Grace Harbour, Inc. Demographic Information

CLIENT INFORMATION:

First Name: _____Middle Name: _____ Last Name: _____

Address: _____ City: _____State:_____

Zip: _____ County: _____ SS#: _____-____-_____ Date of Birth: _____ Age:_____

Phone #: _____ May we leave a message ☐Yes ☐No May we Email Appt Reminders Email:_____

Cell phone #: _____May we leave a message ☐Yes ☐No Receive Txt notifications ☐Yes ☐No

Race: _____ Sex: _____ Marital Status: _____ # of Household members: _____

Employment Status:_____ Work Number: _____ May we call at work: ☐Yes ☐No Work hours: ____

Legal Guardian: _____ _____Phone #:_____

Relationship to Client: _____

Emergency Contact: _____Phone #: _____

Referral Source: _____ Phone #:_____

Name of the Pharmacy you use: _____ _____Phone #: _____

Are you living in the US Lawfully: ☐Yes ☐No Who do you rely on for Social Support:

_____

School Attending: _____Grade: _____

FINANCIALLY RESPONSIBLE PARTY/INSURED (if other than patient):

Last Name: _____ First Name: _____ Middle Initial: ____ Sex: ___

SS#: _____-____-_____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State & Zip: _____

Occupation: _____

INSURANCE INFORMATION:

Primary: _____ Policy #: _____ Group: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

Secondary: _____ Policy #: _____ Group: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

I give my permission for the following people to gain access and have knowledge regarding my (or my child's) treatment with Grace Harbour.

_____ _____ _____

****

I authorize the provider of services to release all information necessary to secure payment of benefits to carry out a reasonable level of treatment. I directly assign all medical benefits from my insurance to the provider, if applicable. As a courtesy to you, we may choose to bill your insurance. However, we will allow no more than 60 days for payment. After 60 days, you will be billed for any outstanding balance on your account. All outstanding balances are due 10 days from the statement date. Late fees will be assessed at 10% of the balance. If I have Medicaid as my insurance, I hereby agree that I have been given a freedom of choice of my treatment provider.

Signature of Responsible Party: _____ Date: _____

Revised 6/2012

Grace Harbour, Inc.
Behavioral Health

FINANCIAL STATEMENT OF UNDERSTANDING

Client Name: _____

This statement of understanding is intended to answer questions you may have regarding payment for services rendered by Grace Harbour.

PAYMENT FOR SERVICES: We work with a number of insurance companies via managed care contracts and we will assist you in filing any insurance claims or forms which may be utilized for payments for services rendered; however, you maintain full responsibility for paying all charges for services rendered. **You will need to provide all required insurance information when checking in for services; all primary, secondary, and/or co-insurances must be identified at the initial session.** You accept all financial consequences if all insurance policies are not identified, and you will need to update any insurance information immediately upon the date of change. All payments, co-payments, co-insurance and unsatisfied deductibles are to be paid at the time services are rendered. Therapist reserve the right to charge their session rate under the following circumstances: returning phone calls to clients and their attorneys, completing affidavits, writing letters on behalf of clients, etc. Account balances are due on date of service; we allow 60 days from the date of service for your insurance(s) to pay. Beyond 60 days, unpaid account balances are the client responsibility. Any balance greater than 90 days will be submitted to a professional collection agency unless payment arrangements have been made.

CANCELLATIONS: If you cancel your scheduled appointment less than 24 hours prior to the scheduled session, will be you will be charged the full session fee, which must be paid before the beginning of your next session. Monday appointments need to be cancelled by noon on Friday. To cancel an appointment scheduled on the day after a holiday, it needs to be cancelled on the day prior to the holiday**. If you miss an appointment without giving any notice at all, you will be charged the full session fee**, which must be paid prior to the beginning of your next session. Insurance will not pay for broken/missed appointments. Failure to show for a total of 3 scheduled sessions without proper notification will lead to an administrative discharge from treatment.

INSURANCE COVERAGES:

Your Clinician's Participation with your Insurance Plan: Our agency accepts a wide variety of insurance plans. Prior to your initial visit with our agency, you should confirm that the clinician participates with your personal insurance. If the clinician does not participate with your insurance plan, you will be responsible for payment of all charges at the time of visit. You will be provided a complete superbill, upon request, listing all the pertinent information you will need to submit to your insurance plan for reimbursement for which you may be eligible.

Current Insurance and Client Demographic Information: If your therapist participates with your insurance plan, we may file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurance or services that are not covered by your plan. For the agency to file your insurance, we must have the current insurance coverage(s) and be made aware of any changes in either insurance or client address or phone numbers. Please bring your insurance card to every visit so that we can confirm your coverage. A current copy of your card must be kept on file in order for us to file insurance claims on your behalf.

Client Payment Responsibility for Non-Covered Services: In some cases, your insurance may not cover certain service or may have coverage limits in place. Limited coverage is common among insurance plans. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date.

Medicaid Clients: Medicaid clients must show proof of current Georgia Medicaid eligibility prior to receiving services. Further, I understand that if I change Medicaid types/CMO's (i.e., Amerigroup, Wellcare, Peachstate, APS), I must notify Grace Harbour immediately. If I fail to do so, I understand that I will be responsible for the payment of all services rendered. Co-payments, if applicable, are to be paid at the time of service.

Signature or Client and/or Parent/Guardian:_____ Date:_____

Grace Harbour, Inc.
Behavioral Health

Client Name: _____ **DOB:**_____

INFORMED CONSENT FOR TREATMENT

We are pleased that you have selected Grace Harbour, Inc. to work with you. This letter serves to inform you about the therapeutic treatment process, give you some information and answer questions about the professional relationship between Grace Harbour therapist, clinicians and clients. We have a number of client expectations about the professional relationship we embark on with each client.

CONFIDENTIALITY: Confidentiality is an important part of the mental health/ addictive disease treatment/therapy process. It means that unless you give us written permission, we may not give any information about you to anyone outside of Grace Harbour, Inc. If you and another adult (someone 18 years of age or older) are seen together, BOTH of you must agree in writing before any information can be released. There are specific times; however, when the law requires us to give information about you with or without your consent:

1. When required by subpoena or court order
2. To report known or suspected instances of abuse, exploitation, or neglect of children and elders.
3. To warn another person that you have threatened his or her life.
4. When you are a danger to your own life.

RISKS and BENEFITS of THERAPY: While mental health/addictive disease therapy can be an effective mode of treatment for a variety of life problems, positive results cannot be guaranteed. One major benefit that can be gained from participating in treatment/therapy includes a better ability to handle or cope with family and other interpersonal relationships. Other benefits relate to the potential to resolve specific concerns brought to treatment/therapy. Seeking to resolve issues between family members and other person can similarly lead to discomfort, frustration and relationship changes not originally intended. Grace Harbour, Inc. clinicians focus on the relational nature of therapeutic problems. At any time, you may ask your clinician(s) to explain more about how they work, why they are gathering information, or why they are prescribing a particular approach.

PAYMENTS & CANCELLATIONS: Payment is due at the beginning of each session. We accept cash, personal checks and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services to insurances who are credentialed with; you must pay your insurance copay or co-insurance amount at the time services are rendered and any remaining balance towards your annual deductible. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference between what is paid by the insurance and our normal rate. Payment arrangements are discussed during your initial session. We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $25. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence. We do not charge for customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Returned checks will incur a $35 returned check fee. It is necessary to give your clinician or the Grace Harbour administrative staff at least 24 hours advance notice if you need to cancel or reschedule an appointment. If you give less than 24 hours advance notice, you will be charged at the full session fee, which must be paid before the beginning of your next session. If you miss an appointment without giving any notice at all, you will be charged the full session fee, which must be paid prior to the beginning of your next session. Insurance will not pay for broken/missed appointments. Failure to show for 3 consecutive session without proper notification will lead to administrative discharge from treatment.

LEGAL SERVICES & COURT TESTIMONY: If your involvement in any legal matters leads to any Grace Harbour, Inc. clinician being subpoenaed or court ordered to appear in court on your behalf, you will be charged a minimum of $250.00 per hour for the time that the clinician spends preparing to testify, travel to and from court, waiting to appear, testifying, depositions, attorney correspondence/communication affidavits, etc. You are responsible for and agree to pay these charges whether or not the clinician ultimately testifies. An initial five hour retainer is required to be paid prior to the court date.

EMERGENCY PROCEDURES: If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department. You can reach our therapist on call by calling our main number (770-486-1140) or call the Georgia Crisis and Access Line for any mental health emergency 1-800-715-4225.

COMPLAINT RESOLUTION PROCEDURES

The staff of Grace Harbour, Inc. wants to know that you are satisfied with your individualized program. We also understand that with any ongoing relationship, there may be times of conflict. It is important to all of us that you feel your complaints or concerns are heard. The following is a guideline and timeframe for filing complaints. The first person to call should I have any problem with my fellow participants or program staff is my therapist. I should expect to have he/she help me resolve the conflict within two (2) business days. Should I feel uncomfortable bringing my concerns to my therapist or feel that the situation has not been resolved to my satisfaction, I can contact my clinician's supervisor at the Grace Harbour office 770-486-1140. I can expect this situation to be resolved within five (5) business days. Should I not feel the situation is resolved to my satisfaction, I may contact Dr. Kevin Freeman, President and CEO of Grace Harbour at 770-486-1140. Again, we believe that in working together to address conflict and concerns can only serve to help you reach your goals in your treatment plan through the services that are provided by Grace Harbour, Inc.

MANDATED REPORTING STATEMENT

As required by our regulatory agencies, the following information is provided:

1. Grace Harbour, Inc. does not support nor condone the use of corporal punishment at any time.
2. Under state law, all supervisors, therapists, and employees of Grace Harbour are mandated reporters of child and elderly abuse and neglect. That is, we are required to make a report to the appropriate county office of the Department of Family and Children Services or related department when there is reasonable cause to believe that an elderly person or a child under the age of 18 years old has had physical injury inflicted upon him or her by a parent/caretaker by other than accidental means, has been neglected or exploited by a parent/caretaker or has been sexually assaulted or sexually exploited.

Please Read and Sign Below:

- I have read and understand the above statement concerning the limits of confidentiality, the risks and benefits of therapy, payment and cancellation policy, and emergency procedures. I do hereby seek and consent to take part in treatment provided by Grace Harbour, Inc. I understand that if payment for the services I receive is not made, the clinician may stop treatment. My signature below indicates my informed consent to receive services and reflects that I understand and agree with all of the above statements. I have been given the opportunity to ask questions regarding this information.
- I understand that the fees for services are payable at the time of service and it is my responsibility to pay any deductible amount or co-insurance. I understand that I am financially responsible for all charges whether paid by insurance or not.
- I understand that at no point shall a person under the age of 14 be left unattended in any waiting areas. Grace Harbour's staff are not responsible or liable for any person left in the waiting areas.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the session fee for that appointment.
- I acknowledge I have received a copy of Client Rights & Responsibilities, received an orientation of services, and give my voluntary consent for treatment.
- I acknowledge I have received the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I acknowledge that I was provided a copy of the "Notice of Grace Harbour's Policies and Practices to Protect the Privacy of your Health Information" and that I have read (or had the opportunity to read if I so choose again).
- Informed Consent: By affixing my signature to this form, I acknowledge that I have read, understood, and agreed to all of the polices detailed above and in the *Notice of Grace Harbour's Policies and Practices to Protect the Privacy of your Health Information*. I consent for my therapist to disclose PHI to my insurance company or PCP if required for payment of claims.

A staff member of Grace Harbour, Inc. has reviewed the forms with me and I have received a copy of each form. I have had the opportunity to ask questions regarding these forms/ policies.

Client Signature: _____ **Date:** _____

Parent/Legal Guardian Signature:_____ **Date:**_____

Grace Harbour, Inc.
Behavioral Health

AUTHORIZATION FOR COMMUNICATION WITH YOUR PRIMARY CARE PHYSICIAN (PCP)

Client Name: _____ Date of Birth:_____

Name of your Primary Care Physician (PCP): _____

PCP Phone Number: _____

PCP Fax Number: _____

PCP Address: _____

Please check one of the below statements:

____ I give my permission for my therapist to contact my Primary Care Physician and share my protected healthcare information for the purposes of coordinating my treatment.

____ I do not give permission for my therapist to contact my Primary Care Physician.

Client Signature: _____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Grace Harbour, Inc.
Behavioral Health

CONSENT TO CORRESPOND ELECTRONICALLY

Client's Name: _____

While the Clinicians at Grace Harbour, Inc. take reasonable precautions to protect your confidential information, I understand that e-mail, text messages and other sources of electronic communication are not completely secure methods of communication.

I understand that electronic communication (emails and/or texts) is not a way of communicating new information regarding care or of communicating emergency needs. I further understand that I must speak to my clinician directly regarding all important information pertaining to my (or my child's) treatment. Although my clinician will attempt to reply in a timely fashion, I further understand that if I (or my child) am experiencing an emergency situation and need to contact someone immediately to help me, then I will call any of the office or emergency numbers that have been provided to me.

I grant my clinician and /or staff of Grace Harbour, Inc. permission to communicate with me via email, text message and any other electronic means.

I acknowledge that if I use an electronic means of communication to initiate with my clinician at regarding my care (or my child's care), the clinician, and/or staff of Grace Harbour, Inc. has my permission to correspond via that email address, text message, or other forms of electronic communications.

I acknowledge that I have the choice for my clinician or staff to include indentifying information when e-mailing me.

_____ By checking this box, I allow my clinician and/or staff to send e-mails and/or text messages to me with indentifying information without encryption.

For Adult Clients:

Signature of Client:_____ Date:_____

For Minor Clients:

Signature of Parent or Legal Guardian:_____ Date:_____

Phone: 770.486.1140 Fax: 678.669.2693

Client Rights & Responsibilities

Client Rights

In compliance with Grace Harbour's policies, and procedures, all clients have the following rights:

1. Right to a humane treatment or habilitation environment that affords reasonable protection from harm, exploitation, and coercion;
2. Right to be free from physical and verbal abuse;
3. Right to be free from the use of physical restraints and seclusion;
4. Right to be informed about plan of treatment and to participate in the planning, as able, to include development of the plan, review of the plan, and notification of changes made to the plan; Right to be involved in the transition and discharge planning process;
5. Right to be promptly and fully informed of any changes in the plan of treatment;
6. Right to accept or refuse treatment, unless it is determined through established authorized legal processes that the client is un-able to care for himself or is dangerous to himself;
7. Right to be fully informed of the charges for treatment;
8. Right to confidentiality of client records;
9. Right to have and retain personal property which does not jeopardize the safety of the client or other clients or staff and have such property treated with respect;
10. Right to converse privately, have convenient and reasonable access to the telephone and mails, and to see visitors, unless denial is necessary for treatment and the reasons are documented in the client's treatment plan;
11. Confidentiality of information rights;
12. Privacy rights;
13. Freedom from abuse, financial or other exploitation, retaliation, humiliation, and neglect
14. Access to information pertinent to the client in sufficient time to facilitate client decision making;
15. Informed consent or refusal or expression of choice regarding: service delivery, release of information, concurrent services, composition of the service delivery team, involvement in research projects, if applicable;
16. Access or referral to legal entities for appropriate representation at the client's expense
17. Access and referral to self-help/ advocacy support services
18. Adherence to research guidelines and ethics when a client is involved, if applicable
19. Right to be free of physical holds (emergency intervention), seclusion, or restraint;
20. Right to be involved in treatment planning, review of the plan, and notification of changes to the plan;
21. Right to be able to access the client's own records and obtain necessary copies when needed; right to request in writing a review of the client's own file and receive a response within 30 days; Grace Harbour, Inc. shall make the determination using up-to-date HIPAA guidelines.
22. Right to be informed of all rights, including legal rights, and exercise rights without reprisal in any form, including continued, uncompromised access to services. Rights should be distinguished from privileges, which may be revoked or revised at any time. Clients may follow the grievance procedure to appeal restrictions placed on privileges. Grace Harbour, Inc. shall review these grievances in accordance with the grievance procedure. Right to file grievances without fear of reprisal; Investigation and resolution of alleged infringement of rights;
23. Right to obtain a copy of the program's most recent completed report of licensing, accreditation, and inspection from the program upon written request within 30 days. The program is not required to release a report until the program has had the opportunity to file a written plan of correction for the violations as provided for in these rules; and (b) Such policies and procedures shall also include provisions for clients and others to present complaints, either orally or in writing, and to have their complaints addressed and resolved as appropriate in a timely manner.
24. Right to be informed of the program's complaint policy and procedures (investigation and resolution of alleged infringement of rights) and the right to submit complaints or appeal without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time;
    a. Right to receive a written notice of the address and telephone number of that state licensing authority, which further explains the responsibilities of licensing the program and investigating client complaints which appear to violate licensing rules;

        HealthCare Facility Regulation Division
        Two Peachtree Street, NW
        Atlanta, Georgia 30303-3142
        Phone: 404.657.5700
        Fax: 404.657.5708

Client Responsibilities

1. All clients/guardians have the responsibility to participate in the planning of their treatment.
2. All clients/guardians have the responsibility to be honest about matters that relate to their treatment.
3. All clients have the responsibility to be respectful of the rights and dignity of other clients, as well as staff.
4. All clients have the responsibility to respect the confidentiality of others in treatment.
5. All clients, upon decision to participate, have the responsibility to support and respect the program at the facility by participating to the best of their ability and by being on time for scheduled appointments.
6. All clients/guardians have the responsibility to learn and comply with the rules of the program.
7. All clients/guardians have the responsibility to meet whatever financial obligations may be incurred as it relates to their treatment.
8. All clients/guardians have the responsibility to advise the provider of services of any changes in the client's condition or any events that affect the client's service needs.
9. All clients/guardians have the responsibility of notifying the front office and administrative staff of any changes in their insurance benefits.
10. All clients/guardians have the responsibility of asking questions about their treatment and for seeking clarification until they fully understand the care they are to receive.
11. All clients/guardians have the responsibility for expressing their opinions, concerns, or complaints to the appropriate personnel in a constructive manner.

Advanced Directives Notice

An "Advance Directive" is a legal document in which an individual describes your personal health care choices should the time ever come that you are unable to speak for yourself, and there is little hope of recovery. The most common forms of Advance Directives are the Living Will and the Durable Power of Attorney for Health Care. These are rights under Federal and State Law:

1. You are not required to have an Advance Directive in order to receive treatment.
2. You have the right to accept or refuse treatment and to create an Advance Directive.
3. If you have an Advance Directive or decide to create one, Grace Harbour will honor it to the extent permitted by Georgia Law and in accordance with Grace Harbour policies and procedures. Grace Harbour clinicians will not be able to follow your Advance Directive unless you provide a copy to the staff, verbalize your treatment preferences, or create a new document.
4. If your care provider cannot implement your Advance Directive on the basis of conscience she/he is obligated to transfer your care to a provider who will respect your wishes.
5. If you are a pregnant woman, your Advance Directive may not be honored once it is determined that the baby has developed enough to be able to survive if delivered, if applicable.
6. Executing a Durable Power of Attorney for Healthcare will assure that your designate agent will have access to your medical record.

To request an official Georgia Advance Directive Form or for further questions call 770-486-1140. For additional information on Advance Directives and to print forms you may go to www.caringinfo.org. Please bring a copy of your Advance Directive, if you have completed one, to be scanned into your medical record.

I fully understand my rights and responsibilities as a client at Grace Harbour.

Client Name (Printed): _____

Guardian Name (Printed): _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

CLIENT COPY

Notice of Grace Harbour's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  — Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  — Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  — Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are the use of electronic health records, email, texting, electronic billing, telemental health services, quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also obtain authorization from you before using or disclosing PHI in a way that is not described in this Notice. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse — If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
- Adult and Domestic Abuse — If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
- Health Oversight Activities — If we are the subject of an inquiry by the Georgia Composite Board, Geogria Board of Psychological Examiners, or other applicable Georgia Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings—If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety — If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker's Compensation — we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

• Exceptions- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease of FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

• *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are 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. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)

• *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.

• *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

• *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

• *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

• *Right to a Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*- You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

• *Right to Be Notified if There is a Breach of Your Unsecured PHI*- You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessments fails to determine that there is a low probability that your PHI has been compromised.

Therapist's Duties:

• We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• We reserve the right to modify the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. In the event of a modification, we will provide you with a revised notice by mail or by a posting in the waiting room, which you will see on your next visit.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Kevin Freeman. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Kevin Freeman can provide you with the appropriate address upon request.

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellation for any other reasons that are not received by center staff at least 24 hours prior to the scheduled session will be billed at the usual session hourly rate. Monday appointments need to be cancelled by noon on Friday. To cancel an appointment scheduled on that day after a holiday, it needs to be cancelled on the day prior to the holiday. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

Grace Harbour, Inc. will assist you in completing and filing any insurance forms which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You must provide all required insurance information when checking in your services; all primary and secondary insurances must be identified when you initially present for services. You accept all financial consequences if any policies are not identified, and you must update any changed insurance information immediately upon the effective date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. Grace Harbour does accept payment by cash, check, or credit card.

IX. Protected Health Information

Your therapist may be required by your insurance company to disclose your protected health information (PHI), and some insurance companies require coordination of care with your Primary Care Provider (PCP).

Grace Harbour, Inc.
Behavioral Health

Acknowledgement of Personal Health Information (PHI)

I have read the *Grace Harbour Inc.'s Policies and Practices to Protect the Privacy of Your Health Information*, and I both understand and approve of its content. I also have been offered a copy of the policy.

_____	_____
Printed Name of Client	Witness
_____	_____
Signature of Client and /or Guardian	Date

Grace Harbour, Inc.
Behavioral Health

200 Westpark Drive, Suite 325 Peachtree City, GA 30269
37 Calumet Parkway, Bldg H, Suite 100, Newnan, GA 30263
678-669-2693 (fax) ♦ 770-486-1140 (phone)

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **Date of Birth:** _____

Client/Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Grace Harbour, Inc. to RELEASE my protected health information (PHI) to:**

_____

☐ **I hereby authorize Grace Harbour, Inc. to OBTAIN my protected health information (PHI) from:**

_____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

☐ Face sheet
☐ Laboratory/diagnostic testing results
☐ Discharge summary
☐ Behavioral health/psychological consult
☐ ER record report
☐ Substance abuse treatment records
☐ Progress & Case Notes
☐ Psychological evaluation/testing results
☐ History & physical
☐ School information
☐ Medication records
☐ Psychosocial assessment/Family history
☐ Psychiatric evaluation
☐ HIV/AIDS lab results & treatment history
☐ Summary of treatment records & contact dates
☐ Other:_____

☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

1. *I understand that the information disclosed pursuant to this Authorization **may** be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for:*
   - ☐ The period necessary to complete all transactions on accounts related to services provided to me.
   - ☐ One (1) year

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness (Title or Relationship to Individual) *Date*

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me at 200 Westpark Drive, Suite 325, Peachtree City, Georgia 30269. Fax: 678-669-2693.

_____ _____

Date this authorization is revoked by Individual Signature of Individual or legally authorized Representative