Client Information Form Heidi Moss Counseling, LLC

Client Name_____ New Client? ð Client Update? ð
Must be full, legal name of the person being seen for therapy

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender ð M ð F

Home Phone _____ ð Y ð N
May I leave a message?

Work Phone _____ ð Y ð N
May I leave a message?

Other Phone_____ ð Y ð N
Please identify May I leave a message?

Client Marital Status
ð Single ð Married ð Other

Client Employed?
ð Yes ð No

Client Student Status
ð Full Time ð Part Time

Email:_____ May we send appointment reminders via email? ð Y ð N

How Did You Hear About My Practice? ***Please be as specific as possible***

Name _____ ð Former/Current Client ð Yellow Pages ð Internet

ð Healthcare Professional ð Mental Health Provider ð Insurance Company ð Word of Mouth

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please complete any information that differs from the client.***

Name_____ Home Phone_____

Address_____ Work Phone_____
Street or PO Box

_____ Relationship to Client:_____
City State Zip

Insurance Information ***Information in this section should pertain to the Primary Person listed on the insurance card. Please complete any information that differs from the client.***

Insurance Co_____ Insurance Phone#_____

Insured's Name_____ ID#_____

Group#_____ Patient Relationship to Insured ð Self ð Spouse ð Child ð Other

Insured's Address _____ Home Phone_____
Street or PO Box

_____Insured's SSN_____
City State Zip

Insured's DOB_____ Gender ð M ð F Insured's Employer_____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature_____ Date_____

Office Use Only Therapist _____ Diagnosis Code_____

Billing Notes_____

Form Updated 5/9/11

Additional Client Information

Emergency Contact:

Name _____ Phone _____

Address_____

_____

List all the people who live in your household (not including self):

Name _____ Relationship_____ Gender_____ Age____

Name _____ Relationship_____ Gender_____ Age____

Name _____ Relationship_____ Gender_____ Age____

Name _____ Relationship_____ Gender_____ Age____

Name _____ Relationship_____ Gender_____ Age____

List any current health conditions and all current medications _____

_____

_____

_____

Reason for seeking counseling at this time _____

_____

_____

_____

Have you been in counseling before __Y __N? If yes:

Dates _____ Previous Counselor _____

Dates _____ Previous Counselor _____

Dates _____ Previous Counselor _____

Describe any other professional involvement (example: physician, psychiatrist, attorney, inpatient facility, social services agency, etc.) or any current or anticipated court involvement _____

Heidi Moss, LISW-CP/S, CEDS/S

Magnolia Counseling Associates • Professional Disclosure Statement

General Information

Magnolia Counseling Associates is located in Spartanburg South Carolina, www.Magnoliacounseling.net. Office hours are by appointment only. The telephone number is 864583-5969 (the answering service is confidential). My confidential email address Heidimoss@therapysecure.com. It is checked at least once every working day.

Educational Qualifications

I have a Masters Degree in Social Work from Wurzweiler School of Social Work in New York. I am a Licensed Clinical Social Worker #5207 with the South Carolina Board of Social Work Examiners, Post Office Box 11329, Columbia, SC 29211-1329, Phone: 803-896-4665.

Other Professional Qualifications

- Social Work Supervisor
- Certified Eating Disorder Counselor, CEDS
- CEDS Supervisor
- Registered Acceptance, Commitment Therapy (ACT) therapist

Therapy Services

- Individual therapy involves a one-on-one relationship between a client and a therapist that aims to increase the individual's sense of well being.
- Family therapy involves a relationship with families or couples in an intimate relationship to nurture change and development between parties.
- Group therapy involves a group of clients meeting to discuss topics pertaining to adjustment to changes in life cycle development or specific issues such as bullying, occupational issues, etc. Therapeutic assessment and treatment of major diagnoses in individuals, groups and families.

Fees

Payment is due for professional services at the time they are rendered.

The initial intake assessment	$135
Individual, couple, and family therapy	$110
Group therapy	$60 per attendee
Written Reports	$25 per quarter hour
Phone calls over 5 min	$25 per quarter hour
Failed Appointments, cxl. less than 24 hours	$100
Medicare failed appointments or cxl.	$65
Meetings and Professional Consultations	$110/ hour
Court Appearance	$1,000 flat fee plus hourly rate for preparation, testimony, meetings, etc.
Returned Checks	processing fee is up to the bank's policy Supervision for Social Workers and CEDS $110

Court Appearances

Please note that I do NOT make court appearances or form opinions regarding custody or legal proceedings of any nature when doing outpatient therapy. I do not enter into the therapy process with

this mindset, so a subpoena or court order can and will do irreparable damage to the therapeutic alliance, especially with children, and often does more harm than good to the client involved in the case. If I am required to do so, there is an hourly charge of $110 an hour for time spent attending to these matters including phone calls and preparation. In the rare event that I am called to court as an expert witness, there is a one-time fee of $1,000 IN ADDITION to any time spent attending to matters regarding the case.

Insurance Payment

Because psychotherapy is a specialty, insurance companies frequently place special requirements on both the patient and the therapist. To ensure you are receiving maximum benefits from your insurer, contact your insurance company prior to your initial appointment to review your benefits for psychotherapy. Generally, insurers refer to this form of treatment as Outpatient Mental Health Services. An outside billing person will be in charge of handling information necessary to secure payment and assign all benefits to which the therapist is entitled. If you have questions, ask your therapist, and the billing person will contact you directly.

Confidentiality

The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina or through a court order (signed only by a judge) but is considered privileged in the federal court system. I am mandated by standards - through Duties to Warn - to breach confidentiality if I discover the following:

1) I must report what is mandated by law such as child or elder abuse.
2) I must report if there is a clear and present danger to a person or persons such as threat of suicide or homicide.
3) I may disclose specific information if I have a signed waiver from each participant in therapy.
4) I must disclose if I believe your mental/emotional condition makes you unable to take care of yourself or people for whom you are responsible.
5) I must disclose if it is determined that you or your family member is in need of hospitalization.
6) I must disclose if I am ordered by a court to do so.
7) I may disclose information in order to defend myself against legal or ethical charges arising from therapy. I am subject to subpoena.
8) I must disclose if you are using insurance to pay for your therapy or there is someone you have deemed as payor of your therapy.

Finally, if you wish your protected health information released to another party, you must sign a specific document called a Release of Information. Verbal authorization is not sufficient. My Code of Ethics states that Social Workers are to limit client's access to their records, with compelling evidence, if such access would cause serious harm to the client.

Electronic Communications Policy

Email provides an easy and convenient way for therapists and clients to communicate but can also introduce challenges into the therapist-client relationship. Below are guidelines for contacting me using email.

- For emergencies, use an Emergency Room. Do not use emails.
- Email is not a substitute for a therapeutic session. If you think you might need to be seen, please call or schedule an appointment.
- Appropriate use of email includes appointment scheduling requests.
- Email should not be used to communicate sensitive medical information such as information regarding mental health or physical health issues.

- Emailing any information to "update" me about you or your child's upcoming appointment is not confidential. If you need to schedule time to speak with me before the appointment, please request that in plenty of time before the session.
- Although my email service is encrypted, email is not confidential. Be aware that if you send emails from your work, your employer has a legal right to read your email.
- Email is part of your record. A copy will be printed and put into your charts. • Either you or I can revoke permission to use the email system at any time.

Please initial ONE of the following options:

_____ It is permissible for my therapist to contact me via email regarding scheduling.
Preferred Email Address:
_____

_____ It is NOT permissible for my therapist to contact me via email regarding scheduling.

Texting and Voicemail Policy
Please refrain from text messaging unless used as a request that I call you. Use email or call me directly. Be aware that voicemail is not confidential. Please do not leave a confidential voice message on a cell phone.

Please initial ONE of the following options:

_____ It is permissible for my therapist to contact me via text regarding scheduling.
Preferred Phone Number:
_____

_____ It is NOT permissible for my therapist to contact me via text regarding scheduling.

Ethics
I follow the Code of Ethics of The American Association of Social Workers. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned or tolerated and the therapeutic relationship will be terminated.

Informed Consent
You will be required to sign this document. Your signature verifies you have been given this document and the HIPAA document that follows, that you have read and understand these documents, and that you consent to treatment.
Further you need to be aware of the following:
o Treatment isn't always successful and may open unexpected emotionally sensitive areas.
o I am not a physician and cannot prescribe medications. o I may need to consult with your physician, attorney, or other counselor. o I am not available 24 hours a day.
o I am licensed through the SC Board of Examiners for Social Workers, Marriage and Family; this Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803-8964652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).

Consent for Treatment of a Juvenile
Any child under the age of 18 who is seen must have his or her parent or legal guardian sign this consent. By signing the form below, you are confirming that you have legal custody of the child and have the right to authorize treatment for the minor. In the case that there is any type of alternative custody situation, the client must provide written documentation of the custody agreement.

Please be advised: generally, children under the age of 18 do not legally have a right to confidentiality from their parents/legal guardians. This means that parents have a legal right to their children's files. However, we want to stress that a very important part of what makes therapy work is when clients (i.e., children) know that the information they choose to share will be kept private. Therapy is often a safe place for children to process things in their lives that are scary or uncomfortable to share with the adults who take care of them. If children feel that they can expect a reasonable amount of privacy in the therapy room, they are much more likely to make progress. We ask that parents respect this and not ask children questions about what happened in their therapy sessions, but rather let children bring it up if they choose to. It is also important that both you (the caretaker) and the child understand the limits of confidentiality. In the event that the child shares something during the course of therapy which is necessary for the parent to know (such as a safety issue), we will let the child know that that is something we have to share and then inform the parent about the issue. Also, all of the legal limits of confidentiality apply. Part of the first session will be dedicated to answering questions about these limits and deciding what level of privacy is appropriate for your particular situation.

Special Note

Clients must make their own decisions regarding marrying, separating, divorcing, reconciling, and setting up custody and visitation. If necessary, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision.

To be the best therapist for you means taking care of my family and myself when I am not at work. Please respect my time when we are not in session. If you have an issue you need to speak with me about between sessions, please make an appointment using the email address above or call the answering service.

The relationship between therapist and client is unique and important. It is normal and healthy to feel emotions of friendship towards your therapist. Please be advised however that it is considered a dual relationship for a client to develop a social relationship with a therapist. This includes becoming Facebook friends or becoming friends with your immediate family.

I acknowledge that I have read and understand the above document.

_____

Client/Parent/Guardian Signature Date

_____

Client/Parent/Guardian Signature Date

_____

Heidi Moss, LISW-CP/S, CEDS/S Date

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and 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. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. 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 our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Spartanburg County Department of Social Services. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Spartanburg County Department of Social Services. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the

reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.

- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or if you disagree with a decision I made about access to your records, you may contact me, the State of South Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Heidi Moss, LISW-CP/S, CEDS/S Date

Provider, Heidi Moss, LISW/CP/S, CED/S

License #5207

Client Name_____Date_____

Thank you for choosing Heidi Moss counseling, LLC. Please read the following video therapy consent and sign below. If you have any questions please let me know before the session begins and I will be happy to answer them for you. You can reach her at 864-316-6835 or heidimoss@bellsouth.net.

1. I understand that I am about to engage in video therapy sessions with my provider, Heidi Moss. Payments will be made in one of the following ways:
    a. Have a check sent in advance that arrives before the session.
    b. Provide credit card information at the end of the session, where a charge is immediately made and the credit card information is not kept.
    c. Pay at the end of the session through an invoice sent by the Square.
    d. Most insurances do not cover these sessions. If you chooses to submit for reimbursement I will provide a receipt for you to use.
    e. You must be in the state of South Carolina. I am not certified to practice in any other state.
2. I understand that the video conferencing technology will not be the same as in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate to the situation.
4. My provider agrees to inform me and obtain my consent if another person is present during the consultation for any reason. I agree to inform my provider if there is another person present during the session or if I wish to tape the session.
5. I understand that there are alternatives to a video therapy session available and will ask my counselor or in person referrals instead of using video.
6. I understand that I can direct question about the video therapy session at any time.
7. I understand that this consent will last for the duration of the relationship with my provider including any additional video therapy sessions I may have; I can withdraw my consent for video therapy session at any time.
8. I understand that same confidentiality protections, limit to confidentiality, and rules around my records apply to a video therapy session as they would be an in-person session.
9. I agree to work with my provider to come up with the safety plan,, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.
10. I understand that my provider may decide to terminate video therapy services if they deem it inappropriate for me to continue therapy through video sessions.
11. In case of a crisis where immediate help is needed please provide the name of two people I can contact, and by signing this form you give me permission to call them in an emergency.

    Name _____ Phone number_____

    Name_____ Phone number_____

    If you are in a rural area outside the Greenville/Spartanburg vicinity, please give the number for local law enforcement_____.

By signing this form, I certify:

- I have read or had the form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.

- I agree to participate in video therapy session(s) with Heidi Moss.

_____ _____

Client's/parent/guardian signature Date