INFORMATION AND CONSENT for Treatment

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Welcome!

I offer Behavioral Health services through a confidential internet connection to address personal problems that may include depression, anxiety, relationship difficulties, anger management, chemical dependence or other concerns. At this time, all sessions are conducted via the internet. No in-person sessions are available in the schedule.

While it may not be easy to seek help for issues like these, I hope that by using my service, you will be better able to understand your situation and move toward resolving your difficulties. I will use my knowledge and professional skills to help you improve your situation. While no particular results are guaranteed, and in some cases, services may lead to unanticipated emotional stress as well as improvement, I feel it is important for you to explore your own thoughts and feelings and to try new approaches in order for change to occur. Should you have special needs or requests, I will do my best to satisfy them. I want to make you as comfortable with this process as I can. Please let me know if you need any special accommodation.

You may bring family members to appointments if you feel it would be helpful or if this is recommended. However, because our sessions are confidential, I must be informed up front if someone is to be with you, and it will be necessary for them to understand and also sign this consent.

1. Appointments

To set or cancel an appointment, call my office at 704-874-2387. Leave a message if the phone is not answered immediately. If you do not show up for an appointment and do not cancel, you cause difficulty by depriving another client of an opportunity to work on their problem. If you no-show more than once you may receive a letter asking you to call and discuss this matter with me. I may recommend that you stop making appointments until you can get better control over your schedule, or I may make some other recommendation. In some cases, you may be charged a "no-show" fee if you do not cancel an appointment that you do not attend. Please initial this blank _____ indicating that you understand and accept this policy.

2. Consent for Services

In order to receive Behavioral Health services with me, you must provide written consent. Anyone older than age 18 is considered competent to consent to treatment. If you have a legal guardian, your legal guardian must consent to your services. Also, because we use the internet for sessions, you will be asked to accept the fact that this consent covers telehealth services. (All telehealth sessions are HIPAA compliant and strictly confidential.)

Telehealth is a new and different way to receive MH treatment and I need to let you know a bit more about what to expect from the process. There are some elements and expectations that are different than you may have experienced before.

Because of the nature of the internet connection, it is possible that there may be misunderstandings due to connection problems caused by image delay or poor image quality. I may not catch your body language, vocal inflection, eye movements or other non-verbal cues. If you think that I am not understanding you, please let me know as soon as possible so that we can discuss it. When you consent to telehealth treatment you do so with the understanding that although I shall be using a secured network, transmission can be interrupted or distorted due to technical failures. You cannot hold me responsible for breaches of confidentiality caused by your own situation/system. Please understand that you must take responsibility for ensuring that the room where you are, while in session, is secured and no one else has access to our conversation.

If services are disrupted by connectivity problems, and if they are not resolved within 5 minutes, I shall attempt to contact you by phone to determine how to proceed.

3. Number of Visits

The number of sessions needed depends upon many factors and will be discussed with you. You should be aware that you will be asked to work toward specific goals that you set with my help. Generally speaking, the more often you come to treatment, the closer you come to meeting your stated goals. You will be informed of the anticipated length of treatment to meet your particular goals.

4. Cost of Services

Therapy sessions are charged on a "per-session" basis. Please check with me about the cost of each session. Usually, health insurance such as Medicare or most private insurance companies pay for services with me. It is important to talk with my office to be sure that the cost of your treatment is covered by your insurance provider. In some cases, you are asked to pay a "co-pay" at the time of the session. If you have no insurance or are paying out of pocket, I will do my best to give you a good faith estimate of the cost.

5. Length of Visits

The length of visits varies according to your needs. Some last only about 30 minutes, some last as long as 60 or 90 minutes. Most sessions last about 54 minutes. Please take precautions while we are in session to turn off phone interruptions and make sure that you will not have to take time out to talk with someone else while we are working together. I will not hold a session while you are driving a car, although I am fine with your sitting in a car to use it as a confidential space in which to talk with me.

6. Frequency of Visits

The frequency of your Behavioral Health visit depends on your needs. This will be discussed with you. You will make the most progress toward your goals if you keep regular appointments as recommended. Usually, you will be given an appointment for the next visit at the time we end a session.

7. Relationship

When you enter treatment your relationship with me will be a professional and therapeutic one. In a rare instance, it is possible that you and I may run into each other in person out in public. If this should happen, I shall maintain confidentiality of the fact that we have a relationship by not acknowledging that I know you. Please understand that this is not meant to be rude.

Gifts, bartering, trading and so on are not permissible and should not be a part of our relationship. Should there be a conflict or a reason why you are not comfortable with me, or if I am not the best match for you, you will be offered some choices of other qualified professionals who might be able to serve you. You are always free to determine what services you wish to receive and which provider you see.

8. Goals, Purposes and Techniques of Behavioral Health

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding treatment with me, and to have a chance to make decisions about what goals you would like to pursue. As your treatment progresses your goals may change. You have the right to determine what goals you would like to pursue and to have input into the methods used to achieve your goals. You may have a written copy of your goals, as well as the plan for how they will be achieved.

In some cases, I may determine that online counseling is not the best alternative for you. There are several types of clients who are not properly served by this service, including those who are actively suicidal or homicidal or those who are experiencing manic/psychotic symptoms. If this is the case, you will be offered an alternative to receive services from another provider in person with a face-to-face option.

9. Your Right to Confidentiality

Your conversations with me are confidential. No information is released without your written consent unless mandated by law. Possible exceptions to this important rule of confidentiality may include but are not limited to the following situations: suspicion of child or elder abuse, criminal prosecutions, child custody cases, suits in which the mental health of a person is at issue, situations which involve fee disputes, negligence suits, complaints to the licensing board or other state or federal regulatory authority. *For further information, review the notice of privacy practices I furnish to you.* If you have any questions regarding confidentiality, bring them to my attention. By

signing this Information and Consent form, you are giving your consent for me to share confidential information with all persons mandated by law. If I find that I am required to release information about you, before I do it, if possible, I shall try to contact you to tell you about this kind of release. You are also releasing and holding me harmless for any departure from your right of confidentiality that may result. It is your responsibility to secure your own computer hardware, access points and passwords.

If anyone outside this practice requests information from me or requests your Behavioral Health records, your written permission on a special "Authorization to Release PHI" form is necessary. Before giving permission, satisfy yourself that the information is really needed, that you understand the information being sent out, and that the release of the information will help you. You have the right to approve or refuse the release of information to anyone except as provided by law.

You should know that my personal rule in this regard includes refusing to acknowledge that I know your name or that you are my client.

10. Your Right to Understand the Potential for Redisclosure

Should your confidential protected information be disclosed to another party by you or with your consent, you must understand that it can no longer be assured of confidential treatment by me. Please let me know if there is information that you do not wish for me to disclose.

11. Risks of Behavioral Health Treatment

Effective Behavioral Health treatment involves helping you change. You may learn things about yourself that you don't like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of your work with me depends upon the efforts you make. You are responsible for the lifestyle choices/changes that may result from treatment.

12. After-Hours Emergencies

There is always someone on call when the Behavioral Health office is closed. This person can be reached for emergencies 24/7 by calling: 828-606-6024. Emergencies are urgent issues that require immediate action by me. If the situation is life threatening, please call 911 or go to the hospital emergency room. Please do not count on the electronic system to reach me in the case of emergency. Even email and texting entail lag time. If you are in an emergency life/death situation, please use 911 or call the suicide hot line number at 988 or 1-800-273-8255.

13. Record Retention and Release

Your treatment record is stored in a locked cabinet or in a computer which is protected from unauthorized access. Your records include a diagnosis, treatment plan, progress notes, reports and consents. Your record is available only to me and my office staff.

14. After Your Case is Closed

Your records are maintained under lock and key and even after your case is closed your records will be maintained in confidential fashion. By signing this information and consent form, you give your consent to allowing a licensed mental health professional to provide copies of your record to other parties when you submit a written request. Generally speaking, your record will be destroyed if there has been no contact for 10 years or more.

15. Your Right to Read Your Own Record

Generally speaking, you have the right to read and take a copy of your own record, unless I believe that it may not be in your best interest to do so. If you wish to request a copy of your record, you must follow procedures related to such request; I prefer that you meet with me to review the information in the record prior to it being given to you. I will assist you in understanding your record and will be available to answer questions and to explain the meaning of technical terminology. You may inform me of any inaccuracies of information in your record and you may give me a written amendment that can be placed in your record.

Your billing record is stored separately. It is accessible only by billing office staff. If you use an insurance company, Medicare or an EAP to pay for Behavioral Health services, they will receive only a minimal amount of information, including your name, birth date, social security number, diagnoses, type of service provided, and dates of service. If they request additional information from me in order to process the billing, (such as the date your problem started,

history of your problem, symptoms that meet the criteria of the diagnosis, your progress in treatment, your goals and objectives in treatment,) by signing this consent you are consenting to such release.

At times, I may seek out professional consultation about some aspect of the work with you. Usually, it will not be necessary to share your identity with that consultant. The consulting professional must also abide by all applicable laws and ethics to protect your confidentiality.

16. Your Right to Refuse Treatment

You have the right to consent to or refuse recommended treatment. You can be treated without consent only if there is an emergency and, in my opinion, failure to act immediately would jeopardize your health. No audio or video recording of a treatment session can be made without your written permission. You may refuse to participate in any treatment if you feel uncomfortable, and you may terminate your services with me at any time you wish. With this consent you are agreeing to seek written permission from me before you record any portion of a session.

17. Your Right to Know Your Provider's Qualifications

I am licensed as a Clinical Social Worker to provide services in the State of North Carolina. You are entitled to ask me what training I have and where I received it. You are entitled to ask about professional competencies, experience, education, attitudes and any other relevant information that may be important to you. You have the right to expect that I have met the requirements of training and experience, and you have the right to examine my license.

18. Your Right to Voice Grievances

You have the right to voice grievances and request changes in your treatment without restraint, interference, coercion, discrimination or reprisal. I encourage you to share your concerns directly with me. You also have the right to report a complaint about services you receive. If you have a concern you would like to discuss, feel free to contact me at 828-606-6024 or dcranelcsw@gmail.com or the North Carolina Social Work Certification and Licensure Board at 866-397-5263.

19. Your Right to be Free from Harassment

You have the right to be safe from sexual, physical or verbal harassment or threats. Clients are accepted and treated without regard to age, gender, race, culture, disability, sexual orientation or economic status.

20. Freedom from Experimental or Non-standard forms of Treatment

I provide services using techniques and methods that represent best practices in the field. If unusual or non-standard forms of treatment are considered you will be informed and have the right to choose not to participate.

21. Psychotropic Medications

Should you need medications in the treatment of your condition, recommendations will be made to you and, if you consent, to your physician. As appropriate, referrals will be made to experts in the community who might be able to prescribe these medications. You are always free to refuse medications if you would prefer not to use them. If you do decide to take these medications, I can work closely with the prescriber to ensure that they are working properly.

22. Contact with Your Physician

I feel strongly that the mind and the body affect each other and I may ask your permission to communicate with your personal physician regarding your care and treatment. I do this because I believe that you will improve faster if I coordinate care with your medical provider. You have to right to consent or refuse to consent to this coordination.

23. Your Responsibilities

As a client, you have responsibilities as well as rights. You can help yourself by being responsible in the following ways:

Be Honest. You are responsible for being honest and direct about everything that relates to you as a client. Please tell me exactly how you feel about the things that are happening in your life.

Understand Your Treatment Plan. You are responsible for understanding your treatment plan to your own satisfaction. If you do not understand, ask me. Be sure that you do understand, since understanding is critical to the success of your plan.

Follow Your Treatment Plan. It is your responsibility to discuss with me whether or not you think you can or want to follow your treatment plan.

Keep Your Appointments. You are responsible for keeping your appointments. If you cannot keep an appointment, you must notify the office (828-606-6024) as soon as possible so that another client can use the time.

Keep me Informed. So that I can contact you when necessary; you must keep me informed of any changes to your address or phone numbers.

24. My Rights

I have the responsibility to provide care appropriate to your situation. To accomplish this goal, I have certain rights, including:

- The right to the information needed to provide appropriate care;
- The right to provide services in an atmosphere free of verbal, physical or sexual harassment;
- The right and ethical obligation to refuse to provide services that are not clinically indicated.
- Having executed this consent, you also agree to my policy that I will not appear in court in your behalf. The purpose of counseling is for you to grow, learn and change, and it is not to be used as a vehicle for establishing a particular position in an adversarial court proceeding.
- Duty to Warn/Protect. In the event that I reasonably believe that you are a danger, physically or emotionally, to yourself or another person, with this form you specifically consent for me to warn the person in danger and to contact any person in a position to prevent harm to you or them. I may also contact medical and law enforcement personnel.

The following information is being given to me in order to prevent harm to you or another person. This authorization expires upon the termination of your Behavioral Health service and you have the right to revoke this authorization in writing at any time to the extent that I have not taken action in reliance on this authorization. Even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of Notice of Privacy Practices hereto attached.

(Please fill out the next pages and return them to me prior to your first appointment.)

Should it be necessary for your own personal safety or the safety of another person, or in a medical emergency, I ask that you allow me to contact the following person(s) to assist you:

(Please list the name and phone number of a trusted person whom I may call IN AN EMERGENCY)
Name(s) Phone number(s)

_____

_____

Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. Please talk to me if you would like a full copy of this form or if you have any questions or problems about this issue.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. **When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.**
2. **When we are required to do so by lawsuits and other legal or court proceedings.**
3. **If a law enforcement official requires us to do so.**
4. **For workers' compensation and similar benefit programs.**

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. **You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.**
2. **You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.**
3. **You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact us to arrange how to see your records.**
4. **If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to us. You must also tell us the reasons you want to make the changes.**
5. **You have the right to a copy of this notice. If we change this notice, I shall inform you.**

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions or problems about this notice or our health information privacy policies, please contact me, Debbie Crane, personally.

X

_____

Client/Guardian signature Date

Consent to Treatment

I voluntarily agree to receive Behavioral Health assessment, care, treatment or services and authorize Debbie Crane, LCSW/ACSW, to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care, treatment or services at any time. I understand and consent to the fact that these services will be provided via confidential telehealth linkages.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. I understand that I have the opportunity to ask questions and seek clarification of anything unclear to me. I acknowledge that I received a copy of this signed Information and Consent form on this _____ day of _____, 20__.

X

_____

Client/guardian signature Date

_____

Witness Date

COMMENTS:

Client Information

Date Form Completed: _____ (If it is necessary to contact you by mail or phone, the following address and phone numbers may be used to reach you. Should this information change, you MUST contact our office immediately. If you choose to communicate with us by email, you are aware that this is not a secure method of communication.)

LAST NAME:	MIDDLE	FIRST NAME:
ADDRESS:		OK TO MAIL TO THIS ADDRESS? ☐ YES ☐ NO
CITY:	STATE:	ZIP:
E-MAIL: CELL: HOME PHONE NUMBER: OTHER PHONE NUMBER:		OK TO CALL/TEXT/LEAVE MESSAGE? ☐ YES ☐ NO
GENDER:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

MARITAL STATUS:

☐ SINGLE	☐ MARRIED	☐ WIDOWED	☐ DIVORCED	☐ SEPARATED	☐ DOMESTIC PARTNER

HEALTH INSURANCE: YES ☐ NO	NAME OF COMPANY:	
GROUP NUMBER:	POLICY NUMBER:	
PRIMARY INSURANCE POLICY HOLDER NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
RELATIONSHIP TO PATIENT:	OTHER INSURANCE:	

EMPLOYMENT STATUS:

☐ UNEMPLOYED	☐ DISABLED	☐ EMPLOYED BY:

REFERRAL SOURCE:

☐ SELF	☐ PRIMARY CARE PHYSICIAN	☐ FAMILY	☐ OTHER

ADDITIONAL INFORMATION:

YEARS OF EDUCATION:	FINANCIAL PROBLEMS: YES NO	MILITARY SERVICE: ☐ YES ☐ NO BRANCH OF SERVICE:
SMOKER: ☐ YES ☐ NO (AMOUNT) ALLERGIES:		WHAT EXERCISE DO YOU DO?
OTHER IMPORTANT INFORMATION:		NAME & PHONE # OF CASE MANAGER: MAY WE CONTACT THEM? Yes ☐ No ☐

What concerns brought you to behavioral health?

What would you like to see happen as a result of behavioral health assistance?

What have you tried on your own to address these concerns?

BEHAVIORAL HEALTH QUESTIONNAIRE

Name: Date:

Please check any symptoms you may be experiencing today or on a regular basis over the past two weeks. Then put a star next to the three which cause you the most problem and interfere with your life the most.

__ Poor appetite and/or weight loss*
__ Overeating and/or weight gain*
__ Difficulty falling asleep or staying asleep*
__ Sleeping too much*
__ Feelings of worthlessness*
__ Crying spells
__ Low self-esteem
__ Difficulty breathing
__ Fear of loss of control or going crazy
__ Sadness, loneliness*
__ Difficulty making decisions
__ Trouble concentrating*
__ Irritability
__ Feelings of hopelessness*
__ Suicidal thoughts**
__ Suicidal plan**
__ History of suicide attempts
__ Homicidal thoughts
__ Lack of interest or motivation
__ Anxiety*
__ Loss of interest in sex
__ Loss of enjoyment in usual activities*
__ Isolation from friends and family
__ Poor self-care, cleanliness, hair appearance
__ Muscle tension
__ Restlessness or feeling agitated*
__ Trouble getting along with people
__ Tire easily*
__ Low energy*
__ Racing heartbeat
__ Tightness in chest
__ Fear of having heart attack or dying
__ Numbness or tingling sensations
__ Headaches
__ Chills or hot flashes
__ Digestive or GI problems
__ Menstrual problems
__ Frequent pain (where?)*
__ High risk activities (business, financial, legal, sexual)
__ Excessive spending
__ Racing thoughts
__ Talking too fast
__ Shoplifting or stealing
__ Very little need for sleep, (2-3 hrs/night)*

__ Binge eating
__ Regular use of laxatives
__ Other eating disorder
__ Excessive exercising
__ Self-induced vomiting
__ Self-mutilation
__ Often angry
__ Physically aggressive toward others
__ Swearing or name calling during arguments
__ Throwing or breaking things during arguments
__ Inattentive
__ Careless mistakes
__ Forgetful
__ Disorganized
__ Easily distracted
__ Trouble listening
__ Avoid/dislike mental tasks
__ Often lose things
__ Feel driven/on the go
__ Hyperactivity*
__ Fidget a lot
__ Often interrupt people/blurt out answers before questions are completed
__ Impulsive
__ Anger outbursts
__ Nightmares related to past trauma
__ Recurrent/distressful thoughts of past trauma
__ Acting/feeling as if re-experiencing past trauma
__ Repeating behaviors like counting or checking
__ Significant debt or relationship problems due to gambling
__ Gambling to escape problems
__ Excessive pre-occupation with sex
__ Excessive shopping
__ Use of alcohol/drugs to feel better
__ Hearing voices/sounds that might not be there
__ Seeing things that might not be there
__ Other types of hallucinations
__ Excessive time on internet/phone

THINGS THAT ARE STRESSFUL TODAY:

_____
_____
_____
_____

(Thanks to Noel Holdsworth, DNH, PMHNP, BC, CTS, for the creation of this checklist)