JCS | Journey Counseling Services
Walking with you in hope & compassion

Notice of Privacy Policies and Consent for Treatment

This notice involves your privacy rights and describes how information about you may be disclosed, and how you can obtain access to this information. Please review it carefully.

I. Confidentiality

In order to allow for a relationship built on trust, confidentiality is assured at JCS. Client files are kept with the counselor in a traveling file or in a secure location at our office. The information you share will not be disclosed without your written consent. Your Protected Health Information (PHI) is also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). Your PHI includes information created or noted by us that can be used to identify you such as your past, present, or future health (including mental health) or condition, the counseling services we have provided to you, or the payment for such services. We are required to provide you with this Notice about our privacy procedures. Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Should we make any significant changes to our policies, we will immediately change this Notice and make it available to our clients.

II. Limits of Confidentiality

1. As a client of JCS it is important for you to understand that limits to confidentiality do exist. We may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

2. For treatment: We may use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with other JCS therapists and interns. Example: discussing your treatment with another JCS therapist in order to facilitate your care.

3. To obtain payment for treatment: we may disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: we might send your PHI to your insurance company in order to get payment for the health care services provided.

4. Emergency Situations: We may disclose your PHI if we are compelled by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger. In addition, if you are involved in a life - threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

5. Child or Adult abuse reporting: If I have reason to suspect that a child is being abused or neglected, or that an elderly or incapacitated adult is abused, neglected or exploited, I am required by law to alert proper authorities.

6. Court Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I am required to be involved in court proceedings, I will charge $300 per hour which will include travel time.

7. Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

IV. Multiple or Dual Relationships

Dual relationships occur when the counselor and client have a relationship in multiple settings (counseling, church, community group, Facebook, etc.). Ethical considerations suggest using caution within these relationships in order to protect the client. These ethical considerations benefit the client by allowing the counselor to serve in a professional role and meet them where they are in an unbiased manner. While multiple relationships may occur, the counselors at JCS will always approach the relationship in a professional manner and will seek to protect confidentiality and privacy.

V. Social Media Policies

The following statements outline Journey Counseling Services policies regarding social media.

1. Friending and Following: Unless there is a prior relationship with a client or a community connection which may benefit both the client and counselor, we will seek to avoid friending or following past or present clients in order to maintain proper ethical boundaries and to protect client privacy and confidentiality.

2. Email: We use email for arranging and modifying appointments. We use email for administrative tasks and would discourage the use of email by client or counselor to discuss any confidential content that occurred within the counseling process. We cannot guarantee complete security and confidentially for any emails that we receive from you or any responses that we send.

3. Professional Profiles: JCS utilizes social media sites to advertise our services, relay relevant content to followers, and to pass on articles and other material related to mental health. JCS social media sites are for professional use; therefore, it is not encouraged that clients post any personal information to those sites in order to safeguard their privacy and confidentiality.

4. Collaboration with Counselor: While emailing, or other messaging services, are a great way for the client to communicate with their counselor, you should NOT contact your counselor in cases of emergencies. In the case of an emergency, you should contact your Emergency Contact Person (ECP) or call 911. Please refer to the client emergency plan for further guidelines. If you contact your counselor, you can expect a response withing 24-48 hours upon the time of your inquiry.

VI. Patent's Rights

1. Right to request restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care.

2. 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. Example: you might request that we send bills to another address or contact you only at work, or that I do not leave voice mail messages.

3. Right to see and get copies of your PHI: In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that.

4. Right to correct or update you PHI: If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

5. Right to a copy of this notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

This notice went into effect on November 7, 2014.

Client Intake Form

Name: _____

Date of Birth: _____ Marital Status: _____

Employment: ☐ Employed ☐ Student ☐ Unemployed/other

Address: _____

City/State/Zip: _____

Mobile Phone: _____ Voice or text messages ok? Y N

Home Phone: _____ Voice or text messages ok? Y N

Email Address: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Client: _____

Responsible Party: _____ Session Fee: _____

If Other than Self: _____

Address: _____ City/State/Zip: _____

Phone: _____

Insurance: _____ ID: _____ Group #: _____

If person insured is other than self: Name: _____ Birthdate: _____

Address: _____ City/State/Zip: _____

Phone: _____ Card Copied? Y N HIPAA Agreement? Y N

Religious Preference: _____

Home Church: _____

Current Medications/Diagnoses:

Previous Counseling:

Psychiatric Hospitalizations:

Primary Doctor: _____ Clinic: _____

Missed Appointment Agreement

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time *just for you* and that time is valuable. When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. If a situation arises that requires you to reschedule your appointment, notice to your therapist must be made 24 hours in advance of the appointment time. In the event that an appointment is rescheduled or missed without a 24-hour advance notice, a $75 missed appointment fee will be applied for the first missed appointment. A $150 fee will be applied for the second missed appointment, as well as any subsequent missed appointments.

Thank you for your understanding and cooperation with this matter.

By signing this agreement, I commit to paying any charges incurred due to a missed appointment for myself or a child of mine.

_____ _____

Client Signature Date

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Psychosocial History – Minors

Instructions: Please complete the following information about your child and family. If any questions do not apply to your child, simply write "NA" (not applicable) in the space provided or leave the space blank. It is best if this form is completed by all parents or primary caretakers. This information will help your child's therapist better understand your child and their family.

Child's name: _____ Age: _____ DOB: _____ Sex: _____
Address: _____ City: _____ Zip: _____

Family Demographics

Father's name: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Employment: _____ Days/Hours: _____ Highest Grade/Degree Completed: _____
Is this child your: [Y] [N] Biological child: [Y] [N] Adopted child: [Y] [N] Foster child: [Y] [N] Other? _____

Mother's name: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Employment: _____ Days/Hours: _____ Highest Grade / Degree Completed: _____
Is this child your: [Y] [N] Biological child: [Y] [N] Adopted child: [Y] [N] Foster child: [Y] [N] Other? _____
Parents divorced: [Y] [N] If yes, child's age when divorced: _____
With whom does this child live? _____
Who has legal custody of this child? _____

Other persons living in child's home:

NAME	BIRTH DATE	AGE	EDUCATION

Describe any differences or similarities between the parents' style in handling disruptive behavior.

Reason for coming: (e.g. circumstances, people involved, etc.)

Has there been a recent crisis or loss in your child's life? Explain:

Behavior Characteristics: *check all that CURRENTLY apply to your child.*

☐ Overactive	☐ Inattentive	☐ Under-active	☐ Moody	☐ Cooperative
☐ Fidgety	☐ Stubborn	☐ Destructive	☐ Temper Tantrums	☐ Has a conscience
☐ Rebellious	☐ Easily Afraid	☐ Sensitive	☐ Shy Easily	☐ Happy/Cheerful
☐ Excitable	☐ Impulsive	☐ Cries Easily	☐ Angered	☐ Age-appropriate
☐ Sad/Unhappy	☐ Nervous/Worried	☐ Follower	☐ Mean to Children	☐ Playmates
☐ Loner	☐ Mean to Animals	☐ Lying	☐ Cheating	
☐ Stealing	☐ Fire Setting	☐ Moody	☐ Plays Well	
☐ Nail Biting	☐ Thumb Sucking	☐ Nervous Habits	☐ Leader	

Spirituality:

Desire to pursue counseling from a Christian perspective? [Y] [N]

Desire for prayer to open or close therapy session? [Y] [N]

Church affiliation: _____

Describe your spirituality if other than Christian: _____

Importance of faith/spirituality (Rate 1-10): _____

Current spiritual/religious issues seeking help for: _____

Medical and Developmental History:

Child's Physician: _____ Phone: _____

Child's general health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Current prescribed medications/dosage: _____

Benefits/adverse effects of medication: _____

Past hospitalizations, surgeries, medical issues: _____

Pregnancy-related issues (infertility, abortion, etc.): _____

Current medical issues: _____

Ongoing physical pain: [Y] [N] Frequency: _____ Location: _____

Physical disabilities/limitations of movement, sight, or hearing: [Y] [N] If yes, explain: _____

Developmental Delays: [Y] [N] If yes, please explain: _____

Education

Highest level of education/grade completed: _____ Current School: _____

Has your child ever repeated a grade? [Y] [N] If so, which grade? ____ Comments: _____

After school/part-time job? [Y] [N] If yes, describe: _____

After school activities/sports? [Y] [N] If yes, describe: _____

In general, describe your child's performance at school. List any outstanding strengths or problems.

Indicate if teacher(s) describe any of the following as significant problems at school:

- ☐ Doesn't sit still in seat.
- ☐ Frequently gets up and walks around the classroom.
- ☐ Shouts out.
- ☐ Does not wait their turn to be called on.
- ☐ Does not cooperate well in group activities.
- ☐ Typically does better in a one to one relationship.
- ☐ Does not respect the rights of others.
- ☐ Does not pay attention during lessons.
- ☐ Fails to finish assigned homework.
- ☐ Bullies other children.
- ☐ Wets / soils self.
- ☐ Difficulty transitioning.
- ☐ Is not sought out by others to play or work together.

Describe any problems your child may have in school with learning.

Describe any problems your child may have with homework (e.g. forgets, does not return it to school, etc.)

Psychiatric Treatment History:

Outpatient: [Y] [N] If yes, Therapist/Agency: _____ Dates: _____

Area of concern: _____

Inpatient: [Y] [N] If yes, Therapist/Agency: _____ Dates: _____

Area of concern: _____

Abuse:

History of sexual abuse? [Y] [N] History of physical abuse? [Y] [N]

If yes, relationship to abuser: _____ Dates of abuse: _____

Was the abuse reported? [Y] [N]

Any abuse of any kind to other members of family? [Y] [N] If yes, to whom? _____

Substance use/Addictions History:

Tobacco use: [Y] [N] Frequency: _____ Quantity: _____

Alcohol use: [Y] [N] Frequency: _____ Quantity: _____ Problem? [Y] [N]

Drug use: [Y] [N] Frequency: _____ Quantity: _____ Type: _____ Problem? [Y] [N]

Gambling: [Y] [N] Describe: _____

Pornography: [Y] [N] Describe: _____

Other addictions: _____

Harm to Self/Others:

Thoughts of harming yourself? [Y] [N] If yes, explain: _____

Thoughts of harming another person? [Y] [N] If yes, explain: _____

History of any harm to self or others? [Y] [N] If yes, explain: _____

Personal history of suicidal attempts? [Y] [N] If yes, explain: _____

Family history of suicidal thoughts or attempts? [Y] [N] If yes, explain: _____

Please complete each question by checking yes or no.

1. [Y] [N] Have you wished you were not alive anymore or wished you could go to sleep and not wake up?
2. [Y] [N] Have you had any thoughts of harming yourself?
   If YES to 2, answer questions 3, 4, 5, and 6. If NO to 2, go directly to question 6
3. [Y] [N] Have you been thinking about how you might harm yourself?
4. [Y] [N] Have you had these thoughts and had some intention of acting on them?
5. [Y] [N] Have you ever planned the details of how to harm yourself? Do you intend to carry out this plan?
6. [Y] [N] Have you ever done anything, started to do anything, or prepared to do anything to end your life?
   ***If YES, how long ago did you do any of these? _____
7. What prevents you from harming yourself? _____

Strengths, accomplishments, and social supports (family, friends, etc.)

Please use the space below to describe your child's strengths, talents, gifts, accomplishments, and social supports.

Goals for Counseling:

1. _____
2. _____
3. _____

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Client Emergency Plan for Telehealth Services

I. If you have a mental health emergency, you agree to not to wait for communication back from your counselor, but to do one or more of the following (include at least one person you could call, ex: partner, parent, friend):

- Call: _____
- Call: _____
- Call National Crisis Line at (800) 273-8255
- Call Iowa Crisis Chat at (855) 325-4296
- Call 911
- Go to the emergency room of your choice

II. Emergency procedures specific to telehealth services

There are additional required procedures specific to telehealth services. These are for your safety in case of an emergency and are as follows: You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, your counselor may determine that you need a higher level of care and telehealth services are not appropriate. We require an Emergency Contact Person (ECP) whom we may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below. Your ECP must be willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or your counselor determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand that Journey Counseling Services providers will only contact this individual in the event of extreme circumstances stated above.

Please list your ECP here:

Name: _____

Mobile Phone: _____

Work/Other Phone: _____

III. You agree to inform your counselor of the address where you are located the beginning of every session. Please list the primary address where you will participate in therapy sessions:

Location Name/Type (ex. home, office): _____

Address: _____

IV. You agree to list the nearest police department and hospital to your primary location that you prefer to call or go to in the event of an emergency. Please list the nearest police station and hospital to your primary location:

Name of Police Department: _____

Address: _____

Phone: _____

Name of Hospital: _____

Address: _____

Phone: _____

I have read this statement and understand it fully. By signing this document, I agree to follow this plan in the case of a mental health emergency.

Client Signature: _____ Date: _____

Counselor Signature: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.

Credit Card Information:
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Security Code: _____
Billing Information:
Address: _____ City/State/ZIP: _____

I, _____ , authorize _____ to charge my credit card above for agreed upon fees for counseling services. I understand that my information will be saved to file for future transactions on my account.

I acknowledge that this authorization will remain in effect until it is canceled in writing. I also agree to notify Journey Counseling Services in writing of any changes in my account information and termination of this authorization at least 15 days before the next billing date.

_____ _____

Customer Signature Date

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1. AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER
I hereby authorize Journey Counseling Services to communicate with my insurance carrier and provide all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, progress, and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier. I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims.

2. AUTHORIZATION TO PAY JOURNEY COUNSELING SERVICES
I hereby authorize payment of Medical Benefits to Journey Counseling Services for services rendered.

3. AUTHORIZATION FOR TREATMENT
I give Journey Counseling Services consent to treat myself or my minor child.

4. AUTHORIZATION FOR COLLECTION
I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

5. ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have been provided a copy of Journey Counseling Services Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I acknowledge that the above items have been reviewed with me and I fully understand and agree with them.

Signature: _____

Printed Name: _____

Date: _____