New Client Information

Name	
Pronouns (Ex: She/her/hers)	
Date of Birth	
Address	
Phone Number	
May I leave voicemail messages?	Yes___ No___
Email Address	
May I send email?	Yes___ No___ Note: Email is not considered a secure means of communication, so I will limit messages to information about scheduling and/or payment unless otherwise consented
Preferred method of contact (circle one)	Phone call Text message Email
Emergency Contact Name	
Emergency Contact Phone #	
Payment	Self Pay: $___ per 50-minute session Insurance Type: _____ Name and DOB of insured part, if other than client: _____ Credit Card: _____ Exp Date: _____ CVV:_____
Do you have any medical conditions or allergies that you feel I need to consider?	If so, list here:

Informed Consent of Practice Policies

Confidentiality:

The information you share and all documentation related to your treatment will remain confidential. Client information, including sessions notes, is submitted and stored securely through Therapy Notes. Hard copy documents will be stored in a locked filing cabinet.

Exceptions to Confidentiality:

- ◊ You express intent to do harm to yourself or others
- ◊ You disclose information about potential abuse of a minor, elderly, or disabled individual
- ◊ I am subpoenaed by the court system. Please note that, in the absence of a court order, my license obligates me to preserve your confidentiality.
- ◊ You provide written authorization for me to exchange information with a third party, such as your medical doctor.

Cancellations and No-shows:

Please notify your therapist via phone or text message as early as possible if you will be more than 15 minutes late or need to cancel or reschedule an appointment. If you cancel with less than 24 hours' notice, you will be charged a late cancellation fee of $50. If you no-show for an appointment, you will be charged the full amount of your session fee. Please note this charge cannot be billed to your health insurance provider so you will be responsible for the full amount. Exceptions to this cancellation policy include emergencies, illness, and inclement weather.

Session Length:

Sessions are typically 50 minutes in length. If you arrive late for your appointment, please note that your session will end at the time it was scheduled to end.

Your signature below acknowledges that you have received a copy of these policies. You understand that if you have any questions regarding them, you can contact me business manager at ambercoxlcsw@gmail.com.

_____ ____/____/____
Signature of Client Date

_____ ____/____/____
Signature of Parent, Guardian, or Legal Representative Date

Authorization
Contact by Telephone/Email in Event of Breach of PHI

I, _____ [Insert Name of Client], authorize Amber Cox, LCSW of Cox Counseling Services, PLLC to provide notice to me by telephone or email in the event of a breach of my protected health information (PHI) by Cox Counseling Services, PLLC. Such conversation shall be documented by Cox Counseling Services, PLLC.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the telephonic or electronic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Cox Counseling Services, PLLC.

Signature of Client/Patient	Date
Signature of Parent, Guardian, or Legal Representative	Date

Psychotherapy varies depending on the therapist, the client, and the client's particular situation and goals. There are many different methods which may be used to address goals and objectives. For the best outcome, each client must choose to invest energy in the process and work actively on relevant topics and skills both during and between sessions.

If a crisis arises and you feel that you would benefit from between-session coaching, I can offer this service, which is covered by insurance if you have it but otherwise would be another private pay charge. You can contact me at ambercoxlcsw@gmail.com for more information about what coverage may cost for you.

Before reaching out to me you agree that you will do the following:

1. **Reach out to a friend or emergency contact**
2. **Employ at least two (2) learned skills to reduce distress**
3. **Identify the nature of your crisis and how it affects your ability to remain safe**

If you are unable to complete the requirements above, phone coaching will not be offered and you will be referred to your local emergency room for assistance. Other resources include the Suicide Hotline, which can be reached by dialing 988. In the event that I will be unavailable for an extended time I will provide you with the name of a colleague to contact if necessary.

I am often not immediately available by telephone or email. While I am usually in my office during regular business hours I will not answer the phone or email when I am with a client. When I am unavailable my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call or text on the same day you make it with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, please reach out to your emergency contact, the Suicide Hotline at 988, local emergency services at 911, or the nearest emergency room.

Please identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist. Authorization is provided below allowing me to contact your emergency contact person as needed during such a crisis or emergency. If you express that you are in crisis and I do not receive a call back or connection within fifteen (15) minutes, then I will reach out to the phone number you have provided and/or appropriate emergency services. By signing this document, you are stating that you are aware that I may contact the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911.

By signing below, you agree to honor the guidelines set forth in this document.

Client name: _____ Client Signature: _____

Emergency contact name: _____

Emergency contact relationship: _____

Emergency contact phone number: _____

Authorization for Electronic Communication

As a convenience to me, I hereby request that Amber Cox, LCSW of Cox Counseling Services, PLLC communicate with me regarding my treatment via electronic communications (e-mail or text message). I understand that this means that my therapist will transmit my protected health information such as information about my appointments, diagnosis, medications, progress, and other individually identifiable information about my treatment to me via electronic communications.

I understand that there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Cox Counseling Services, PLLC shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Cox Counseling Services, PLLC, to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize my provider Amber Cox, LCSW of Cox Counseling Services, PLLC to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from my provider, I may revoke this authorization by providing written notice to Amber at ambercoxlcsw@gmail.com.

I agree that Cox Counseling Services, PLLC may communicate with me electronically unless and until I revoke this authorization by submitting notice in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____

Client Name

_____ _____

Signature of Client Date

HIPAA 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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me at ambercoxlcsw@gmail.com:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend**. If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me if you have any questions.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication**. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for

accommodating your request. I will not ask you for an explanation of why you are making the request.

- **Breach Notification**. If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me at ambercoxlcsw@gmail.com or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

This Notice is effective May 1st, 2023.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Cox Counseling Services' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Amber Cox, LCSW at ambercoxlcsw@gmail.com.

Signature of Patient/Client **Date**

Signature of Parent, Guardian, or Legal Representative* **Date**

*If you are signing as a personal representative of an individual, please describe your legal authority to act fort his individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt:**

Signature of Staff Member **Date**

Cox Counseling Services, PLLC
2309 Tomahawk Trail
Hillsborough, NC 27278

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE.

Simple Practice in the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the telehealth service, Simple Practice provides no medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Simple Practice facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in Simple Practice – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in Simple Practice.
5. To maintain confidentiality, I will not share my login information with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Name _____

Client Signature _____

Date _____