Gye Nyame Therapeutic Counseling LLC

(The information requested in this form will be kept confidential.)

CONTRACT, OFFICE PROCEDURES, and FINANCIAL AGREEMENT
FOR PSYCHOTHERAPY SERVICES

***Welcome** to Gye Nyame Therapeutic Counseling, LLC. This document contains important information about Gye Nyame Therapeutic Counseling, LLC. professional services and business policies. I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may affect you. Therefore, I am providing this information in writing.*

I encourage you to take the time to read through this carefully before your first appointment. Please jot down any questions you might have so that you and your therapist can discuss them at your initial meeting. When you sign this document, it will represent an agreement between you and Gye Nyame Therapeutic Counseling, LLC.

GYE NYAME THERAPEUTIC COUNSELING, LLC. (GNTC) is an independent corporation that is educational, therapeutic, and benevolent by nature..

GNTC employs counselors who are:
a) Licensed by the Georgia, and are practicing therapists;
b) Graduate interns who have a Master's degree and are working towards completing their hours for licensure; and
c) Trainees who are working towards the completion of their Master's degree program in counseling.

CONFIDENTIALITY: **All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.**

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled.

Initial here: _____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by GNTC. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. GNTC counselors will use their clinical judgment when revealing such information. GNTC will not release records to any outside party unless they are authorized to do so by all adult family members who are part of the treatment.

Initial here: _____

Health Insurance & Confidentiality of Records: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law recently took effect and is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that I give to you a **Notice of Privacy Practices (NPP)** that describes your rights and protections regarding your health care records (PHI). The Notice explains your rights regarding your private healthcare information, including your right to:

- Inspect and copy your medical records;
- Request an amendment or addendum to your medical records;
- An accounting of disclosures of your private health information;
- Request restrictions to release your medical information; and
- Request restrictions of confidential communications with you.

This document is included as part of the **website** *First Visit Forms Packet* that you can review and/or print out as you wish prior to your initial appointment. Upon request, **paper copies** may also be obtained from the front office receptionist.

Gye Nyame Therapeutic Counseling LLC

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By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. GNTC has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

I have received and understand GNTC's HIPAA policies- Notice of Privacy Practices and have been made aware of how my records may be used and disclosed.

Signature of Client/Responsible Party Print Name Date

TELEPHONE & EMERGENCY PROCEDURES:

- The ***best phone number*** for the offices is ***(973) 568-1462***. If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office.
- ***In a crisis,*** if your therapist cannot be reached and ***you are in imminent danger, call the police (911), or go immediately to your local emergency hospital.***
- If you need to contact GNTC between sessions, for an emergency, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and therefore, I cannot guarantee immediate return calls. GNTC counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call or session.
- If there is an emergency whereby a GNTC counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, the counselor will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care. For this purpose, the counselor may also contact the person whose name you have provided as an **Emergency Contact** on the *Intake Form*.

Initial here: _____

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT: Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with GNTC constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Many people feel comfortable communicating via email, because they have installed programs designed to detect spy ware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.

2. Sent and received emails are stored on both GNTC and your computer until deleted. GNTC may or may not delete such emails. Any saved emails will be kept in a password-protected account that only GNTC has access to.

3. In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities to locate and read such emails under various circumstances, this is not a policy of GNTC, but is due to the nature in which email is transmitted using the Internet, and other services or networks. For more information on this, please contact your Internet Service Provider or email service.

4. By initialing below, I agree that I understand the disclosures listed above regarding communicating with GNTC using email. I also agree that if I send an email to a GNTC counselor and request a response via email, that I am willing to accept the above-stated risks. I also agree that I will not use email for emergencies.
Initial here: _____

Permission for GNTC to initiate emails to you:

Initial below if you give your permission for GNTC to initiate sending emails to you.

Initial here: _____
Print your email clearly: _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I, (print name of responsible party) _____ **consent for treatment to be rendered by a therapist of Gye Nyame Therapeutic Counseling. I grant the therapist to perform those procedures and treatments, which may include professional consultation or emergency telephone responses, necessary for my condition that are generally used in this and similar settings. I understand that information or opinions will be given to others only with my written consent.**

Signature of Client/Responsible Party | Print Name | Date

APPOINTMENTS: All office visits are by appointment and may be scheduled through the office manager or your counselor directly. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. If you are unable to keep a scheduled appointment, you must notify GNTC **at least 24 hours in advance** to avoid having to pay for the canceled or missed appointment. Please leave a message if you get the voice mail. If you miss or cancel your appointment, you will need to contact the office for a new appointment time.

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours notice** is required for rescheduling or canceling an appointment. **You will be charged for the full amount of a scheduled fee without such notification;** $120 for licensed counselors and $60 for interns. Most insurance companies do not reimburse for missed sessions.
Your compliance in keeping appointments and active participation in treatment is vital.

Initial here: _____

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a ***cash basis***, and not billing any insurance company are expected to ***pay in full at time of service*** unless other arrangements have been made.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- **Insured clients are expected to take care of their fees as services are rendered.** Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.
- My office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment, deductible, and insurance claims on your account.
- ***Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 30 days after the rendering of services.***
- The client portion (co-pay) of fees is expected at the time of service. ***Co-pays are not negotiable***. *Failure to pay your part may jeopardize your benefits*.
- ***Additional fees*** are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.
- There is a ***$30.00 service fee*** **for checks returned** for non-sufficient funds, and the client will be required to pay for future

sessions in cash. Before any future visits occur, the client or responsible party must pay ***in cash*** the service charge ***PLUS*** the value of the check.

- At any time during treatment ***should the client become ineligible for insurance coverage****, the client and/or responsible party agrees to notify the counselor and* ***will be responsible for 100% of the bill.***

Initial here: _____

Collection Policy: My office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to my collection agency, your financial records will be released to them and your delinquent balance will be recorded with the three (3) major credit bureaus, i.e., Trans Union, Equifax, and Experian.

- Accounts become ***delinquent after thirty (30) days***. Delinquent accounts may be turned over for collection.
- A ***12% fee*** will be added for balances ***over 30 days*** old.
- If legal proceedings become necessary, the client hereby agrees to bear ***all financial responsibility*** for all attorney and court costs associated with collecting an unpaid debt. Please be aware that I take this action only as a last resort.

Initial here: _____

Appeals And Grievances: I acknowledge my right to request reconsideration (an Appeal) in the case that client care is not certified by Managed Care Company. I understand that I would request an Appeal directly through my Managed Care Organization.

I also understand that I may submit a Grievance to my practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company. My practitioner has access to information to facilitate this.

I understand that the GA Department of Community Health (GA DCH) is responsible for regulating health care services. The GA DCH can be reached at 404) 656-0409 to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan I can contact the Managed Care Patent's Rights.

Initial here: _____

Consent To Treatment And Fee: By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Gye Nyame Therapeutic Counseling, LLC and all insurance benefits due to me to the full extent of my financial obligation to GNTC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Georgia State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Signature of Client/Responsible Party | Print Name | Date

THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that GNTC carry out counseling treatment and/or diagnostic procedures that now or during the course of your care as a client are advisable.

Gye Nyame Therapeutic Counseling LLC

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Participation in therapy can result in a number of benefits, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy.

Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. GNTC will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. GNTC may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that are not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the case of therapy, GNTC is likely to draw on various psychological approaches according, in part, to the problem that is being treated and an assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

- ❖ I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- ❖ I understand that my paths may cross in social situations, but that my therapeutic relationship comes first, along with protection of my confidentiality.
- ❖ I understand that there are some occasions when confidentiality can/must be breached. These are:
    - a) I sign a *Release of Information Form* or I verbally direct my counselor to tell someone else,
    - b) My counselor determines that his/her client poses a threat to self or others,
    - c) My counselor is ordered by a court to disclose information,
    - d) My counselor suspects child abuse has taken place and will notify Child Protective Services, or
    - e) Forensic consultation or treatment ordered by the courts.
- ❖ I understand that counseling can improve as well as upset the equilibrium in any person or family.
- ❖ I understand that GNTC counselors are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: _____

Rights and Risks:

- ❖ Please feel free to ask questions about any aspect of the counseling process. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the GNTC counselor's expertise in employing them, or about the treatment plan, please ask and you will be answered fully.
- ❖ If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- ❖ You need to be willing to discuss what troubles you and be open to change.
- ❖ You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- ❖ You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that GNTC does not provide, the therapist has an ethical obligation to assist you in obtaining those treatments.

Initial here: _____

You are entitled to receive a copy of your records, or your therapist can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in the presence of your counselor so that she/he can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Initial here: _____

TERMINATION:

- An orderly end of therapy has positive effects for clients. It is suggested that you discuss openly with your counselor your wish to end therapy at least three (3) sessions before your last session. A final closure session has proved to be very important for clients. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. While not required they are strongly recommended; you have the right to terminate therapy at any time. If you choose to do so, GNTC will offer to provide you with names of other qualified professionals whose services you might prefer.
- If at any point during psychotherapy, a GNTC counselor assesses that she/he is not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, the counselor would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, the GNTC counselor will talk to the psychotherapist of your choice in order to help with the transition.
- If at any time you want another professional's opinion or wish to consult with another therapist, GNTC will assist you in finding someone qualified, and with your written consent, will provide her or him with the essential information needed.
- If you don't show-up for three consecutive scheduled appointments, your treatment will be considered canceled and terminated and you will be financially responsible for the fees of the missed sessions. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

Initial here: _____

Consent: In order to evaluate my services may I have permission to contact you once you have completed your counseling with the understanding your response will be held confidential? ____Yes ____No

Initial here: _____

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

I have discussed these policies with a Gye Nyame Therapeutic Counseling, LLC staff person of desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desire.

Signature of Client/Legal Representative	Print Name	Date
Additional Client Signature (Spouse, /Partner, Family Member)	Print Name	Date

Gye Nyame Therapeutic Counseling LLC

(The information requested in this form will be kept confidential.)

INTAKE FORM

Please print legibly.

EAP? ☐Yes ☐No EAP Name:_____

Counseling Request

What **type of counseling** are you pursuing? ___ Adult Individual ___Child Individual ___ Adolescent Individual
___Couples ___ Family
___Group or Classes Please specify: _____

When are you **available** for counseling sessions? I will try to accommodate your schedule as much as possible.
___Morning ___Afternoon ___Evening ___Saturday ___Certain days: _____

Client Information

Client's Name: _____ Today's Date: _____
(Last) (First) (Middle Initial)

Soc. Sec. #: _____

Gender: M____ F____ Age: _____ Birth date: _____

Address:_____

City, State,Zip:_____

Home Phone _____ May I leave a message at home? Yes No

Work Phone _____ May I leave you a message at work? Yes No

Cell Phone _____ May I leave a message on the cell? Yes No

E-mail _____ May I email you or put you on my mailing list? Yes No

Responsible Party, if the client is an underage minor: Who is the legal guardian? _____

Name: _____

Address _____

City, State & Zip _____

Social Security#_____ Birth date: _____

Home Phone _____ Work Phone _____ Cell Phone _____

May I call you or leave a message for you at: Home [ ] Work [ ] Your Cell [ ]

Important persons to contact in case of emergency (Please provide name and telephone number):

[ ] Spouse_____ [ ] Parent _____ [ ] Other _____

#_____ #_____ #_____

Employment Information

Client Occupation: _____ Employer: _____

Employer Address, City, State, Zip Code: _____

Phone # (_____) _____ Check One: ___Employed Full-Time ___Employed Part-Time

___Unemployed How long have you worked for your current employer? _____ What is your gross income: _____

(I may need your income to set your fee)

Gye Nyame Therapeutic Counseling LLC

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Personal History

Primary Language: _____ **Ethnicity:** _____

Was the client adopted? Yes_____ No _____ Lived at any time in foster care? Yes_____ No _____

Is the client a student? Yes_____ No _____ Name of School/College _____

___Part-Time Student ___Full-Time Student Highest grade/education/degree completed _____

Marital Status: ___Never Married ___Married ___Separated ___ Divorced
___Widowed ___Common Law ___Engaged ___ Partners

Spouse/Partner's Name: _____ Soc. Sec. #: _____
(Last) (First) (Middle Initial)

Gender: M F Age: _____ Birth date: _____ Length of Relationship: _____

Work #_____ Home #_____ Cell #_____

If separated: Address, City, State & Zip _____

Occupation of Spouse _____ Employer: _____

Employer Phone # (_____) _____ Check One: ___Employed Full-Time ___Employed Part-Time ___Unemployed

Employer Address _____ City, State, Zip: _____

How long working for the current employer? _____ What is their gross income? _____
(I may need this income to set your fee)

Children and/or dependents currently at home & their ages: _____

_____

COUNSELING CONCERNS

Why are you seeking help now?

_____

_____

What would you like to see happen as a result of counseling or psychotherapy?

_____

_____

PSYCHOLOGICAL HISTORY

Psychiatrist's Name: _____ Psychiatrist's Phone: _____

Have you ever had counseling or psychotherapy in the past? ☐Yes ☐No

If yes, when? _____ With whom? _____

Current Medication Dosage Frequency Prescribing MD

_____

_____

Have you or any other family member received help for drug or alcohol dependency? ☐Yes ☐No

If yes, when? _____ Where? _____

Check which of the following you use, and note the amount and frequency of each:

Caffeine: _____ Tobacco: _____ ☐Coffee ☐Sodas ☐Other drinks ☐Pills

Alcohol: _____ Marijuana: _____
Cocaine, Crack: _____ LSD: _____
Inhalants: _____ Other: _____

Have you been concerned or ever felt guilty about your use of drugs/alcohol? ☐Yes ☐No

Has anyone ever expressed concern about your use of drugs/alcohol? ☐Yes ☐No If yes, who? _____

Have you ever had a DUI? ☐Yes ☐No If yes, how many?_____ When? _____

Have you ever felt the need to cut down on your use of drugs/alcohol? ☐Yes ☐No

Have you or others ever felt annoyed by criticism of your use of drugs/alcohol? ☐Yes ☐No

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope with withdrawal symptoms? ☐Yes ☐No

Checklist of Concerns
Please check any relevant concerns.

THOUGHTS/FEELINGS/MOOD
☐Anger/frustration/hostility ☐Anxiety, nervousness ☐Attention, concentration, distractibility ☐Confusion ☐Depression ☐Disliking others ☐Emptiness ☐Euphoria ☐Excessive worry ☐Failure ☐Fatigue ☐Fear ☐Grieving (death, loss, divorce, etc) ☐Guilt ☐Hearing things other people don't ☐Homicidal thoughts ☐Intrusive thoughts ☐Judgment problems ☐Memory difficulties ☐Negative thoughts ☐Obsessive thoughts ☐Oversensitivity to criticism ☐Oversensitivity to rejection ☐Panic attacks ☐Perfectionism ☐Sadness ☐Seeing things other people don't ☐Self-centeredness ☐Self-esteem ☐Shyness ☐Spiritual, religious, or moral issues ☐Stress ☐Sudden mood changes ☐Suicidal thoughts ☐Suspiciousness ☐Temper problems ☐Thoughts of hurting self or others

BEHAVIOR
☐Aggression, violence ☐Alcohol use ☐Argumentative ☐Avoidant ☐Compulsive behavior/rituals ☐Controlling ☐ Decreased/lack of sexual interest ☐Dependency ☐Destruction of property ☐Drug use – prescription, over-the-counter, street ☐Eating problems ☐Financial problems, debt ☐Gambling ☐Hyperactivity ☐Internet problems ☐Irresponsibility ☐Isolation ☐Legal problems ☐Letting others take advantage of you ☐Lying Not able to relax ☐Loss of interest on what I used to like ☐Loss of appetite ☐Overeating ☐Pornography ☐Preoccupation with sex ☐Procrastination ☐Purging ☐Self destruction/sabotaging ☐Self-neglect ☐Sexual dysfunction ☐Smoking ☐Stealing ☐Sleep difficulty ☐Threats ☐Weight gain or loss ☐Withdrawal from others ☐ Self-injurious behavior ☐Sexual promiscuity

FAMILY & RELATIONSHIPS
☐Infidelity ☐Childhood issues (your childhood) ☐Divorce ☐Friendships ☐Housework/chores ☐Interpersonal conflicts ☐Parenting ☐Problems with child(ren) ☐Problems with parents ☐Problems with spouse/partner ☐Separation

ABUSE
☐Abuse of alcohol ☐Abuse of drugs ☐Emotional abuse by another ☐Emotional abuse of another ☐Financial abuse ☐Neglect ☐Physical abuse by another ☐Physical abuse of another ☐Sexual abuse by another ☐Sexual abuse of another ☐Verbal abuse

WORK & SCHOOL
☐Absenteeism ☐Career concerns, goals, choices ☐Difficulty with coworkers ☐Difficulty with supervisor ☐Performance ☐Tardiness ☐Procrastination ☐School problems

OTHER CONCERNS

_____

☐ I have no problems or concerns bringing me here at this time.

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Referred By? How Did You Hear About Us? (Check all that apply):

___I am a former client returning. How long ago? ____	___Family or Friend	___A client
___Brochure/Flyers	___Internet	___Yellow Pages
___Employee Assistance Program	___Employer/Supervisor	___Colleague
___Union Representative	___School _____	
___Insurance Company/Managed care	___Physician _____	
___Court/Legal	___Probation _____	
___Another Therapist _____	___Minister/Priest/Rabbi _____	
___Word of mouth	___Other _____	

PLEASE SIGN BELOW TO INDIGATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Legal Guardian/Foster Parent/Conservator/Other Date
(Required if participant is a minor, under age 18)

Gye Nyame Therapeutic Counseling LLC

(The information requested in this form will be kept confidential.)

INSURANCE INFORMATION
Who Is Responsible for this account? Who is the insured? What are your insurance requirements?

Primary Insurance Insured is: Self ___ Spouse/Partner ___ Child _____ Other _____

What is the insurance company name? _____

Billing Address _____

Phone Number (_____)_____ Is it a PPO? [ ] or HMO? [ ]

Membership/Benefit Policy Number _____ Group # _____

Plan # _____ Effective Date: _____/ _____/_____

How much coverage do you have in a year? _____ Have you met your deductible? Yes ___ No ____

What are your insurance company's credential requirements for pursuing counseling? (e.g. licensed MFT, registered social worker, etc.)

_____

Secondary Insurance: **Insured is:** Self ___ Spouse/Partner ___ Child _____ Other _____

What is the insurance company name? _____

Billing Address _____

Phone Number (_____)_____ Is it a PPO? [ ] or HMO? [ ]

Membership/Benefit Policy Number _____ Group # _____

Plan # _____ Effective Date: _____/ _____/_____

How much coverage do you have in a year? _____ Have you met your deductible? Yes ___ No ____

What are your insurance company's credential requirements for pursuing counseling? (e.g. licensed MFT, registered social worker.)

_____

Please Provide A Copy of Your Insurance card To Office Staff So Benefits May Be Verified. Thank You.

Although **you are ultimately responsible for your fee**, health insurance may pay a portion of the charge. At your request, the office staff will contact your insurance company to file your claims.

If your annual deductible has been met, it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the Center. If the deductible has not been met, you will be responsible for paying the full fee until the deductible has been satisfied, or you may agree to a plan with the office manager for paying the deductible and co-payment amounts. **Co-pays are due at the time of your session.**

Initial _____

FOR OFFICE USE ONLY

Number of sessions per year: _____

Number of sessions in a lifetime: _____

Allowable charges: $ _____

Do they consider a parity diagnosis? _____

Coverage per session: $ _____/ _____%

Allowable Co-payment: $ _____

Gye Nyame Therapeutic Counseling LLC

(The information requested in this form will be kept confidential.)

Notice of Privacy Practices

I respect my clients' confidentiality and only release information about you in accordance with state and federal laws.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT GAREFULLY.

This notice describes my policies related to the use of the records of your care at Gye Nyame Therapeutic Counseling, LLC. I am required to give you this Notice about (1) the use and disclosure of your health information, (2) my legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for additional information, contact Gye Nyame Therapeutic Counseling, LLC, 1479 Brockett Rd. Suite 102, Tucker, GA 30084. Ph: 973-568-1462 Fax.770-734-3256

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I use and disclose the minimum necessary health information about you regarding your treatment, to process payment for services, and for Gye Nyame Therapeutic Counseling, LLC.'s mental health care operations.

a. For Treatment. I use and disclose your health information internally in the case of your treatment at Gye Nyame Therapeutic Counseling, LLC. If I wish to provide information outside of Gye Nyame Therapeutic Counseling, LLC. for your treatment by another health care provider, I will have you sign an *Authorization For Release Of Information*.

b. For Payment. I may use and disclose your health information to obtain payment for services I provide to you as delineated in the "Contract, Office Procedure, and Financial Agreement" form. For example, I may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service I have provided to you.

c. For Health care Operations. I may use and disclose your health information within Gye Nyame Therapeutic Counseling, LLC. as part of my internal health care operations. For example, this could mean a review of records to assure quality. Alternatively, I may provide information to the student intern who is your therapist and is authorized to receive training at Gye Nyame Therapeutic Counseling, LLC. and to staff who supervise him or her. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

2. INFORMATION DISCLOSED WITHOUT YMY CONSENT

Under GA and federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. I may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you are to make a claim for Workers Compensation.

c. Public Health Activities. If I felt you are an immediate danger to yourself or others, I may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. I may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. I may disclose health information if a crime is committed on my premises or against my personnel, or if I believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. I may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.

g. Health Oversight Activities. I may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. Business Associates. Gye Nyame Therapeutic Counseling, LLC. may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide us with services if the information is necessary for such functions or services. For

example, Gye Nyame Therapeutic Counseling, LLC. contracts with a financial audit firm to review the finances of Gye Nyame Therapeutic Counseling, LLC. on a yearly basis. In the process of the audit, they may encounter client-billing records. All of my business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in my contract.

l. Research/Supervision. Under certain circumstances, Gye Nyame Therapeutic Counseling, LLC. may use and disclose health information for research and/or supervision. Before I do so, the project will go through a special approval process that includes a consent form for clients to sign if they are included in the research study/supervision. Even without the special approval, however, Gye Nyame Therapeutic Counseling, LLC. may permit researchers affiliated with Gye Nyame Therapeutic Counseling, LLC. to look at non-identifying information to help them plan research projects.

j. Marketing. Gye Nyame Therapeutic Counseling, LLC. may send you newsletters or information about services I provide in which I feel you might be interested. You may at any time request that your name be removed from my mailing list. I will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic mail.

k. Fundraising/Activities. Gye Nyame Therapeutic Counseling, LLC. may use certain client demographic information-such as your name and address-to contact you about fundraising, ministries, workshops, training events, calendars of events, etc. Gye Nyame Therapeutic Counseling, LLC. regularly seeks contributions from the general public to support my charitable and educational programs such as free care for children and families in low-income communities, a reduced-fee clinic, student scholarships, and research projects. If you do not wish to be contacted about fundraising, send a written request to Gye Nyame Therapeutic Counseling, LLC., 1479 Brockett Rd, Suite 102 Tucker GA 30084 , Office # 770-686-3601.

l. Scheduling Appointments. Gye Nyame Therapeutic Counseling, LLC. may use your phone number to call you and leave messages to schedule or remind you of appointments.

3. YMY RIGHTS REGARDING YMY HEALTH INFORMATION:

a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. Right to Amend. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I have the right to deny your request under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which I have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to the Executive Director. Such accountings are available for disclosures beginning April 14, 2003, and remain available for eight years after the last date of service at Gye Nyame Therapeutic Counseling, LLC.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information I use or disclose about you. For example, you could ask that I not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. While you are in treatment, a written request should be made with your therapist. To request a restriction after therapy is completed, you must make your written request to the Executive Director of Gye Nyame Therapeutic Counseling, LLC. I am not required to agree to your request, but I will consider the request very seriously. If I agree, I will abide by my agreement unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communications. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For example, you may ask that I contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. I will make every attempt to accommodate reasonable requests.

f. Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available at the reception desks or lobbies at each Gye Nyame Therapeutic Counseling, LLC. site. You may also obtain a copy of this notice at my website, www.gyenyametheraptuticcounseling.com.. Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by the records department of Gye Nyame Therapeutic Counseling, LLC. and will only be for disclosures not already completed.

I reserve the right to change my privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, I will change this Notice and make a new Notice available to you at the reception desks or lobbies at each Center site and on my website.

Beginning January 1, 2016, I am required to abide by the terms of Notice.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the U. S. Department of Health & Human Services www.hhs.gov/ocr/hipaa/. To obtain additional information, or to file a complaint with us, contact us at (973) 568-1462. I will not retaliate in any way if you choose to file a complaint.

This Notice is effective 01/2016

Gye Nyame Therapeutic Counseling LLC

(The information requested in this form will be kept confidential.)

Credit Card Processing Form

Name on credit card _____

Credit Card Type: VISA ___ | MASTERCARD ___ | AMEX ___ | DISCOVER ___

Company Name __Gye Nyame Therapeutic Counseling Services, LLC

CREDIT CARD INFORMATION

Account Number _____ Expiration Date _____ CVE _____

Billing Address _____

City_____ State_____ Zip Code _____

Phone_____ Email _____ | Fax _____

AUTHORIZED USER OF CREDIT CARD INFORMATION

Name _____

Company Gye Nyame Therapeutic Counseling, LLC

Telephone number _____

Email address _____

Relationship with owner _____

Type of charges $_____

Amount authorized _____

AUTHORIZATION OF CARD USE

Cardholder Name _____

Signature _____ Date _____