Informed Consent and Confidentiality Agreement

Grief & Loss Group

Purpose Statement

Grief and Loss Group is a psychoeducational group providing a safe, nonjudgmental psychoeducational and support environment for adolescents who perceive a current need to learn coping skills and mechanism to aid in managing and regulating emotions associated with grief or loss. The intended outcome is for members to understand the potential detriments of unhealthy behavior(s) and discover techniques of coping allowing successful transition through the stages of denial, anger, bargaining, depression and acceptance. This will be accomplished through in-depth personal disclosure, cognitive behavioral techniques and activities that may include art therapy, role-playing, accountability, at-home assignments and others.

About Northwest Georgia Behavioral Health

Northwest Georgia Behavioral Health, LLC (NWGBH) is a limited liability company in the state of Georgia providing a comprehensive therapeutic environment in which our therapists can provide counseling services for adolescents and adults. NWGBH maintains professional offices for client therapy, as well as group services and peer consultation contracting with both fully licensed therapists and associate licensed therapists who all provide a full range of therapeutic services for adolescents, parents, families and individuals.

Potential Risk

Your participation in this group is of your own voluntary decision and may pose some risk to you. Group therapy can produce a wide-range of positive and negative emotions which may make you uncomfortable or may impact your relationship with others. If you experience any difficulties during the course of your sessions, you should immediately discuss your concerns with your group leader; however, **this is a short-term and informal group specifically addressing grief and loss issues only and will not address other psychological disorders. Therefore, it is not intended to replace other therapy modalities including individual or family therapy.**

Licensure and Qualifications

Your therapist has earned an M.A. in Professional Counseling from Liberty University and is licensed by the State of Georgia, through the Georgia Composite Board of Examiners, as a Licensed Associate Professional Counselor (LAPC), license # APC004672.

As a Licensed Associate Professional Counselor, your group leader must adhere to certain ethical guidelines established by state and national organizations as well as state and federal laws. He is a member of the American Psychological Association and the American Counseling Association; if at any time you have an ethical or legal concern, please immediately contact your group leader.

Dual Relationship

Dual relationships are prohibited. A dual relationship exists when a mental health professional has a relationship (e.g. friendship, family member, business partnership, supervisor, etc.) with a client/member outside the scope of care and treatment. This separation is important as it allows the group leader to remain neutral and provide unbiased evaluations that are in the best interest of the member. If you feel a dual relationship exists, you should immediately express your concerns with your group leader.

Fees

The fee for the Grief and Loss Group is waived; however, reasonable and customary professional fees may be incurred should the group leader become engaged outside the scope of this group or for individual or family therapy.

Member Responsibility

Change takes work, work requires effort, and effort may be uncomfortable. In depth exploration of your inner-self can sometimes arouse intense feelings of anger, anxiety, frustration, etc. Confronting behavior can sometimes cause discomfort for you, your family and your friends.
As a member, you are expected to be honest, put forth an effort, and follow the procedures set forth in this document. If you are currently receiving or have received past mental health services, you are expected to inform your group leader. It is also essential you complete your screening and intake forms in their entirety by disclosing all past and current drug use; current medication (prescription and over-the-counter) and all mental health and medical conditions and present concerns. Any changes to the above or to your well-being should be addressed with your group leader prior to your next session. If you have questions or concerns about the group process, your goals, confidentiality, your safety or your progress, it is your responsibility to inform your group leader. It is very important that you complete your mental health plan, either with us or another qualified professional. Therefore, if at any point you decide to pursue mental health services elsewhere, we expect you to inform us immediately. We will not abandon you and will assist you in the referral and transfer process.

Everyone within the group setting (members and the group leader) will treat each other with courtesy and respect. Disagreements will occur and may be addressed within the group; however courtesy and respect will be maintained at all times. For severe or continued disruptive behavior, the group leader will determine if the member should be addressed with the group or in private and will have sole discretion regarding the member's status in the group.

Physical Health

There is a strong relationship between mental and physical health. Some mental health concerns can be caused by physical conditions and vice-versa. Therefore, it is recommended you receive a physical examination if you have not had one within the past 12 months.

Record Keeping

A file will be created containing your name and information. It will be stored according to HIPAA guidelines for a period of ten years from the termination of the relationship, at which time it will be destroyed.

Confidentiality

Due to the sensitive nature of this group, privacy and confidentiality will be of the utmost concern. Therefore, it is required that any and all information presented within the group, whether by the group leader or group member is not to be discussed outside of the group setting with anyone for any reason. However, due to the group setting, confidentiality cannot be guaranteed between group participants.

According to Georgia law, there are four reasons confidentiality may be breached by the group leader: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There is a reasonable suspicion of abuse/neglect against a minor, elderly person (60 years or older), or a dependent adult, or 4) A court order is received directing the disclosure of information. Before mandated disclosure, privileged communication will be asserted on behalf of the client. Further, clients will be apprised of all mandated disclosures as soon as notification has been received.

Confidentiality includes not acknowledging your receipt of services without your permission. Therefore, if you happen to see your group leader outside the office setting, please do not be insulted if he does not initiate contact. This is for your protection; however, you may initiate an interaction based on your level of comfort and disclosure.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

_____Yes, I understand my mail, voicemail, email, text messages, and all other forms of electronic communication(s) is a limit to confidentiality and privacy cannot be guaranteed. With acknowledgment of said notice, I authorize communication via the below methods:

Mailing Address:

____

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Cell Phone: ________________________

Text Messaging: ____________________

Email: ____________________________

Signature: ___________________________ Date: ___________________

In the case of my death or major medical incapacitation, all of my records will be accessed by Steven Lambert, LPC and, or, J Scott Pennington, LPC.

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

Notice of Privacy Practices

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 practice is dedicated to maintaining the privacy of your protected health information. I am required by law and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

1) When there is a serious threat to you or your child's health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
2) Some lawsuits and legal or court proceedings.
3) If a law enforcement official legally requires me to do so.
4) For workers compensation and similar benefit programs.

There are some other situations like these that do not happen very often. They are described in the long version of NPP.

Client Records

You should be aware that, pursuant to Health Information Portability and Accountability Act (HIPAA), I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $35 charged for copying and mailing the record for release.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists 237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Signature indicating I have read and received the Notice of Privacy Policies:

Member Name (Print): ____________________________ Date: ________________

Member Signature: ______________________________ Date: ________________

Parent/Guardian Name (Print): ______________________ Date: ________________

Parent/Guardian Signature: _________________________ Date: ________________

Agreement to Enter into Counseling Services and Fee for Services Agreement

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

I understand that I am entering into a contract with Northwest Georgia Behavioral Health (NWGBH) for the professional time and services provided for within that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agreed that my fee for group sessions will be **$0.00.** I understand groups are limited to a specific number of members and sessions, and attendance is very important.

Emergency Situations

In life-threatening emergencies, call 911 or go to your nearest hospital emergency room. If you need assistance before our office can return your call, contact the 24-Hour Crisis Center at (770) 422-0202, call 911 or seek assistance at your nearest hospital emergency room; or if you are under the care of a psychiatrist, contact his/her office. If at any time, you feel an imminent need to harm yourself or someone else, immediately call 911 and accept their assistance.

I have read, understand and agree to the above information and voluntarily choose to enter this relationship under the circumstances described herein.

Member Name (Print): ______________________________ Date: _________________

Member Signature: _________________________________ Date: _________________

Parent/Guardian Name (Print): _______________________ Date: _________________

Parent/Guardian Signature: ___________________________ Date: _________________

Group Leader Name (Print): __________________________ Date: _________________

Group Leader Signature: _____________________________ Date: _________________

Client Information (***please add additional pages as needed***)

Client Name: ____ Date of Birth: _______

Parents/Guardians:(if child client) ____

Address: ____ City/Zip: ________________

Home Phone: _______________________________ Cell Phone: __________________________

Email Address: ____

Employer/Occupation/School Info/Grade: ____

Emergency Contact (Name, Relationship, Phone): _______________________________________

Referred by: ____

What is the primary reason you are seeking counseling for you and/or your child/adolescent at this time?

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____

When did you first notice the problem, issue, or symptoms?

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What have you already tried to improve the problem or symptoms? What has helped or has not helped?

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Have you or your child or family ever been in counseling before? If yes, please provide approximate dates and provider. What helped or did not help?

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Please list current medications, dosage, prescribing physician and office telephone number, and length of time taking this medication.

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Please sign to indicate permission to consult with prescribing physician:

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Have you or your child (if child client) ever expressed or experienced thoughts or feelings of suicide, self harm, or harm to others? If yes, please provide approximate time frame(s) and details.

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Please describe any significant medical history (including chronic conditions, hospitalizations, surgeries, premature birth, etc.)

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What goals or changes would you like to see accomplished by your child and/or family through counseling?

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Please list anything else you would like me to know before we begin our work together:

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Authorization for Release of Information

Client Name: _________________.___________________________ Date of Birth: ________________

I have been informed that under Georgia state law and Federal Law, that any and all verbal and or written communication between a client and Counselor is considered privileged information which may not be disclosed by the Counselor unless given consent by the client. Records maintained by the Counselor may contain alcohol and drug treatment information, client photographs, medical conditions and or psychiatric/psychological or other mental health privileged or confidential information. I have also been informed that client records maintained by a Counselor or other mental health or medical professional may not be disclosed to third parties except with the Client's consent or through legal process.

Therefore, I hereby request and authorize: ___**Glen N Barden, MA, LAPC**________________________________**,** of Northwest Georgia Behavioral Health to obtain and/or release information to and from:

__**Allatoona High School**______________________________
(Name of provider or agency)

____
(Address) (City) (State)
(Zip Code)

______________________ ______________________________
(Telephone Number) (Fax Number)

I agree to indemnify and hold harmless Northwest Georgia Behavioral Health's owner members, contractors and staff from any and all liability that may arise from the release of the information herein requested.

I understand that information to be obtained will be held strictly confidential and will not be released by Northwest Georgia Behavioral Health without my written consent. Furthermore, I understand that this authorization is subject to revocation, in writing at any time, and is valid for a period of one (1) year from the date of my signature, unless I specify another date or event here:

Member Name (Print): _____________________________ Date: ________________

Member Signature: _________________________________ Date: ________________

Parent/Guardian Name (Print): _______________________ Date: ________________

Parent/Guardian Signature: __________________________ Date: ________________