SUNRISE COUNSELING

Christine Burrell Townsend, LCSW, ACSW
Child, Adolescent, Adult and Family Therapy

Office Location:
2386 Clower Street, Bldg C Ste 101
Snellville, GA 30078

Office Phone: 770 985-2050

Cell Phone: 678 521-7533

It is my belief we can establish a better relationship and I can service you more efficiently if you are familiar with the procedures and services of the office. Sunrise Counseling believes in continuous improvement and quality of services that are provided by Christine Burrell Townsend, LCSW, and ACSW. Please assist me with this process by completing evaluations and personal data information as well as other required paperwork.

Client Name: _____Date of Birth: _____

Address: _____

Please provide a contact phone number(s) where you can be reached or a message can be left.

#1_____ _ home___cell ___work

#2_____ _ home___cell ___work

APPOINTMENTS AND SCHEDULING
Clients are only seen in the office. Intensity/frequency of service is based on the needs of the individual. Sessions are 50 minutes in length. Group therapy ranges from 50 to 90 minutes.

If you need to cancel an appointment please give at least 24 hours notice. **If you do not give 24 hours' notice, or if you fail to keep an appointment, you will be charged the full fee for the appointment.** The reason for this is that when you make an appointment you are reserving a time. I have agreed not to utilize that timeslot for any other purpose. If you fail to keep your appointment, I am unable to schedule another use for that part of my workday. This is true for groups also as groups are limited by number of participants.

____*(initial)* I would like Sunrise Counseling to notify me, via email, of upcoming appointments. I understand the confidentiality of email transmissions cannot be guaranteed. I also understand that I am responsible for cancelling appointments at least 24 hours in advance to avoid being charged for the appointment regardless of whether or not I have received an email reminder.

Email Address: _____

PLEASE NOTE! Insurance companies, managed care companies and employee assistance programs (EAPs) do <u>NOT</u> reimburse for missed appointments. Therefore, you will be responsible for the entire charge for missed appointments and appointments canceled without 24 hours' notice, even if an insurance company or other third party normally covers all or part of the counseling for you. In December of 2016, I will be leaving several insurance plans; you may file what is called a superbill provided by us for possible reimbursement or credit towards a deductible.

In case of bad weather, counseling appointments will be cancelled when Gwinnett County School District closes. When appointments are canceled as a result of bad weather, you will be contacted to reschedule your appointment.

FEES

An **initial** individual consult and assessment is $150. Couple or family **initial** are $150. Regular individual sessions are $110 for 50 minute sessions and regular couple or family sessions are $150. Group sessions are $50 per person per session. All fees are due prior to services being rendered. Other specialty assessments are available at variable rates. Payment can be made by cash or check at the time of the appointment, or by debit or credit card. Should you have any questions about fees,

payment arrangements, insurance benefits, or other financial questions, please do not hesitate to discuss them with me or my office assistant.

Many insurance policies include coverage for counseling. My services are covered by **some** of the major insurance and managed care companies, either as a provider or a non-participating provider – you will need to check with your individual insurance provider about your benefits. If these companies do not pay for services, you are responsible for payment.

If you have a medical emergency, please call 911. In cases of emotional distress, the therapist is available via phone conference or consultation for a charge of $25 per 15 minutes of consult.

Informed Consent:

I_____*(Name)* consent to diagnostic assessment and treatment by Sunrise Counseling, Inc. The purpose of the assessment is to clarify the nature of, and possible causes for, the presenting problem(s). The expected outcome of the assessment is the development of a treatment plan aimed at reducing the severity of the problem(s). The treatment plan may include, but may not to be limited to, psychotherapy, counseling, coaching, and education. I understand the diagnostic assessment and treatment may cause me to experience uncomfortable emotional reactions including, but not limited to feelings of sadness, depression, anxiety, anger and decreased relationship satisfaction. I understand the assessment and treatment are voluntary, and I could choose to forgo treatment for the problems(s). The risks of forgoing such treatment are the continuation and possible worsening of the problems. I understand it is also possible for the problems to decrease in severity over time without treatment.

CONFIDENTIALITY

Effective counseling is best accomplished in an atmosphere of trust and freedom of expression and disclosure. Christine Burrell Townsend, LCSW, ACSW will take every reasonable measure to ensure confidentiality. 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 Record 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 my privacy policies and procedures. I am happy to discuss any of these rights with you.

Should your counselor be subpoenaed (usually only for troubled custody cases), we normally provide the requested information, whether or not information is favorable to the undersigned. If we are required to present records to comply with a court order, it is our legal responsibility to do so. In the event of a subpoena or attorney's request, it is fully understood that we may bill you at an hourly rate of up to $400 per hour for reports, court appearances, or travel.

Otherwise, the information that you share with your counselor is not shared with anyone without your written consent. Please note confidentiality does not apply in the following circumstances:

1. If information is revealed, which might indicate you are a present and clear, imminent danger to yourself or another individual, information will be disclosed to the designated governmental agency to help protect persons from harm.
2. If information is revealed that might indicate you have physically, sexually, or emotionally abused a child, adolescent, or senior citizen, I am obligated by law to report this information to the designated governmental agency.
3. Your counselor may share information with an employee of this practice and also regularly collaborates with other mental health professionals regarding information that is pertinent to your case. Due to such, information may be discussed with such professionals who would then be held accountable to this policy of confidentiality.
4. If you give us written permission to release information to a managed care company or employee assistance program (EAP), we are required to give them whatever information they request with the exception of case notes. That information is customarily entered into a computer databank. We have no control over who has access to that data bank. Please contact the company for their policy regarding confidentiality of the information. Information given to insurance companies not associated with managed care is coded and usually limited to diagnosis and expected length of treatment only.

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If you have any concerns or questions regarding this policy, please discuss them with me or my office assistant.

PHILOSOPHY
The practice of counseling requires mutual understanding, respect, and confidence. I look forward to providing you services of the highest professional standards of counseling. Christine Burrell Townsend is a Licensed Clinical Social Worker with both GA State and National Certifications and have over 25 years of experience. I received my Masters in Social Worker (MSW) from Adelphi University in NY. I work with children, teenagers, and adults, individually, in families, couples, and in groups.

If the problems you or your family experience is outside of my expertise, I will help you with appropriate referrals to other professionals.

It is important to understand that participation in counseling can lead to individual changes that could affect your relationships and interactions with others in both positive and negative ways. If you wish, your therapist can discuss alternate forms of treatment for your concerns.

TREATMENT OF MINORS
Parents and legal guardians have the right to request information concerning a minor's evaluation and treatment. We will protect the right to confidentiality of all minors can to ensure success and to decrease negative impacts to relationships. The therapist will use her discretion in communicating information disclosed by minors in private. Risky behavior such as drug use, running away, sexual promiscuity, or self-harm will be reported to parents/legal guardians.

EMERGENCY CONTACT
In the case of an emergency, or if there is concern about your safety or the safety of those around you, we may need to contact someone close to you (a relative, a close friend, or a spouse). Please write down the name and contact number for the person of your choosing for an emergency contact:

Name: _____ Address: _____

Phone: _____ Relationship: _____

My signature affirms that I have read, understand and accept the client contract and that it was presented to me in a clear, non-technical language. This client contract enables me to make an informed, voluntary consent to counseling for myself.

Signed: _____ Date: _____
Printed Name: _____

This client contract enables me to make an informed, voluntary consent to counseling for myself and/or the child/children listed below. I attest that I have the right to consent for treatment of the child or children presented for counseling, and I have provided documentation of this, as needed.

Child/Children: _____ _____
_____ _____

_____ _____ _____
Parent/ Legal Guardian Name Signature of Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES
This notice tells you how we make use of your health information at **Sunrise Counseling**, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do

everything possible to protect that privacy. We have legal responsibility under the laws of the United States and the State of Georgia to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at **Sunrise Counseling**. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in the document, please ask us for assistance which we will provide at no charge. Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information…

1. To your physician or other health care provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only affect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.
8. The Sunrise Counseling expects staff to follow the laws of the State of Georgia in reporting to the designated authorities intentions on the part of clients to commit suicide, homicide, or incidents of child abuse. (Georgia Code: 19-7-5)

As a client of Sunrise Counseling you have these important rights: A. You have the right to restrict disclosure of your protected health information to health plans and/or insurance companies if you are paying out of pocket in full for services provided. B. You have the right to be notified in the event of any unintended disclosure of your protected health information. C. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use. D. You can ask us for photocopies of the information in part “C” above. E. We will charge you $1 per page for making these photocopies. F. You have a right to a copy of this notice at no charge. G. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. Your written request must specify the alternative means and location. H. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency. I. You can make a written request that we amend the information in part “C” above. J. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing. K. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request. L. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center’s operations. This can go back as far as six years. M. If you request the accounting in “L” above more than once in a 12 month period, we may charge you a fee based on our actual costs of tabulating these disclosures. N. If you believe we may have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Compliance Officer: Christine Burrell Townsend, 770 985 2050. O. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

2016 Fee Schedule

90791 Diagnostic Interview ……..….$150.00

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90834 Individual Psychotherapy (45-50 min)…….$110.00

90837 Individual Psychotherapy (75-80 min)……..….$150.00

90847 Family Therapy……...$150.00

90853 Group Therapy……..….$50.00

Informational Consultation (<15 min)……..n/c

Telephone Therapy (>15 min)…….. $25/15 min.

Court Fees
(Preparation, reports, availability and travel time)……..…….$400/hr

Missed appointment fees (without 24 hr. notice)…….….$ 110/session fee

Preparation of a report……...……$75.00

Returned Check Fee……..$35.00 + bank fees

Effective 12/16, Sunrise Counseling will not accept medical insurance directly and therefore will be considered an out-of-network provider. Payment arrangements are made exclusively between Sunrise Counseling and our clients. Many of our clients will be able to use their health insurance benefits to help with our fees by submitting an itemized receipt, called a super bill that can be provided at the end of each appointment. Your insurance company will reimburse you directly at a rate determined by your specific policy. For details, contact your insurance carrier and ask about your "out-of-network" benefits for "outpatient mental health."

My signature affirms that I have read, understand and accept the fee schedule and that it was presented to me in a clear, non-technical language. This fee schedule enables me to make an informed, voluntary consent to counseling for myself.

Signed: _____ Date: _____
Printed Name: _____