for personal, marital, or family problems?

☐Yes ☐No Dates:_____

Name of Professional (Doctor, Agency, Pastor, etc.) _____

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency? ☐Yes ☐No

Dates:_____Name of Professional or Agency_____

List medications you are currently taking for emotional distress (e.g., nervousness, anxiety, depression, etc.):

_____

List any other medications you are
taking:_____

IMPORTANT QUESTIONS FOR YOU AND YOUR COUNSELOR

Please describe your reason(s) for seeking help: _____

_____

_____

_____

_____

Who is aware of your problem(s)? _____

What would you like to have happen for you as a result of therapy?_____

_____

_____

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PRESENTING PROBLEMS

SYMPTOMS

- ☐ Anger
- ☐ Loss of interest (in pleasurable activities
- ☐ Anxiety
- ☐ Memory loss
- ☐ Compulsive behaviors
- ☐ Mood swings
- ☐ Confusion
- ☐ Nausea/vomiting
- ☐ Depression
- ☐ Self-critical
- ☐ Excessive use of alcohol or drugs
- ☐ Seizures
- ☐ Headaches
- ☐ Shortness of breath
- ☐ Hopelessness
- ☐ Difficulty concentrating/paying attention
- ☐ Racing thoughts
- ☐ Identity issues
- ☐ Sleep Difficulties
- ☐ Impulses to hurt yourself or others
- ☐ Self-harming behaviors
- ☐ Suicidal thoughts
- ☐ Disorientation (Not knowing where or who you are)
- ☐ Suspiciousness
- ☐ Confused thinking (Thought Disorder)
- ☐ Visual or auditory hallucinations (seeing or hearing things)
- ☐ Obsessive preoccupations or repeated thoughts
- ☐ Irritability
- ☐ Recent weight gain or loss
- ☐ Lack of energy
- ☐ Experience of trauma or abuse
- ☐ Medical Problems: (Explain)_____

_____

- ☐ Legal Problems

COUPLE/RELATIONSHIP

- ☐ Tension
- ☐ Arguments
- ☐ Emotional distance
- ☐ Communication problems
- ☐ Alcohol or other addiction problems
- ☐ Stresses from health problems
- ☐ Sexual difficulties
- ☐ Financial or other stresses:_____

_____

RELATIONSHIP WITH CHILDREN

- ☐ Tension
- ☐ Angry interchanges
- ☐ Children exhibiting emotional problems
- ☐ Children exhibiting behavioral problems
- ☐ Problems in relationships between siblings
- ☐ Health problems
- ☐ Other Concerns:_____

EXTENDED FAMILY

- ☐ Recent losses
- ☐ On-going difficult interactions with:

_____

_____

WORK-RELATED (OR SCHOOL RELATED)

- ☐ Upsetting interactions
- ☐ Financial insecurity
- ☐ Unemployed/loss of job

COMMUNITY-RELATED

- ☐ Insufficient friendships
- ☐ Tensions in friendship relationships
- ☐ Over-extended in friendship or community role
- ☐ Other

Name:_____ Date:_____

(Please Sign)

Revised March 2020

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FINANCIAL AGREEMENT

The regular fees for counseling are $140 per session (45-50 mins.), $200 per co-counseling session (two counselors present) (70-75 mins.). Supplemental support is available for persons with financial need. Please complete the following information if you wish to apply for an adjusted fee. If applying for the income-based fee scale, please bring to your first session your most recent tax filing form or your two most recent payroll receipts.

Number of People in Household (including yourself): _____

Your Gross Annual Income: $_____

Other Household Members' Annual Income: $_____

TOTAL: $_____

Agreed upon fee per 45-50 minute session: $_____

Amount of Assistance to be underwritten by INSIGHT: $_____

I/We agree to the payment of this fee as services are rendered, including late cancellations (less than 48 hours notice) and "no shows" as designated in Insight Counseling Centers' policies.

_____ _____
Signed Date

_____ _____
Signed Date

Counselor overseeing this agreement:

_____ _____
Signed Date

Other agreements not specified above: _____

Income verification
☐ Most Recent Tax Return
☐ Other: _____

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PATIENT NOTIFICIATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights is Insight's attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, Insight will do all it can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask your therapist for further clarification.

By law, Insight Counseling Centers is required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

I,_____(*Print Name*), understand and have been provided a copy of Patient Notification of Privacy Rights Document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____

Patient Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

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THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I. Preamble

This notice will tell you about how we handle information about you. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. We are also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of this state are very complicated and we don't want to make you read a lot that may not apply to you, we have simplified some parts. If you have any question or want to know more about anything in this Notice, please ask our Privacy Officer for more explanation or more details.

There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, know as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient himself/herself.

HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three (3) components: *treatment, payment, and health care operations.*

***Treatment* refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.**

***Payment* is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs**

of the mental health services provided you.

***Health care operations* are activities related to the performance of our practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary".**

The *use* of your protected health information refers to activities our office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* our office related to your care. *Disclosures* reflects to activities you authorize which occur *outside* our office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

Tennessee requires authorization and consent for treatment, payment and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your Consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you).

Additionally, if you ever want for me to send any of your protected health information of any sort to anyone outside our offices, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement of you signing an additional authorization form in an added protection to help insure your protected health information is kept strictly confidential.

There is a third, special authorization provision potentially relevant to the privacy of your records: our psychotherapy notes. In recognition of the importance of the confidentiality of conversations between counselor-patient in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designate medical record". "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *our* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that separated from the rest of the individual's medical record". "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and our psychotherapy notes in order to pay for your care. If your counselor is forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release our psychotherapy notes. Most of the time, we will be able to limit reviews of your protected health information to only your "designated record set" which includes the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summarizes of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests which are protected by copyright laws and the need to protect patients from unintended, potentially harmful use are not part of your "designated mental health record".

You may, in writing, revoke all authorizations to disclosure protected health information at

any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Business Associate Disclosures

HIPAA requires that Insight Counseling Centers train and monitor the conduct of those performing ancillary administrative services for our practice and refers to these people as "Business Associates". In our practice, "business associates" includes our secretaries who provide services such as typing, making phone calls, and filing insurance claims-all activities which bring them into some measure of contact with your protected health information. Other "business associates" in the office, in compliance with HIPAA, have signed a formal contract with these business associates, which very clearly spells out to them the importance of them protecting your mental health information as an absolute condition for employment. We train them, monitor their compliance, and correct any errors, if they should occur.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information *may* be released without your consent or authorization:

- **Child abuse or other abuse as required by law**
- **Suspected sexual abuse of a child**
- **Health Oversight Activities (i.e., licensing board in Tennessee)**
- **Judicial or administrative proceedings (i.e., if you are ordered here by the court for an independent child custody evaluation in a divorce)**
- **Serious Threat to Health or Safety (i.e., our "Duty to Warn" Law, national security threats)**
- **Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).**

V. Patient's Rights and Our Duties

You have a right to the following:

- ***The right to request restrictions* on certain uses and disclosures of your protected health information which I may or may not agree to but if I do, such restrictions shall apply unless our agreement is changed in writing;**

- ***The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;**

- ***The right to inspect and copy* your protected information in our designated mental health record set and any billing records for as long as protected health information is maintained in the record;**

- ***The right to amend*** **material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care.**

- ***The right to an accounting of non-authorized disclosures*** **of your protected health information;**

- ***The right to a paper copy*** **of notices/information from Insight Counseling Centers, even if you have previously requested electronic transmission of notices/information; and**

- ***The right to revoke your authorization*** **of your protected health information except to the extent that action has already been taken.**

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. We are required by to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of our policies when you come for your future appointment(s). Our duties as counselors on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of our internal policies for executing privacy practices, please let us know and we will get you a copy of these documents that we keep on file for auditing purposes.

VI. Complaints

You may request to speak to the "Privacy Officer" by calling 615-383-2115 for the INSIGHT practice per HIPAA regulations. If you have any concerns of any sort that somehow your privacy rights have been compromised, please do not hesitate to speak to your counselor, the Privacy Officer or the director immediately about this matter. You will always find us willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written compliant to the Secretary of the U.S. Department of Health and Human Services.

VII. This notice shall go into effect April 14, 2003 and remain so unless new notice provision effective for all protected health information are enacted accordingly.