Cord of Three Counseling Services
Information and Office Policy Statement
Informed Consent

I. New Client: Welcome!

Cord of Three Counseling Services is a private Christian Counseling Service offered to families of Southeast Georgia. Thank you for considering the use of our counseling services. The information below is to help you understand the nature of counseling with our agency and to understand the necessary procedures that are required by law to provide for your safety and confidentiality as well as the agency's.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through Christian clinical counseling.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session. You may be contacted by a Cord of Three Life Coach. The role of the Life Coach is to contact you via the phone and encourage you through prayer and biblical discipleship.

I. Appointments:

Appointments are usually scheduled for 50 minutes. Sessions are by appointments only. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. Cord of Three is not an emergency facility, therefore, in the event of an emergency; please call 911, your primary care physician or the Focus on the Family crisis hotline: 1-800-232-6459

II. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. Those situations include: 1. Suspected abuse or neglect of a person, 2. When your psychiatrist or therapist believes you are in danger of harming yourself or are unable to care for self, 3. If you report that you intend to physically harm someone the law requires the agency to inform that person and the legal authorities, 4. If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, 5. When your insurance company is involved (i.e. filing of claims, etc…), 6. In natural disasters whereby protected records may become exposed, or 7. When otherwise required by law. You may be asked to sign a release of information so that your therapist may speak with other mental health professionals or to family members. If you are deemed a threat to yourself or to someone else, Cord of Three will make a referral for you to the appropriate facility.

Client Information and Office Policy Statement – continued

III. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are kept under the care of your therapist.

IV. Fees:

Fee for the initial visit is $120.00 and each 45-50 minute session thereafter is $95.00.
Other fees may apply when assessment instruments are used. Cord of Three does provide services on a Sliding Fee Schedule, if you do not have insurance and cannot afford to pay for the cost of your sessions, please indicate your needs to your therapist or contact our program office at 912-282-0992 and speak to the Administrative Assistant about your payments.

V. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will file you insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

VI. Cancellations and Missed Appointments:

You will be billed for any sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day at 912-282-0992. You will be billed $50 --not just a co-payment. Insurance companies generally do not reimburse for missed appointments. After two consecutive no-show's, your may not be able to schedule another appointment with Cord of Three.

VII. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your physician, therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform our accrediting agency (The Joint Commission) at www.jointcommission.org .

VIII. Consent for Treatment

By signing below, you are stating that you have read and understood this 2-page policy statement and you have had your questions answered to your satisfaction. You also understand that you may be contact by one of the Cord of Three Life Coaches and are giving your consent to their calls. You are also acknowledging that as a Christian counseling agency, we recognize the Holy Bible as the authority on moral/emotional/social issues and you agree to the counselors use of the bible as the standard for counseling services. **Therefore, I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.**

I understand that I am financially responsible for payment of services received by me or my dependent(s). I authorize the release of clinical or medical information to my insurance company, primary care physician and referral source or agency when needed for insurance coverage and/or payment. I understand that insurance claims will be electronically filed to my insurance carrier on my behalf. I am responsible for payment(s) not received from the insurance company within 90 days of treatment and will make payment to Cord of Three Counseling Services. I assign insurance benefits payable to me to Cord of Three Counseling Services Inc.

Name of patient (please print): _____

Signature: _____ Date: _____

Cord of Three Counseling Services
Premarital Intake Form

This information will remain confidential.

Date: _____
Name: _____ DOB _____ Gender: Male___ Female___
Age:_____ Occupation: _____
Address _____ City: _____ State: _____ Zip code: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Can we leave a message? _____ Email: _____
Employed at: _____

Relationship status:
Current Relationship status: ____Seriously Dating ____Engaged ____Separated
How long have you been together: _____
If engaged, how long have you been engaged?_____
How long have you known your finance? _____
How many times have you been engaged? _____
Have you ever been married before?_____

Current Household Family: Do you have children? Yes No If yes provide information below:

Name	Age	Lives at	(Circle One)
			Biological / adopted / step-child
			Biological / adopted / step-child
			Biological / adopted / step-child

Family-of-Origin
Mothers Age:_____ If deceased, how old were you when she died?_____
Father's Age:_____ If deceased, how old were you when he died?_____
Number of Brothers:____ Their ages:_____
Number of sisters: ____ Their ages:_____

Briefly describe your relationship with your father:
_____
_____
Briefly describe your relationship with your mother:
_____
_____
List family members with mental health past:

_____

Educational Background:
GED HS Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other
If degree applies please specify major: _____

Religious / Spiritual Background:
Were you affiliated with any church / religion growing up? Yes___ No____ What Church or Religion?_____
Are you currently affiliated or attending a church/religion now? Yes___ No____ What Church or Religion?_____

Describe your religious upbringing? _____
_____
_____

Describe your current relationship with God: _____
_____
_____

What differences / similarities have you discussed concerning religious / spirituality? _____
_____
_____

Medical history:
Do you have any significant health/medical issues? Yes No If yes what is/are the health issue(s) and are you limited in any way?
_____
_____
_____

Have you ever had a trauma to head, unconsciousness, or seizures? Yes___ No____
If yes, explain:_____

Counseling History: Have you attended counseling previously? Yes ____ No_____

When (Specify Dates):	Where and with whom:	Presenting issues at that time:	Diagnosis given:

Are you currently in therapy or counseling with anyone? Yes____ No____
Whom _____ Where _____
How long _____ Reason _____
Describe the experience _____

Have you ever been hospitalized for any mental health reasons? Yes____ No_____

When	Where:	Reason:	Presenting problem / Diagnosis

Psychotropic medications: Are you currently taking any psychotropic medications? Yes____ No____
(Specify current & past meds)

Medication	Condition	Dosage	Dates of usage	Side effects	Physician

Alcohol/drug usage:
Do you currently use alcohol or drugs? Yes____ No____
Describe the use of drugs and alcohol (type, amount, frequency): _____
When did you start using drugs or alcohol? _____
What has your past use of alcohol been like? _____

Suicide risk: Have you ever attempted suicide? Yes____ No____
If yes, when? _____ How many times? _____
Have you recently had thoughts of suicide? Yes____ No____
How or what did you plan to do? _____
What were the circumstances at the time? _____
Has anyone close to you ever attempted or committed suicide? Yes____ No____
If yes, who, how, and when? _____

Abuse history: Please circle if you have either been physically, emotionally, or sexually abused?
If yes, briefly explain (who, what and when): _____
_____

Support Systems:
Do you have people that you can turn to for support? Yes____ No____
If yes, who? _____
Relationship to you: _____

Presenting Issues:
Briefly explain what concern(s) that you would like to address during premarital counseling:_____
_____

What do you hope to achieve or accomplish through premarital counseling? _____
_____

Please describe what you believe your fiancé's specific goals for counseling:
_____
_____

What concerns do you hope to resolve by the time you get married?
_____
_____
_____

Emergency Contact Information
Name _____ Relationship _____
Phone #(s) _____

Please Read the Following Carefully

I understand that I am responsible for my own and/or my spouses fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I understand that the credit card on file will be charged for outstanding fees if I am not in contact with the therapist. Cord of Three Counseling Services will honor contractual agreements made with those managed care companies which stipulate specific reimbursement restrictions. I understand I may be charged for late, canceled, or missed appointments with or without 24 hours advance notice. It is my responsibility to keep track of my appointment dates and times.	
Client Signature:	**Date:**

I hereby authorize the release of necessary medical information for insurance reimbursement purposes. I authorize the payment of medical benefits to the provider of services.	
Client Signature:	**Date:**

I understand that I must be committed to attend my own sessions on a consistent basis, on time in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform the therapist of my decision prior to my last visit. If my therapist believes that I or my spouse/children can receive more effective treatment elsewhere, I will be given referrals. I understand that I or my spouse/child may not attend a session if under the influence of alcohol or other drugs, or in the possession of a dangerous weapon. My signature below indicates my desire and consent to receive counseling for myself and spouse/children from Cord of Three Counseling Services.	
Client Signature:	**Date:**

Credit/Debit Card Authorization Form

(If your insurance is Wellcare or Amerigroup, this only applies if your insurance becomes inactive)

*****All Information must be provided to receive services*****

Balances: Any outstanding balances must be paid prior to scheduling an appointment. If you would like to set up a payment plan on your balance, you must call in to the main office and speak with a secretary. Payment plans are based on 10% of your current bill or 25.00 whichever is greater (i.e. if your current bill is $150.00, then your payment plan would be $25.00 per month until paid in full. Payment plans will be billed to your credit/debit card on the 15ht or 30th of each month pending on which date you choose.

This policy is not meant to be punitive, but appointment times you schedule are reserved for you at the exclusion of others who may be waiting to see the therapist.

- The office voice mail system records the day and time of all messages left and is completely confidential. Messages left in the appropriate time frame are considered the same as a conversation.

You are responsible for the full payment at the time of service.

_____ (initial) I hereby authorize Cord of Three Counseling to charge any outstanding balance due on my account if I have not contacted my therapist's office 24 hours after a late cancellation or missed appointment.

_____ (initial) I hereby authorize and agree to the above stated fees for services as outlined by the fee schedule or by my insurance or EAP plan. I understand that denial of payment by any third party does not waive my responsibility to pay for services.

_____ (initial) I hereby authorize Cord of Three Counseling to charge my card on file for any returned checks with an additional returned check charge of $40.00 if I do not resolve that issue within 24 hours of contact.

_____ (initial) I hereby authorize Cord of Three Counseling to charge the card on file for any missed EAP session as allowed by my EAP plan.

By signing below I certify that my information is correct, true and accurate and that I am an authorized user on the credit/debit card account. I authorize and agree to have the credit/debit card kept on file and charged for late cancellation, no show fees or other above listed fees. I agree to have the credit/debit card below charged for any outstanding balances after 30 days.

I understand that Cord of Three Counseling uses the credit card company Cornerstone. I understand that this form is valid for 3 years unless I cancel the authorization in writing.

I agree to pay Cord of Three Counseling any and all copays or owed balances towards sessions rendered, missed, or late cancelled in less than a 24 hour period. In the event that I fail to pay my copay, unless an agreement is made within 30 days, the card on file will be charged. If at any time my card on file is rendered invalid or not in service, I will provide another card to cover any and all balances.

I agree that I will not dispute any valid charges on my card and fees that are assessed by Cord of Three Counseling as a result of the dispute. I understand that I will be financially responsible for paying the resulting fees charged to Cord of Three Counseling.

By signing below I certify that my information is true, accurate and I am an authorized user on the account and all names listed below may be charged for fees and services listed on the Client Financial Policy and Fee Schedule. My signature below also represents that I have read, understand and agree to all items of the Client Financial Policy and Fee Schedule.

Authorized client(s) allowed to be charged under this credit/debit card information: _____

_____

*Please note: The portion of this form containing your credit/debit card information will be destroyed permanently by secure means (shredding) at the completion of services and after ALL outstanding balances have been paid.

I hereby authorize Cord of Three to have my credit/debit card on file and charge any fees that are my responsibility as listed on the Client Financial Policy and Agreement Form.

We accept Cash, Personal Checks and Debit/Credit Cards (Visa, Master Card, Discover)

Name as Printed on Card:			
Card #:		**Exp. Date:**	**CVV Code:**
Billing Address:			
City:		**State:**	**Zip Code:**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my PHI. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Insurance companies require that you are given a diagnosis
- Conduct normal healthcare operations such as a quality assessment and physical certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at 204 S. Crawford Street Waycross, GA 31503 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed Name	Date
Signature Of Responsible Party	Cord of Three Witness

NOTICE OF PRIVACY PRACTICES
(KEEP THIS COPY FOR YOUR OWN PERSONAL RECORDS)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPA) is a federal program that requires that all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use ad disclose your health information. We may use and disclose our medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** includes the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and duplicate de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization in writing and we are required to honor and abide by that written request, except in the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your Protected Health Information (PHI), which you can exercise by presenting a written request to the Privacy Officer at Cord of Three: Clay Gill or Tracy Crews at 912-282-0992.

- The right to request restriction on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by your signature. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice is effective as of January 1, 2015 and we are required to abide by the terms of this Notice of Privacy Practices and make the new notice provisions effective for all PHI that we maintain. You may request a written copy of a revisited Notice of Privacy Practices. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint to our office at 204 S. Crawford Street Waycross, GA 31503 912-282-0992/Phone 912-285-8817/Fax	For Information about HIPPA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue S. W. Washington, DC 20201 Toll Free: 877-696-6775