Healing Hearts Counseling Center LLC
Heather Conyers, LPC – Founder/ Therapist
8310 Office Park Dr Suite 1A
Douglasville, GA 30134
Cellular: (678) 895-5681 Fax: 1 (877) 575-9128
Email: heather@healingheartscounselingcenter.com
https://www.healingheartscounselingcenter.com

Client Information

This form is completely confidential

IDENTIFICATION

Today's Date: ______________

Client's Name: ____

Client's Date of Birth: ___/____/___ Social Security #: ______________ Sex: ____________

Home Street Address: ____

City: ________________________________ **State:** ______ **Zip:** ______________

Name of Employer: ____

Address of Employer: ____

City: ________________________________ **State:** ______ **Zip:** ______________

Home Phone: ____________ **Work Phone:** ______________ **Email** ____________________

- Calls will be discreet, but please indicate any restrictions: ____________________

Referred by: ____

- May I have your permission to thank this person for the referral?

☐ Yes ☐ No

Emergency Contact: Name ________________________ Phone ______________________

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Signature): ____________________________

INSURANCE INFORMATION- Please provide insurance card - Skip if self-pay

Policyholder's Name______________________ Policyholder's SSN:_______-_______-________

Date of Birth ______________ Primary Insurance Co. Name ______________________

Insurance company's customer service phone #______________ Member ID # ______________

Policyholder's Employer ______________________ Group # ______________________

Co-pay $ ____________ Deductible? YES NO Amount $ ______________

Has any of the deductible been met as of yet? IF SO, HOW MUCH?______________________

Authorization Required? **YES NO** Authorization # ____________________________

Of Sessions Authorized ______ Maximum # of Sessions Allowed per year ______

Is the client covered under a secondary insurance policy? YES NO

Insurance Company Name ______________________

FOR OFFICE USE ONLY: ADDITIONAL COMMENTS/CONCERNS

____

____

____

____

____

I, ______________________________ (Client or legal guardian) authorize Heather Conyers, LPC / Healing Hearts Counseling Center, LLC, or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly to Heather Conyers, LPC / Healing Hearts Counseling Center, LLC in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian.

Client or Legal Guardian Name ______________________ Signature ____________________ Date ___________

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

____

____

Name of Medication	Dosage	Purpose/ Reason	Date Started	Name of Prescribing Doctor

Previous psychiatric hospitalizations (Approximate dates and illness reported)

____

____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? **YES** **NO**
(Please list approximate dates and purpose): ____

____

FAMILY OF ORIGIN

Relative	Name	Age	Illness	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						
Brother(s)						
Sister(s)						

SYMPTOMS:

Physical Health Systems:

_______ Headache _______ Vomiting _______ Diarrhea _______ Chest Pain _______ Shortness of Breath

Function/Activity:

_______Fatigue _______Little/No Sleep _______ Weight Loss _______ Weight Gain_______ Academic
_______ Loss of Interest/Pleasure _______ Excessive Worry _______Self-Esteem ______ Substance Use

Emotional Symptoms:

______ Hopelessness _______ Panic/Anxiety _______Anger _______Tearful_______Suicidal Thoughts _____
______ Indecisiveness _______ Fearful _______________________________Other

IF ANY ITEM APPLIES TO CLIENT THEN PLEASE FILL OUT----IF NOT PLEASE LEAVE IT BLANK or WRITE N/A

RELATIONSHIPS/SOCIAL SUPPORT/SELF -CARE (if applicable to client)

POOR EXCELLENT

Currently in Relationship? _____ How Long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7
Married/Life Partnered? ______ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships____________________________
Do you have Children? _____ If YES, how many and what are their ages/sex: _________________________

Describe any problems YOU or YOUR FAMILY are having presently:

____
____
____
____
____
____

Academic problems:____
____
____
____

Please briefly describe any history of abuse, neglect and/or trauma: _________________________
____
____
____
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____
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____
____

DO YOU HAVE A SUPPORT SYSTEM? IF SO, PLEASE NAME WHO YOU RELY ON FOR SUPPORT (family, friends, church, hobbies, etc)

____

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Is spirituality important in your life, if so please explain:

____

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Is there any other important information or concerns not reported thus far?

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PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

____

____

____

CONSENT & AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below to:

__________RELEASE __________RECEIVE __________EXCHANGE

****

I, ____ (client), hereby authorize **Healing Hearts Counseling Center LLC/Heather Conyers** to discuss my Mental health treatment, medical, academic information and records in writing by phone contact and/or mail. Any information obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis; alcohol/drug abuse; addiction; in accordance with case manager, social worker, attorney, CASA and any other professional personnel with Georgia Statutes, Guidelines and Regulations, and HIPPA compliance.

Name of Person/Facility/School ____

Address ____

Phone/Fax ____

I understand that such disclosure will be made for the following purpose(s):

- Treatment progress *Psychiatric Evaluation * Child Custody/Visitation *Treatment Planning
- Social History * Competency to stand trial * Medical treatment * Treatment Summary Diagnosis
- Reimbursement for Treatment * Other ____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations and it will expire upon written notice

I may withdraw this consent at any time by giving written notice to Healing Hearts Counseling Center/ Heather Conyers, LPC. If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated therein. I further understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at 8310 Office Park Drive Suite 1A Douglasville, GA 30134, to be effective.

Client's Signature: ____ Date: ______________

Parent's/Legal Guardian's Signature: ______________________________ Date: ______________

Therapist's Signature ____ Date: ______________

CONSENT & AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

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Address ____

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Client's Signature: ____________________________________ Date: ______________

Parent's/Legal Guardian's Signature: ______________________ Date: ______________

Therapist's Signature ___________________________________ Date: ______________

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****

I, ______________________________________ (client), hereby authorize **Healing Hearts Counseling Center LLC/Heather Conyers** to discuss my Mental health treatment, medical, academic information and records in writing by phone contact and/or mail. Any information obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis; alcohol/drug abuse; addiction; in accordance with case manager, social worker, attorney, CASA and any other professional personnel with Georgia Statutes, Guidelines and Regulations, and HIPPA compliance.

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Name of Person/Facility/School ____
Address ____
Phone/Fax ____

I understand that such disclosure will be made for the following purpose(s):

- Treatment progress *Psychiatric Evaluation * Child Custody/Visitation *Treatment Planning
- Social History * Competency to stand trial * Medical treatment * Treatment Summary Diagnosis
- Reimbursement for Treatment * Other ____

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Please indicate your preference regarding the information to be shared:
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Client's Signature: ____ Date: _______________
Parent's/Legal Guardian's Signature: _____________________________ Date: _______________
Therapist's Signature ____ Date: _______________

TRAINING OF PROFESSIONALS:

Healing Hearts Counseling Center, LLC is committed to providing excellent mental health services to the community. Because of this, from time to time we will engage in training interns and/or newly licensed professionals. This can result in more affordable fees to those who are in need as well as the professional growth of those we train. In order to provide this opportunity, sometimes trainees are required to sit in on sessions, record/take notes of sessions or discuss the case with a fully licensed mental health supervisor. During this, none of your identifying information is ever disclosed and your confidentiality will remain of upmost regard. If you wish to participate in this training opportunity, please sign. You can opt out at any time simply through verbal or written communication.

____

Signature and Date

I further understand that case management services are provided as a support to clients and Healing Hearts Counseling Center and understand that my insurance **WILL NOT** be billed, but a separate rate of $35.00 (per 30 minute increments) will be charged. I am responsible for this payment. _________________(Initials)

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PROFESSIONAL SERVICES AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPA NOTICE FORM DESCRIBED ON THE FOLLOWING PAGES

CLIENT (OR PARENT/GUARDIAN, IF PATIENT IS A MINOR)

__________________________________ __________________

Signature of Client or Parent/Guardian — Date

__________________________________ __________________

Name of Client or Parent/Guardian ***(Please Print)*** — Relationship to Client

Healing Hearts Counseling Center LLC Heather Conyers, LPC – Founder/ Therapist
8310 Office Park Drive Suite 1A
Douglasville, GA 30134
Cellular: (678) 895-5681Fax: 1 (877) 575-9128
Email: heather@healingheartscounselingcenter.com
www.healingheartscounselingcenter.com

PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice, Healing Hearts Counseling Center LLC. I am very pleased that you selected my practice for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at Healing Hearts Counseling Center LLC. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time. It also contains summary information about the Health and Insurance Portability and Accountability Act (HIPPA) a federal law that provided new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health information in greater detail. The law requires tht I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have at that time.

EDUCATIONAL BACKGROUND

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

AA, Business Administration
B.S., Social Science (Human Services)
M.A. Professional Counseling (Licensed Professional Counselor)
National Certified Counselor
Certified Anger Management Specialist
Christian Counselor
Licensed Marriage Officiant
Telemental Health and E-Counseling
Distance Credentialed Counselor (DCC)
Doctoral Student (Biblical Counseling) – Premarital / Couples Counseling
Certified Trauma Professional
MAC (Currently Processing- June 2016)

Informed Consent

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, client participation is important. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at Healing Hearts Counseling Center LLC. We also don't believe in creating dependency or prolonging therapy if the therapeutic interventions do not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number ONE priority.
We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever ways seem to produce maximum benefits.

At Healing Hearts Counseling Center our main forms of therapy are Cognitive Behavioral Therapy, Trauma Focused Therapy and Solution Focused Therapy. However, we also utilize an eclectic approach to tailor treatment to each individual client. Other treatment modalities focused on trauma using Gestalt, Adlerian & Person Centered Therapy. Homework assignments also play a vital part in therapeutic services away from HHCC.

Psychological Services

Psychotherapy is not easily described in general. It varies depending on the personalities of the therapist and client, and the particular problems you or your child are experiencing. There are many various methods I may use to deal with the problems that you hope to address. Psychotherapy requires a very active effort on your part. In order for therapy to be most successful, you or your child will have to work on things we talk about during Sessions, AT HOME, Community and School. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown and proven to have many great and lasting benefits with consistent therapy. Therapy often leads to better relationships and solutions, which in turn leads to better relationships, coping skills and significant reductions in stress related to life's challenges. Therapy involves a large commitment of time, money and energy and at any time please feel free to ask questions and to let your therapist know what works best for you.

Sessions

I normally conduct an evaluation that lasts from 1-3 sessions. During this time, I will complete an assessment of your needs and services, (client and/or family – if child is a minor) in order to find out if I am the best fit for you, your child and family to assist in meeting your treatment goals. If therapy is begun, I will usually schedule one 45-60 minute session per week, although some clients need more intensive therapeutic services, and being a trauma focused practice, may last longer or meet more frequently for intensive therapy. I utilize various techniques to "reach" individuals that I serve and family sessions will ALWAYS be needed if therapist is working with a minor child; however, you are the expert in your family and your assistance and collaboration is highly appreciated. Once an appointment hour is scheduled it is your responsibility to notify HHCC by phone or text to cancel or reschedule appointment within 24 hours or you will be charged **$25** for a missed appointment fee and Insurance does not cover this fee. We certainly understand that emergencies occur, However, this will free up time for another client to be served should you become unavailable for our scheduled time.
Please initial you understand this fee is not paid by Insurance and you are responsible for this fee. ______

Contacting ME

Due to my work schedule I am often not immediately available by phone. I am also not available to answer phone calls when I am in sessions with clients or returning important phone calls or conducting business with business associates. When I am unavailable, my phone is answered by confidential voicemail. Please allow time for me to check voicemail and call you back usually within 24-48 hours. However, if it is an emergency please call 911. I will make every effort to call and update you and provide you with a back up therapist should I become unavailable for an extended period of time (sickness/vacation/personal time/trainings, etc.) or should you need extra care between sessions.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. We take great lengths and precautions to protect your confidentiality to the fullest extent. Additionally, your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Minors & Parents

Clients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful programs, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Family sessions are usually facilitated and initiated by therapist at least monthly. Therapist and client's parent/guardian will determine more frequent sessions if needed.

FINANCIAL AGREEMENTS

Professional Structure and Fees

SESSIONS:
INDIVIDUAL SESSIONS CAN LAST 30 MINUTES, 45 MINUTES, OR 50-60 MINUTES AND SOME FAMILY/COUPLES SESSIONS OR GROUP THERAPY CAN LAST FROM 1 HR-90 MINUTES.
Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed **10 MINUTES** in duration will be billed at **$25 per 15-minute increments**. The fee for each session will be due **before the session begins (Copayments, reduced fees agreed upon with therapist, session fees, and medical insurance).** Cash, Visa, MasterCard, Discover, or American Express are acceptable forms of payment, and we will provide you with a receipt of payment. The receipt of payment or super bill may also be used as a statement for insurance, if applicable to you.

I usually conduct an evaluation that lasts from 1-3 sessions. During this time, we can both decide if I am the best person to provide the services you or your child needs in order o meet your treatment goals. After the initial assessment is completed recommendations will be made for the type and frequency of sessions. We are a

(1) Full Service Center
(2) Trauma Informed Care (TIC) Center which provides Intensive Mental Health services using Evidence Based (EB) Interventions & Practices and Outcomes.

At this time I accept the following insurance carriers: Aetna, Amerigroup, Blue Cross Blue Shield, Tricare and I am Out of Network for other insurance companies at this time. However, should you provide your insurance information it may be possible for me to apply as a provider for that particular insurance company. Out of Network insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with assistance in helping you receive benefits for which you are entitled; however, **YOU (not your insurance company)** are responsible for full payment of my fees. **It is very important that you find out exactly what mental health benefits your insurance policy provides, such as co-pays, deductibles, maximum number of sessions allowed, etc. At this time we do not file secondary insurance, but will provide you with a super bill or payment receipt to file with your insurance company.**

Should you experience a hardship or find it difficult to continue therapy due to finances please speak with you therapist/Founder to discuss financial options. Reduced fees are available in some instances.

Billing and Payments
You will be expected to pay for each session at the time it is held, unless you have insurance coverage or we agree otherwise. If you have insurance, you are required to pay your co-pay/deductible at the time of service. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than **30 days** and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. If it is necessary to clear confusion, I, or my staff, are willing to call the company on your behalf. Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. **It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate**. I will submit the appropriate bills to your insurance company and try to remedy any denial or payment problem related to billing. If after these billing attempts, the insurance company refuses to pay the bill, it will become **your (the client's)** responsibility to work with the insurance company to obtain appropriate reimbursement.

Secondary Insurance
If you or your child is covered by a secondary insurance plan, I will be happy to provide you with appropriate billing forms from your primary plan. I ask that you be responsible for payment of the portion of services not covered by your primary plan and that you seek reimbursement from the secondary plan yourself. Typical insurance plans such as HMO's and PPO's are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. It will typically be my responsibility to obtain authorization for further sessions. While much can be accomplished in short-term therapy, some patients feel and/or require more services after insurance benefits end. Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to plan to continue working with you or find another provider who will help you continue your psychotherapy. Should you experience a hardship or find it difficult to continue therapy due to finances please speak with you therapist/Founder to discuss financial options. Reduced fees are available in some instances. You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, by request. By signing this agreement, you agree that I can provide requested information to your insurance carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the aforementioned requirements described above unless prohibited by contract.

Some Other Insurance Information
We have had circumstances where clients have questioned whether a visit can be "coded" as something other than what it may be (individual session, family session, couples session, evaluation, etc.). Not only is such action unethical, but it also constitutes insurance fraud, which is illegal. Just as we commit to our clients to be honest and forthright, so too are we honest and straightforward with the insurance companies.

Lastly, it is important that you know that your insurance companies have the right to review claims for proper reimbursement for up to one year after the claim is made. This means that reimbursements that were made in the past for what was communicated by the insurance company as a covered diagnosis or service can be reversed. When this occurs, the insurance company can demand refund reimbursement from you or from Healing Hearts Counseling Center, LLC depending on who was paid the benefit. Should an insurance company in the future deny benefits for services rendered in the past and thus request refund of payment to them, the payment for the services becomes the responsibility of the client. Insurance companies and HHCC can and will

pursue reimbursement from clients and will use any and all means necessary to get these payments including legal action.

Please understand your plan -what it covers and what it does not. Make certain that all of your decisions in your treatment process are based on your full understanding of the nature and scope of the related clinical, psychological and financial elements.

Court Attendance, On-Call

Healing Hearts Counseling Center, LLC bills at the rate of **$200.00 per hour** for court attendance and requires credit card information to be on file. The hourly rate begins when the therapist leaves the office location and a fee for two hours will be paid prior to court attendance, **($400.00)** and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for your therapist to be on-call for court attendance, Healing Hearts Counseling Center, LLC bills at the rate of **$60.00** per hour for on-call and requires credit card information to be on file for payment to be charged. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable. **Insurance does not reimburse for court appearances, testimony, travel, etc.**

Communication with Attorneys/Other Professionals/Report Writing

Healing Hearts Counseling Center, LLC bills at a rate of **$100 per hour** for any type of communication with attorneys/other professionals/report writing (Phone calls, letter writing, email, etc.). Phone calls of 10 minutes or less will be honored. You are responsible for providing credit card information prior to any communication your therapist will have with their attorney/other outside professional. A minimum of 30 minute increments will be billed to your credit card on file and is non refundable. **After payment is received and processed, please allow up to 7 business days for paperwork/communication to be completed.**

Please keep in mind, your therapist has to retrieve and review the client's file in order to provide accurate information. This takes valuable time away from client's treatment plan and care. NO MONTHLY STATEMENTS WILL BE PROVIDED HOWEVER, for $25.00 per hour, progress on a letterhead can be provided for court appearances. **These services cannot be billed to insurance companies. They only pay for therapy. This would be classified as fraud.** Please provide your therapist with name, address, phone, email of any DFCS Case Worker, Attorney, CASA, School, Physician, or Psychiatrist to insure therapist can have clear and accurate information/communication with these professionals. Please provide or inform any Case Worker/Custodian (DFCS) of current policies/procedures at HHCC. A copy may be emailed or faxed, upon request, if therapist obtains all information. Frequently funds may be able to be reimbursed by invoice for such services.

School Based Services & Transition

Please be aware that insurance companies do not reimburse for school meetings. These are at the sole discretion of therapist and availability of staff. Occasionally, your therapist will be available with at least seven (7) days notice, and may choose to alter schedule and provide this service as a support to effectively meet the needs of the child, and to assist with treatment plan. Should your therapist meet with family and or child in a separate area, then reimbursement can occur. Therapist may request staff from HHCC to assist or record pertinent information during such meetings.

Initials/ Date______________

Records Request

Healing Hearts Counseling Center, LLC bills a flat rate of **$50** for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed. **No records will be released with an outstanding balance.**

Cancellation Policy
Once you sign up for a program or schedule asession, it is expected that you pay for it unless you provide 24-hour notice of cancellation. The fee for missed appointments without notification is **$25**. **Failure to cancel within 24 hours will result in you being charged the missed visit amount. Please note that insurance companies do not reimburse for missed sessions.**

Please initial that you have read the Professional Structures & Fees ___________________

In Case of an Emergency

Healing Hearts Counseling Center LLC is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call 911.
- Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
- Go to your nearest emergency room.
- Then Call Healing Hearts Counseling Center and leave a message on confidential voicemail with details
- GA Crisis Hotline 1-800-715-4225
- GA Suicide Hotline 1-800-715-4225

In the event that Healing Hearts Counseling Center will be closed for an extended period of time, you will be provided with the contact information of another in office psychotherapist that will provide you treatment in the case of an emergency.

There may be some instances in which your therapist is unavailable or cannot be reached by phone or may be ill. Another therapist will be available to conduct sessions in the absence of your therapist, Heather Conyers. Every reasonable effort will be made to accommodate your needs according to severity.

Professional Relationship
Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise.
A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their client's secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Initials/ Date________________

Technology Statement
In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with your therapist. **However, please know that it is our policy to utilize these means of communication strictly for brief topics such as appointment confirmations, brief updates or contact information.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that we are required to keep a copy of all emails and texts as part of your clinical record.** An encryption email or password may be provided to ensure confidentiality if telemental counseling is offered. Please speak with your therapist prior to utilizing such services to obtain confidential code.

Facebook, LinkedIn, Instagram, Snapchat, Etc.: It is our policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality. Healing Hearts Counseling Center LLC has a business Facebook page, a Twitter account and is on LinkedIn and Instagram. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Healing Hearts Counseling Center LLC. If you would like to follow us on any of these media, you might want to consider using an alias to keep your connection with us confidential, but that is entirely your decision **(If Applicable)**.

Google, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist, as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: We may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let your therapist know so that he/she may discuss any potential implications to your therapeutic relationship. Once again, maintaining your confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to our content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

Authorization For Recording
In order to conduct business in a quick and seamless fashion, we may have to contact you or your insurance company via the telephone. These conversations are documented by our staff and records are kept in the same manner as your Clinical Record . This ensures that our office has evidence if there is ever a dispute over a scheduled appointment, authorization of a credit card, or approval of insurance coverage. At no time will medical issues or therapy be discussed or recorded during a telephone call to our office.

Initials/ Date__________________

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies/procedures of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

____ ________________
Client Name (Please Print) Date

____
Client Signature

If Applicable:

____ ________________
Parent's or Legal Guardian's Name (Please Print) Date

____
Parent's or Legal Guardian's Signature

My signature of the below indicates that I have discussed this form with you and/or your child(ren) and has answered any questions you have regarding this information.

____ ________________
Intake Worker's Signature Date

____ ________________
Therapist's Signature Date

Health Insurance Portability and Accountability Act (HIPAA)

HEALING HEARTS COUNSELING CENTER, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY Healing Hearts Counseling Center, LLC AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related federal regulations. If you have questions about this Notice please contact the Privacy Officer Heather Conyers, LPC at 678-895-5681.

Healing Hearts Counseling Center, LLC is a Limited Liability Company in the state of Georgia responsible for providing a variety of professional services, which deal with mental health and other confidential information. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and Healing Hearts Counseling Center, LLC must comply with those laws. For situations where more stringent disclosure requirements do not apply, this Notice of Privacy Practices describes how Healing Hearts Counseling Center, LLC may use and disclose any Protected Health Information (PHI) for treatment, payment, health care operations and for certain other purposes. **This notice relates only to health information.** It describes your rights to access and control any PHI, and provides information about your right to make a complaint if you believe Healing Hearts Counseling Center, LLC has improperly used or disclosed any "PHI." Protected health information is information that may personally identify you or the child(ren) and relates to any past, present or future physical or mental health or condition and related health care services. Healing Hearts Counseling Center, LLC is required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all PHI that Healing Hearts Counseling Center, LLC maintains at the time of issuance. Upon request, Healing Hearts Counseling Center, LLC will provide you with a revised Notice of Privacy Practices by posting copies at its' facilities, publication on Healing Hearts Counseling Center, LLC's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services from Healing Hearts Counseling Center, LLC

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1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Any PHI may be used and disclosed by Healing Hearts Counseling Center, LLC, its' employees, contractors, agents and attorneys for the purpose of providing mental health services to you. Protected health information is routinely needed in order to ensure proper mental health treatment.

Treatment: Any PHI may be used to provide, coordinate, or manage your or your child's mental health services, including coordination with a third party that has your permission to have access to any PHI, such as other health care professional who may be treating you or your child (ren), a health care specialist or laboratory.

Payment: Your PHI or that of the child (ren) may be used to obtain payment for your or your child (ren)'s health care services.

Health Care Operations: Healing Hearts Counseling Center, LLC may use or disclose any PHI to support the business activities of Healing Hearts Counseling Center, LLC including, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Healing Hearts Counseling Center, LLC may use a sign-in sheet at the registration desk at any facility or office where services are provided. You may be asked to provide your name and other necessary information, and you may be called by name in the waiting room when a staff member is ready to see you, and any PHI may be used to contact you about appointments and/or for other operational reasons. Any PHI may be shared with third party "business

associates" who perform various activities that assist us in the provision of your or your child(ren)'s mental health services.

Other uses and disclosures of any PHI will be made only with your written authorization, which you may revoke in writing at any time, except as permitted or required by law as described below.

Other Permitted or Required Uses and Disclosures With Your Authorization or Opportunity to Object
The Department may use and/or disclose any PHI to a court of law, to a family member, relative or any other persons you identify on the Healing Hearts Counseling Center, LLC Authorization Form. You have the opportunity to agree or object to the use and/or disclosure of all or part of any PHI.

Permitted or Required Uses and Disclosures Without Your Authorization or Opportunity to Object
Healing Hearts Counseling Center, LLC may use or disclose any PHI without your authorization when required to do so by law; for public health purposes, to a person who may be at risk of contracting a communicable disease, to a health oversight agency, to an authority authorized to receive reports of abuse or neglect, in certain legal proceedings, and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner, medical examiner or funeral director, for certain approved research purposes, to prevent or lessen a threat to health or safety, and to law enforcement authorities for identification or apprehension of an individual.

Required Uses and Disclosures:
Under the law, Healing Hearts Counseling Center, LLC must make disclosures to you, when required by the Secretary of the Department of Health and Human Services and to investigate or determine the Department's compliance with the requirements of the Privacy Rule at 45 CFR Sections 164.500 et.seq.

2. YOUR RIGHTS UNDER THE FEDERAL PRIVACY RULE

The following is a statement of your rights with respect to any PHI and a brief description of how you may exercise these rights:

a. You have the right to inspect and copy your protected health information.
Upon written request, you may inspect and obtain a copy of any PHI for as long as the Department maintains the PHI. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or PHI that is subject to a federal or state law prohibiting access to such information.

b. You have the right to request restriction of your protected health information.
You may ask in writing that Healing Hearts Counseling Center, LLC not use or disclose any part of any PHI for the purposes of treatment, payment or healthcare operations, and not to disclose PHI to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. Healing Hearts Counseling Center, LLC is not required to agree to a restriction you request, and if Healing Hearts Counseling Center, LLC believes it is in your best interest to permit use and disclosure of any PHI, the PHI will not be restricted, except as required by law. If Healing Hearts Counseling Center, LLC does agree to the requested restriction, Healing Hearts Counseling Center, LLC may not use or disclose any PHI in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
Upon written request, Healing Hearts Counseling Center, LLC will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation

upon your provision of an alternative addressor other method of contact. Healing Hearts Counseling Center, LLC will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of any protected health information.
If Healing Hearts Counseling Center, LLC created any PHI, you may request in writing an amendment of that information for as long as it is maintained by Healing Hearts Counseling Center, LLC. Healing Hearts Counseling Center, LLC may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.

e. You have the right to receive an accounting of certain disclosures
Healing Hearts Counseling Center, LLC has made of any protected health information. This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures Healing Hearts Counseling Center, LLC made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. Upon written request, you have the right to receive legally specified information regarding disclosures occurring after April 14, 2003, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from
Healing Hearts Counseling Center, LLC.

3. COMPLAINTS RELATED TO USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION OR RIGHTS
You may complain to Healing Hearts Counseling Center, LLC and to the Secretary of Health and Human Services if you believe your health information privacy rights have been violated. You may file a complaint, in writing, with Healing Hearts Counseling Center, LLC, which maintains any PHI. You must state the basis for your complaint. Healing Hearts Counseling Center, LLC will not retaliate against you for filing a complaint. You may contact the Privacy Officer at 678-895-5681, or by mail to Attn: Privacy Officer, Healing Hearts Counseling Center, LLC, 8310 Office Park Drive, Douglasville, GA 30122 for further information about the complaint process, this notice, or your rights set forth above. Please sign a copy of this Notice of Privacy Practices for Healing Hearts Counseling Center, LLC's records.

I have received a copy of this Notice on the date indicated below.

Client Name (Please Print) ____________________________________
Signature ______________________________________
Date ___________________