

INTAKE & HIPPA FORMS

CCS PSYCHOTHERAPY, INC.

If possible, please complete this paperwork before your first appointment. This will allow us more time to make the best use of your first session. If you don't complete the paperwork in advance, we will provide you a copy of these forms when you come into the office.

Date: ____/____/____

Name & Date of Birth	Gender	Address	Phone Number & Email

If a client is a minor, who is the legal guardian? _____ Please bring a copy of the custody order or guardianship provided (if applicable).

Primary Insurance Information?			
Insurance Company		Member Name	
Your Group ID#		Member DOB	
Your Member ID#		Member SS#	
Secondary Insurance Information?			
Insurance Company		Member Name	
Your Group ID#		Member DOB	
Your Member ID#		Member SS#	

Although most major insurance companies and EAP programs cover Dr. Cole's services, please do not assume you are covered until you have received authorization from your insurance provider. For your convenience, we have contracted with a third party (KRD Solutions) to help you with many of your insurance support needs, including authorizations and filing claims. To contact KRD for this complimentary service please call 866-714-1224.

Please initial that you have read this page _____

Basic Information

Your Name _____ Today's Date _____

1. Gender (Please check ✓ one)

Male Female

2. Age (Please check ✓ one)

0 – 10		31 – 40		61 – 70	
11 – 20		41 – 50		71 – 80	
21 – 30		51 – 60		81 or older	

3. Marital Status (Please check ✓ one)

a. Single, no partner		c. Living together		e. Separated		g. Widowed	
b. Single, steady partner		d. Married		f. Divorced		h. Other	

4. Racial Background (Please check ✓ the one that applies the best)

a. White / Caucasian		g. Other Middle-Eastern	
b. Black / African-American		h. Phillipino / Filipino	
c. Asian / Asian -American		i. Native American	
d. Chicano / Mexican-American		j. Pacific Islander	
e. Latino / Spanish-American		k. Other	
f. Indian / Pakistani			

5. Education (Please check ✓ the highest level reached)

a. No formal education		d. Some college or technical training		f. Some graduate school	
b. Grammar school		e. College degree		g. Graduate degree	
c. High school					

6. Your family's annual income (Please check ✓ one. Take your best guess if unsure.)

a. Less than \$10,000		e. \$40,001 – \$50,000		i. \$80,001 – \$100,000	
b. \$10,001 – \$20,000		f. \$50,001 – \$60,000		j. \$100,001 – \$150,000	
c. \$20,001 – \$30,000		g. \$60,001 – \$70,000		k. \$150,001 – \$200,000	
d. \$30,001 – \$40,000		h. \$70,001 – \$80,000		l. More than \$200,000	

7. Please write a brief explanation of why you're seeking therapy at this time:

Please initial that you have read this page _____

Mood Survey*

Instructions: Put a check (✓) after each item to indicate how you've been feeling **over the past week, including today.**

Please answer all the items.

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
Depression					
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					
Total Items 1 – 5 →					

Suicidal Urges

1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					
Total Items 1 – 2 →					

Anxiety

1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
Total Items 1 – 5 →					

Anger

1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Total Items 1 – 5 →					

Relationship Satisfaction*

Instructions: Place a check (✓) in the box that best describes how satisfied you feel **in your closest personal relationship.**

Please answer all 5 items.

	Dissatisfied			Satisfied			
	0—Very	1—Moderately	2—Somewhat	3—Neutral	4—Somewhat	5—Moderately	6—Very
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
Total Items 1 – 5 →							

Please initial that you have read this page _____

Place an <u>X</u> next to all of the following <u>GOALS</u> that you may be interested in talking about as a part of your therapy:	X
I WANT TO: Feel <u>more or less</u> depressed, anxious, fearful and/or angry.	
I WANT TO: Think more rational, optimistic and/or I want to overcome self-defeating thoughts and challenge thinking that upsets me.	
I WANT TO: Replace bad habits or addictions with good ones.	
I WANT TO: Improve relationships (family, friends, work colleagues).	
I WANT TO: Stop hallucinations/dissociating/hot memories related to something bad that happened.	
I WANT TO: Increase my self-esteem and/or self-confidence.	
I WANT TO: Resolve problems due to abuse/neglect that took place in my past.	
I WANT TO: Increase the support I get from my family, friends, co-workers and/or community.	
I WANT TO: Improve my goal setting, planning and/or problem solving abilities.	
I WANT TO: Improve communication, listening, speaking, become more assertive, resolving conflict and/or setting limits or personal boundaries.	
I WANT TO: Manage stress, deal with panic and/or learn to relax when I feel anxious or stressed out.	
I WANT TO: Make or do a better job making important decisions (education, work, relations, health).	
I WANT TO: Improve overall wellbeing: exercise, diet, social life, spirituality, memory/intellect.	
I WANT TO: Improve my ability to interact in social settings without getting anxious.	
I WANT TO: Overcome an addiction or bad habit like drinking too much, pornography, gambling.	
I WANT TO: Decrease self-destructive thinking and behaving	
Other (I WANT TO):	
Other (I WANT TO):	
Other (I WANT TO):	
Place an <u>X</u> next to all of the following statements that apply to you and/or describe in some way what you have been experiencing in the recent past:	X
Do you use more alcohol than you should?	
Do other people in your life complain that you use more alcohol than you should?	
Do you abuse any kind of drug (legal or illegal)?	
Do other people in your life ever complain that you have a problem with drugs?	
Have you ever been arrested for driving under the influence of alcohol or drugs (DUI)?	
Do you have thoughts or fantasies of hurting people?	
Do you have an urge to do something harmful or violent to another person?	

Please initial that you have read this page _____

Place an <u>X</u> next to all of the following statements that apply to you and/or describe in some way what you have been experiencing in the recent past:	X
Do you have an urge to hurt yourself? <i>If yes, how would you do it?</i>	
Are you having academic difficulties or other problems at school?	
Are you having difficulties work or in your career?	
Are you having trouble deciding what you want to do with your life?	
Are you struggling with your sexual identity?	
Are you experiencing difficulties with you goals in life, career choice, friendships, personal values?	
Are you having problems in a relationship with your child or other members of your family?	
Are you having problems in your marriage or in another close romantic relationship?	
Are you struggling because a friend or family member has a medical or psychiatric problem?	
Are you having problems because of the death of a friend or family member?	
During the past six months, have you experienced an upsetting event, such as problems at work or school, marital problems, divorce, a natural disaster, medical problems, or the loss of a loved one?	
Do you have sudden attacks of <i>terror or panic</i> that come from out of the blue?	
Do you sometimes experience sudden, unexpected feelings of overwhelming fear?	
Are you afraid of being alone? <i>and/or</i> Are you afraid something terrible will happen if you are along?	
Are you afraid of being in crowds, stores, bridges, elevators, open places, or riding in cars or any form of public transportation?	
Do you have phobias: Fear of dogs, rats, snakes, insects, bugs, heights, water and/or flying or other?	
Do you feel nervous, self-conscious, or embarrassed in social situations?	
Do you feel uncomfortable or insecure around other people.	
Do you avoid social situations because I feel so awkward or anxious?	
Do you have upsetting or disturbing thoughts go through your head over and over again?	
Once I get these upsetting thoughts, I can't seem to ignore them or get rid of them.	
Do you worry about contamination from germs, sticky substances, dirt and/or bodily secretions?	
Are you ever afraid you will lose control and harm others?	
Do you get upset when things are messy or not in a certain order?	
Are you afraid you may confess to a crime or blurt out something embarrassing or obscene in public?	
Are you worried that you'll be responsible for a terrible event, like a fire, illness and/or an accident?	
Are you plagued or tormented by forbidden or perverse sexual thoughts?	
Do you have any obsessive thoughts? <i>If yes, describe:</i>	
Do you feel a powerful urge to perform certain rituals when you get anxious?	
Have you experienced or witnessed a terrible, horrific traumatic event such as murder or serious injury, torture and/or a threat to your life or someone else's life.	

Please initial that you have read this page _____

Place an <u>X</u> next to all of the following statements that apply to you and/or describe in some way what you have been experiencing in the recent past:	X
Have you recently felt anxious, worried, or nervous because of an upsetting event?	
Have you recently felt down and depressed because of an upsetting event?	
Have you recently been struggling at work or in relationships because of an upsetting event?	
Do you have upsetting dreams about a traumatic event in your life?	
I sometimes have flashbacks and feel like the event is happening again.	
Do you feel like you are losing interest in life?	
Do you often feel isolated or alienated from other people?	
Do you often feel like you have no future?	
Do you have difficulty paying close attention to details?	
Do you often make careless mistakes?	
Do you oftentimes have trouble organizing activities?	
Do you tend to avoid things that take a lot of mental effort for a long period of time?	
Are you often easily distracted?	
Do you often fidgets with hands or feet or squirm in your seat?	
Do you often feel like you are "on the go" or that you are "driven by a motor?"	
Do you often talk excessively?	
Do you sometimes vomit or go to other extremes so that you won't gain weight?	
Do you exercise a great deal to avoid gaining weight?	
Do you sometimes take diet pills to reduce cravings for food?	
Do you have intense fears of gaining weight.	
Do you sometimes feel like you have additional personalities -- like there is more than one of you?	
Do you sometimes forget where you have been for long periods of time?	
Do you sometimes feel like different identities with different names control you?	
Do you sometimes I hear voices talking to you or giving you instructions?	
Do you believe that people are out to get you?	
Do you believe people want to harm you or take advantage of you?	
Do you often obsess over whether you said and did the right thing.	
Do you often hate and/or dislike yourself?	
Do you often feel worried, guilty or discouraged?	
My relationships feel frustrating and unsatisfying.	
Do you sometimes feel like you need everyone's approval to be ok?	
Do you rely on others too much?	
Do you believe people do not listen when you speak?	
Do you think most people view you negatively?	

Please initial that you have read this page _____

Place an X next to all of the following statements that apply to you and/or describe in some way what you have been experiencing in the recent past:	X
Do you have difficulty asking for what you want?	
Do you have a hard time knowing what you want?	
Do you sometimes feel lonely and isolated?	
Do you have a problem being alone? That is, do you always need someone in your life?	
Do you procrastinate or avoid things you must get done?	
Do you sometimes avoid relationships because you fear rejection?	
Do you tend to think of things in all or nothing terms?	
Do you have trouble delegating tasks?	
Are you having trouble developing a permanent relationship with others?	
Do you feel stuck in your marriage?	
Is your spouse having an affair?	
Do you have a "spending" problem?	
Are you having an affair?	
Do you have trouble with perfectionism?	
Do you use pornography?	
Are you having an affair?	
Have you ever been convicted of any crime?	
Have you been arrested in the past 2 years?	
List the 4 problems you are most concerned about.	
Problem 1:	
Problem 2:	
Problem 3:	
Problem 4:	
Please provide any additional information here that will help your therapist better understand what you are seeking help for at this time.	

Please initial that you have read this page _____

INFORMATION, AUTHORIZATION, AND CONSENT TO TREATMENT

Welcome to CCS Psychotherapy, Inc., (hereafter known as “CCS”). We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. Because you are scheduling your therapy at this CCS site (www.ccstherapy.com), the therapist assigned to work with you is Dr. Galen E. Cole, PhD, MPH, LPC, (hereafter referred to as “your therapist” and/or Dr. Cole). If for any reason you would like to meet with another therapist instead of Dr. Cole, please call: (404) 671-9371 (ext. #2). This document is designed to inform you about what you can expect from your therapist regarding confidentiality and emergencies, and several other details regarding your treatment here at CCS. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Confidentiality & Records: Your communications with your therapist will be recorded in writing and/or videotaped. These communications will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. It is filed under your first name and last initial to protect your confidentiality to the fullest extent. Additionally, your therapist will always keep everything you say to him completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a “Release of Information” form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist’s license does provide him with the ability to uphold what is legally termed “privileged communication.” Privileged counselor-client communication is your right as a client to have a confidential relationship with a counselor. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential. Please note that in couple’s or marriage counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Structure and Cost of Sessions: Your therapist agrees to provide psychotherapy for a fee. Our fee structure is as follows: Intake Session (\$175 or Insurance Co-Pay), and Regular Session (\$125 or Insurance Co-Pay). The fee for your first session is due in advance of the session and is non-refundable and must be paid by credit card unless other arrangements are made in advance. In the event that you (the client) do not pay for subsequent sessions or administrative fees (including missed appointments, witness or legal fees, fees required to communicate with an attorney, etc.), the credit card used to pay for the first session will be charged to cover your incurred expenses which, in the case of administrative expenses like preparing for court, communicating with your attorney, or witness fees, will be charged at the rate of \$125 per hour. You also agree that, under no circumstances, will you attempt to reverse these charges for services provided, including administrative services in connection with preparing for and/or participating in court proceedings (please see our website for additional information on administrative fees). The fee for each subsequent session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$35 fee for any returned checks.

Witness and/or Legal Fees: In the event that CCS psychotherapist Dr. Galen Cole, PhD, MPH, LPC, is subpoenaed to testify as a witness in a court hearing related to your case or the case of your family member and/or is required to provide the court with records related to a legal proceeding involving you or your family member, you hereby agree to pay all of Dr. Galen Cole’s administrative and/or legal costs associated with this court appearance and or record research and submission. This includes his related attorney fees, travel expenses to and from the hearing site, reasonable lodging expenses, and \$125 per hour of the time Dr. Galen Cole is away from his practice (no more than \$800 per day plus travel

Please initial that you have read this page _____

and lodging costs). You also agree to have the credit card you have on file with CCS Psychotherapy, Inc., charged to cover these costs. In the event the credit card we have on file is declined you hereby agree to pay these expenses with cash, check or a major credit card within 7 days of Dr. Galen Cole and/or CCS Psychotherapy, Inc., incurring these expenses.

Cancellation Policy: In the event that you are unable to keep an appointment, you must notify us by phone (404-671-9371) at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions. Unlike a medical or dental office where they overbook patients to overcome the cost of services lost by missed appointments, we cannot overbook clients because we guarantee you that we will provide you service for an entire session. Thanks for your consideration in this regard.

In Case of an Emergency: CCS is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and s/he can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following: Call 911, Summit Ridge at 770-962-0624, Ridgeview Institute at 770-434-4567, Peachford Hospital at 770-454-5589, and/or go to your nearest hospital emergency room.

Our Services: The therapeutic services we provide include individual, couple, family, and/or group counseling. We can also provide experiential counseling including Equine Assisted Psychotherapy (this type of therapy is not covered by insurance). A description of these services is provided in some detail on our website at: www.ccstherapy.com.

Professional Relationship: Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. The therapeutic counseling provided to you, your partner, and/or your family may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client(s). If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their client's secret. As much as your therapist would like to, for your confidentiality s/he will not address you in public unless you speak first. Your therapist also must decline any invitation to attend gatherings with your family or friends, including graduations, weddings and funerals. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety: CCS assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychotherapy Association and/or the American Counseling Association. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately.

Please initial that you have read this page _____

Predicted Results of Therapy: Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise. Nonetheless, it's important for you to be aware of this possibility. Additionally, at times people find that when they first start therapy they feel somewhat worse before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Your Signature: Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

Client Name/Signature (Please Print & Sign)

Date

Parent's or Legal Guardian's Name/Signature (Please Print & Sign)

Date

The signature of the Therapist below indicates that s/he has discussed this form with you and has answered any questions you have regarding this information.

Therapist's Name Signature (Please Print & Sign)

Date

**Please note that doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you.*

Please initial that you have read this page _____

Health Insurance Portability and Accountability Act (HIPAA)

We are required by the **Health Insurance Portability and Accountability Act (HIPAA)** to make you aware of the following information related to CCS privacy practices. Please read this information carefully. Please don't hesitate to ask your therapist any questions you have about this information.

I. COMMITMENT TO YOUR PRIVACY: As a affiliate of CCS Psychotherapy, Inc., GALEN COLE, PHD, LPC, PRACTICES UNDER THE CORPORATE NAME OF CCS Psychotherapy, Inc. (hereafter referred to as "your therapist" or "CCS") is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that CCS maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, CCS is required to ensure that your PHI is kept private. This Notice explains when, why, and how CCS would use and/or disclose your PHI. Use of PHI means when CCS shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when CCS releases, transfers, gives, or otherwise reveals it to a third party. With some exceptions, CCS may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, CCS is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by CCS. Please note that CCS reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that CCS has created or maintained in the past and for any of your records that CCS may create or maintain in the future. CCS will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of CCS's Notice of Privacy Practices.

IV. HOW CCS and/or GALEN COLE, PHD, LPC, MAY USE AND DISCLOSE YOUR PHI: CCS will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: CCS may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, CCS may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, CCS will always ask for your authorization in writing prior to any such consultation.
2. For Health Care Operations: CCS may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - CCS may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that CCS is in compliance with applicable practices and laws. It is CCS practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.
3. To Obtain Payment for Treatment: Your CCS therapist may use and disclose your PHI to bill and collect payment for the treatment and services CCS provided you. Example: Your CCS therapist might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. CCS could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for CCS if either you or your insurance carrier do not remain current with on your account. In this latter instance, CCS will always do its best to reconcile this with you first prior to involving any outside agency.
4. Employees and Business Associates: There may be instances where services are provided to CCS by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, CCS will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of CCS.

Note: Georgia and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how CCS may disclose information about you to others.

Please initial that you have read this page _____

V. USE AND DISCLOSURE OF YOUR “PHI” IN CERTAIN SPECIAL CIRCUMSTANCES – Your CCS therapist, Dr. Galen Cole, PhD, MPH, LPC, and/or CCS may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, CCS may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: CCS may make a disclosure to the appropriate officials when a law requires CCS to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** CCS may disclose information about you to respond to a court or administrative order or a search warrant. CCS may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. CCS will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** CCS may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** CCS may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** CCS may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if CCS determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, CCS may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), CCS may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** CCS may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If CCS has a reasonable suspicion of child abuse or neglect, CCS will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** Your CCS therapist may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. CCS may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** CCS may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person’s involvement in your care or payment related to your care. In addition, CCS may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, CCS may release PHI about you as required by military command authorities. CCS may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** CCS may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, CCS may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

Please initial that you have read this page _____

13. For Research Purposes: In certain limited circumstances, CCS may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. For Workers' Compensation Purposes: CCS may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. Appointment Reminders: CCS is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. Health Oversight Activities: CCS may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess CCS's compliance with HIPAA regulations.
17. If Disclosure is Otherwise Specifically Required by Law.

VI. OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION: In any other situation not covered by this notice, CCS will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying CCS in writing of your decision. You understand that CCS is unable to take back any disclosures it has already made with your permission, CCS will continue to comply with laws that require certain disclosures, and CCS is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI: This section of HIPPA explains your rights regarding your PHI. In general, you have the right to see your PHI that is in CCS possession, or to get copies of it; however, you must request it in writing. If CCS does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from CCS within 30 days of receiving your written request. Under certain circumstances, CCS may feel it must deny your request, but if it does, CCS will give you, in writing, the reasons for the denial. CCS will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than \$.25 per page and the fees associated with supplies and postage. CCS may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

1. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that CCS limit how it uses and discloses your PHI. While CCS will consider your request, it is not legally bound to agree. If CCS does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that CCS is legally required or permitted to make.
2. The Right to Choose How CCS Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). CCS is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.
3. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that CCS has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. CCS will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a

Please initial that you have read this page _____

description of the information disclosed, and the reason for the disclosure. CCS will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each request.

- 4. **The Right to Amend Your PHI:** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that CCS correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of CCS receipt of your request. CCS may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than CCS denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and CCS denial will be attached to any future disclosures of your PHI. If CCS approves your request, it will make the change(s) to your PHI. Additionally, CCS will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.
- 5. **The Right to Get This Notice by Email:** You have the right to get this notice by email. You have the right to request a paper copy of it as well.
- 6. **Submit all Written Requests:** Submit to CCS Director and Privacy Officer, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision CCS made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services, Office of Civil Rights. CCS will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Once again, please discuss any questions or concerns with your therapist. Your signature below indicates that you Acknowledge receipt of this Notice:

Client Name/Signature (please print & sign)	Date
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If Applicable:

Parent/Legal Guardian Name (please print)	Date
---	------

Parent/Legal Guardian Signature	Date
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Please initial that you have read this page _____

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, _____ (client), hereby authorize CCS PSYCHOTHERAPY, Inc. (CCS), therapist: Galen E. Cole, PhD, MPH, LPC, and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

- (1) _____
- (2) _____
- (3) _____
- (4) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

- The parties stated above may discuss my medical and/or mental health information without limitations.
- I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2) or (3) or(4), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist to be effective.

Client's Signature: _____ Date: _____

Parent (Guardian's Signature): _____ Date: _____

Please initial that you have read this page _____