Atlantic
Counseling Services
Comprehensive Individual, Family and Couples Therapy
132 Stephenson Ave, Suite 101
Savannah, GA 31405
Phone: 912.200.3195
Fax: 912-349.7983

atlanticcounselingservices@gmail.com

Client Name: _____ Appointment Date: _____

Client Responsibilities Acknowledgement

The following is a list of your responsibilities as a client receiving services from Atlantic Counseling Services, LLC:

1. To provide accurate and complete information about your current complaints, past illnesses, medications, and emotional status.
2. To report any risks associated with your care and any unexpected changes in your physical or emotional condition.
3. To comply with all agency policy and procedures, to follow recommendations of your therapist, and to be responsible for your own actions and outcomes if you refuse treatment and/or do not follow instructions.
4. Notify us if you will not be able to keep your scheduled appointment.
5. To assure the financial obligations of your treatment are fulfilled promptly.
6. To be considerate of the rights of others and assist us in controlling noise and any other distractions that may affect client care.
7. To accept responsibility for all personal property and valuables brought into the office.
8. To provide us with current contact and insurance information.
9. To help us improve services by providing feedback about your needs and expectations.

My therapist has reviewed and discussed my responsibilities as a client of Atlantic Counseling Services. I have received a copy of these Client Responsibilities and additional policies.

_____ _____
Client or Legal Guardian Signature Date

_____ _____
ACS Staff Signature Date

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Client Rights Acknowledgement

The following is a list of your rights as a client receiving services from Atlantic Counseling Services, LLC:

1. You have the right to confidentiality. All information will be kept private, except in the following circumstances:
a. It is believed you present a threat of harm to yourself or others.
b. It is believed you are being abusive and/or neglectful to a child.
c. Your records are subpoenaed by the court system.
d. Your records are requested by your insurance provider or external review organization.
e. You have signed a release of information granting permission for information to be released to the individual(s) or agency(ies) you specified.
2. You have the right to be treated with dignity, consideration, and respect.
3. You have the right to be protected from abuse, neglect, or unfair treatment.
4. You have the right to receive services within a reasonable amount of time.
5. You have the right to plan for and receive help in getting services that you need.
6. You have the right to know all options for services available to you.
7. You have the right to honest, straightforward communication at all times.
8. You have the right to have your cultural needs met.
9. You have the right to refuse services, ask for clarification, make a complaint without fear of negative consequence, or file a grievance if you feel you have been treated improperly.
10. You have the right to make choices, feel positive about your successes, and be responsible for your mistakes.

My therapist has reviewed and discussed my rights as a client of Atlantic Counseling Services. I have received a copy of these Client Rights and additional policies.

_____ _____
Client or Legal Guardian Signature Date

_____ _____
ACS Staff Signature Date

SECTION I - CLIENT INFORMATION

CLIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email Address: _____

Date of Birth: _____ SSN: _____ Gender: _____Male _____Female

Employer or School: _____ Marital Status: _____

Spouse Name and Phone: _____

Primary Care Physician Name and Phone: _____

Hospital of Preference: _____

Emergency Contact Name and Phone: _____

Do we have your permission to leave a message on the numbers you listed: Y N

Do we have your permission to provide information to your spouse: Y N

Do we have your permission to provide information to your physician: Y N

Do we have permission to provide information via email: Y N

(If you answered "yes" to any of the questions above, please see the receptionist to sign a Release of Information.)

PARENT/GUARDIAN INFORMATION (IF THE CLIENT IS LESS THAN 18 YEARS OF AGE):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ SSN: _____ Gender: _____Male _____Female

Employer or School: _____ Marital Status: _____

IS THE PATIENT COVERED BY INSURANCE?

_____ **YES – PLEASE COMPLETE SECTION II**

_____ **NO – ARMY ONE SOURCE, PRIVATE PAY, AND DFCS PLEASE GO TO SECTION III**

SECTION II - INSURANCE INFORMATION

PRIMARY INSURANCE:

Client's Relationship to Policy Holder: _____Self _____Spouse _____Child

Policy Holder's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ SSN: _____ Gender: _____Male _____Female

Insurance Company: _____

ID/Member Number of the Insured (Client): _____

SECONDARY INSURANCE:

Client's Relationship to Policy Holder: _____Self _____Spouse _____Child

Policy Holder's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ SSN: _____ Gender: _____Male _____Female

Insurance Company: _____

ID/Member Number of the Insured (Client): _____

NOTE: IF YOU FAIL TO PROVIDE SECONDARY INSURANCE INFORMATION, ALL CLAIMS MAY BE DENIED AND YOU WILL BE LIABLE FOR THE FULL AMOUNT.

SECTION III – CONSENT FOR TREATMENT AND REIMBURSEMENT

CONSENT FOR TREATMENT

SIGNATURE BELOW INDICATES YOU UNDERSTAND AND AGREE TO RECEIVE TREATMENT.

I hereby give consent for Atlantic Counseling Services, LLC to treat _____
(Client Name)

who is related to me as __self / spouse / child / other_____ in whatever manner deemed
(Relationship to Client - circle one) (list other)

professionally appropriate.

CONSENT FOR REIMBURSEMENT

SIGNATURE BELOW INDICATES YOU UNDERSTAND AND AGREE TO ABIDE BY THESE STATEMENTS.

I acknowledge that I am responsible for providing a copy of my insurance card and notifying Atlantic Counseling Services, LLC of any changes to my insurance policy.

I authorize the release of treatment information necessary to process all insurance claims.

I authorize payments of benefits to Atlantic Counseling Services, LLC for all services provided.

I understand it is my responsibility to ensure that the providers is in my insurance network. Claims denied or reduced due to the provider being considered out of network are my responsibility.

I agree to pay all co-pays, co-insurance, deductibles, and/or any other costs not covered by my insurance at the time of service.

_____ _____
Client or Legal Guardian Signature Date

_____ _____
ACS Staff Signature Date

SECTON IV – ADDITIONAL POLICIES

LATE POLICY

We greatly appreciate you allowing us to provide you with the best care possible. We want to continue to be able to provide each client with the attention they deserve. Our staff knows your time is important, and we hope you understand the value of our time as well. Therefore, if you are more than 15 minutes late for your scheduled appointment, it may be necessary to reschedule for a later date.

CANCELLATION POLICY

We do not charge for cancellations; however, out of respect for our therapists and clients, we request that you give 12-hour notice when cancelling an appointment. We attempt to fill all open slots from our waiting list in order to increase the frequency with which clients can be seen. More than two cancelled appointments with less than 12 hours' notice may result in future appointments being removed from our schedule. If this occurs, you will be notified via phone, email and/or in writing. **Client/Guardian will be responsible for a $60 reinstatement fee before a new appointment will be scheduled.**

GRIEVANCE POLICY

We continuously strive to improve the services we provide to you. Should you have any complaints or concerns regarding your treatment at this agency, please contact a member of the management staff at (912) 200-3195. We are committed to your satisfaction.

TECHNOLOGY STATEMENT

We make every effort to protect your privacy and confidentiality. We will not transmit your information via electronic means in a way that compromises your confidentiality.

RESEARCH ACTIVITIES

Atlantic Counseling Services, LLC does not conduct research. Treatment data may be anonymously aggregated for internal quality control and improvement efforts only. Your information will never be shared or sold.

By signing below, you acknowledge that you have read and understand the Additional policies of Atlantic Counseling Services.

_____ _____

Client or Legal Guardian Signature Date

_____ _____

ACS Staff Signature Date

SECTON V – HIPAA PRIVACY NOTICE

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your mental health provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for reimbursement for your visit may require that your relevant protected health information be disclosed to your health plan to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, third party reviews, or training. For example, we may disclose your protected health information to interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners; funeral directors; organ donation; research; criminal activity; military activity and national security; Worker's Compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that this practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health care information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If a provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive a confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **5/1/07.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (912) 200-3195.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Printed Name: _____ Signature: _____ Date: _____

SECTON VI – MEDICATIONS

Referring Physician or Agency (if applicable): _____

Psychiatrist Name and Phone: _____

Primary Care Physician Name and Phone: _____

Medication	Dosage	Start Date	Prescribing Physician

Are you experiencing any unwanted side effects from your current medication(s): Y N

Are you receiving regular medication management: Y N

Do you wish to discuss changes to your current medications: Y N

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Effective May 1, 2021: Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 12-hour notice will be considered a no show.

If a **third** No Show or cancellation/reschedule without a 12-hour notice should occur, the patient may be dismissed from Atlantic Counseling Services.

Any new patient who fails to show for their initial visit will not be rescheduled.

If a patient has been dismissed from Atlantic Counseling services d u e to excessive No Show/Cancellation appointments and would like to return, the patient will be responsible for a **$60 reinstatement fee** before an appointment will be made. **The fee is charged to the patient, not the insurance company and is due at the time of the appointment being scheduled.**

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COURT RELATED SERVICES/TESTIMONY

SIGNATURE BELOW INDICATES YOU UNDERSTAND AND AGREE TO ABIDE BY THESE STATEMENTS:

I acknowledge that my/my child's therapist is a mental health professional and will be working with me/my child on mental health concerns.

I understand that court related services/testimony are not typical for the services provided, but if necessary are **NOT** covered by insurance.

I understand it is my responsibility to ensure the provider is reimbursed for court related activities/services at that rate of $100 per hour. These services include but are not limited to, speaking to any attorney, judge, guardian ad litem, or other individual relevant to your situation. These services also include completion of affidavits, letters, or other communication with any court related personnel (attorneys, judges, guardian ad litems etc)

I understand the provider will only provide testimony for my court case and/or appear in court under subpoena from me or an attorney.

I understand that if I or my attorney subpoena the therapist, the therapist will have to cancel a full day of scheduled work to prepare and attend court.

I understand it is my responsibility to ensure the provider is reimbursed for any subpoena at the rate of $1000 per day for each day the provider must attend court.

I understand all fees must be paid prior to the day of testimony.

Client/Legal Guardian Signature:_____ Date:_____

ACS Staff Signature:_____ Date:_____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Atlantic Counseling Services has put in place preventative measures to reduce the spread of COVID-19; however, the Atlantic Counseling Services **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with Atlantic Counseling Services **could increase** your risk and your child(ren)'s risk of contacting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments with Atlantic Counseling Services and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Atlantic Counseling Services may result from the actions, omissions, or negligence of myself and others, including, but not limited to Atlantic Counseling Services, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with Atlantic Counseling Services. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless the Atlantic Counseling Services its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Atlantic Counseling Services, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Atlantic Counseling Services.

_____
Name of Client

_____ _____
Signature of client/parent Date