Journeys End Counseling, Inc.
1035 S Semoran Blvd., Ste. 1040
Winter Park, Florida 32792
P- 407-678-9800 F-407-315-0048

Consent for Treatment

Under The Health Insurance Portability and Accountability Act (HIPAA) of 1996 as a patient you have specific Privacy Rights. The purpose of this form is to notify you of such rights.

The following are your rights as a patient under HIPAA:

1. Right to inspect your own health information and obtain a copy (excluding psychotherapy notes).
2. Right to request an amendment to health information (excluding psychotherapy notes).
3. Right to receive an accounting of disclosures for purposes other than treatment, payment and healthcare operations.
4. Right to request that uses and disclosures of health information is restricted, unless prohibited by court order or mandated abuse reporting.
5. Right to file privacy complaint with your provider and to have that complaint reviewed by an objective reviewer and to receive resolution in writing. Journeys End Counseling, Consulting & Training, Inc will select the reviewer.

As your provider, I am legally required, under Federal Law and HIPAA, to protect your health data and to release only the minimum necessary information for the purpose of treatment, payment or healthcare operations, unless otherwise specifically authorized by you.

Confidentiality

No one will reveal information concerning your counseling to anyone outside of this office except as follows: (1) you consent in writing; (2) if life or safety is seriously threatened (including abuse of children/elderly/disabled) I am required by law; (3) disclosure is required by law (such as a judge requesting the records); (4) you file a benefit claim and the claim payer or your insurance requires information; (5) the files are audited by Quality Assurance bodies; (6) or the I.R.S. (7) I choose to disclose anonymous information pertaining to your case for the purpose of clinical and professional consultation and/or educational illustration. (8) If, through the use of a fax or cell phone, your information, inadvertently, falls in the hands of someone other than the one intended. (9) Other people who may have limited access to your file and/or may learn of your name associated with our counseling relation may include but not be limited to: anyone working for me, the Bank (when check depositing), Collections, Bankruptcy Court, Building cleaning crew/Landlord/its representatives, building emergency, such as a fire. (10) We may contact you to remind you of appointments.11) Child welfare service providers, their designees or legal staff and funding sources for services. 12) We are mandated reporters of suspected child/elderly abuse, neglect or mistreatment and therefore are required to report suspicions to the state Abuse Hotline.

Email and Phone Contact

We may contact you by the phone number or email address that you provide upon intake. Every effort will be made to ensure your privacy via phone contact with minimal information provided. We may also send electronic appointment reminders that will also contain minimal information. We will request that you sign an Authorization to Release Information in the event that there are other persons that are required to have knowledge of your appointments.

Name: _____

Tele Behavioral Health Services

As authorized through the consumer's insurance, funding or personal preference, therapy sessions may be provided using technology such as, Skype or Vsee. In an effort to comply with required HIPPA regulations our goal is to work with such providers that enable us to meet the highest level of confidentiality and security for these communications.

Phone consultation

Billable according to the hourly rate (e.g.: 15 minutes = $27.). As applicable, any time dedicated to legal matters are billed at the $100/hr rate or more. Non-payment of fees may result in termination of professional services and initiation of collection activity ($25 additional fee).

Grievance Procedures

Each client has the right personally, or in combination with other persons, to present grievances and to recommend changes in policies an services on behalf of themselves or others without fear of reprisal, restraint, interference, coercion or discrimination. The client's conduct in presenting these complaints or grievances may not be disruptive or threatening to the therapist or any third party. A complaint or grievance shall be presented in writing to the President/CEO. Complaints should include the name, address and telephone number and nature of the complaint or grievance and date and service provider.

The President/CEO or designated other party upon receiving a grievance shall:

1. Investigate and respond to the grievance within five (5) working days.
2. Provide the client with an opportunity to meet to discuss the situation.
3. Review the information and make decisions.
4. Inform the client both verbally and in writing of the decision.

A copy of the grievance and the written response from the President/CEO will be placed in the client's record. If the client disagrees with the response from the President/CEO, the client may make a final comment in writing and this will be placed in the record with the other information.

This consent will be governed, construed, and enforced in accordance with the laws of the State of Florida. All disputes arising out of or in connection with, any of this provision of this consent will be finally resolved through arbitration under the administration of the American Arbitration Association in accordance with its rules for arbitration. JEC and the consumer agree that for purposes of obtaining and entering any determination or award of the arbitrators, including without limitation temporary or permanent equitable relief, may be entered in any court in Orange County, Florida.

Fees

Payment is due when services are rendered. **Parents/legal custodians**: your signature below is your permission of my treatment of the minor child and your acknowledgment that if s/he is 18-years old or older, but brought here by you, that you are ultimately responsible for the payment. No show appointments will be billed at 50%.

Fees are collected at the start of the session to allow your time to be focused solely on you. Session duration is 45-50 minutes.
Name: _____

If necessary a second or follow up session can be scheduled within the same week.
It is the patients' responsibility to inform us of any changes to your insurance.
Credit card or payment information will be kept in a secure and encrypted file. We will request a copy of your payment information.

Discharge/Termination Protocol

Journeys End Counseling Services, LLC will make every effort to work with the client in developing a collaborative discharge plan. The client is asked not to abruptly discontinue treatment but to discuss the situation with the therapist. If a patient continues to be non-compliant with appointments and/or treatment, the therapist has the right to terminate treatment. An effort will be made to contact the client and /or insurance carrier so that an appropriate referral can be made if necessary. Clients are responsible for any balance on their account even after care has been terminated**. We reserve the right to administratively discharge after 2 missed appointments without prior notification**.

My signature below is proof that I fully understand this form and accept it as the terms of my participation in this counseling. The above remains in effect until revoked by me in writing; should there be any changes to these forms, provided I am still actively involved in therapy, I will be notified and given new ones to sign, as well as a copy. I also assign the following person as my emergency contact, and hold Tammy Austin and associates harmless should the need arise and notifications of person below have to occur:

Emergency Contact:

Name: _____ Phone #: _____

Generalized Consent

I hereby give my consent for Journeys End Counseling and designated business associates to use and disclose my protected health information (PHI) to a third party for the purpose of carrying out "treatment", "payment", and "health care operations" and child welfare case plan service coordination. I understand that in order for my psychotherapy information (Summary of services provided, goals, progress in meeting goals, discharge status) to be released to any party I have to sign an "Authorization for Release of Information" form. I also understand that I have the right to review the Journey's End Counseling Privacy Rights and Practices form, as well as request restrictions on how and to whom my protected health information may be released. I fully understand what I have just read and acknowledge that I have received a copy today. _____ (Initials)

☐ Individual therapy ☐ Family therapy ☐ Group Therapy ☐ Coaching ☐ Evaluation
☐ Treatment Planning ☐ Parenting Enrichment ☐ Marital Enrichment ☐ In Office
☐ In Community ☐ Email contact ☐ Random Urinalysis ☐ Skype ☐ Text Message
☐ Vsee

_____ _____
Patient Signature Witness

_____ _____
Parent or Legal Guardian Signature Date