SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	**DOB:**	**Phone #:**
Payer/Insurance Provider:	**Policy #:**	**Group #:**

CONSENT PACKET

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

HIPAA NOTICE OF PRIVACY PRACTICES

*Please review this notice carefully, as it describes **Safe Haven Counseling, PLLC's policies & procedures effective October 1st, 2018** regarding the use & release of your **Personal** (medical and mental) **Health Information** and your right to access this information, in accordance with Federal & State laws and the Ethics governing the Counseling Profession.*

The ***Protected Health Information***, referred to here as "***PHI***," that you provide us, may ***only*** be released in accordance to the ***Health Insurance Portability & Accountability Act*** (HIPAA, 1996), ***North Carolina General Statutes*** (NCGS), the ***National Board of Certified Counselors*** (NBCC) & ***North Carolina Board of Licensed Clinical Mental Health Counselors*** (NCLCMHC) ***Code of Ethics*** (American Counseling Association, 2014), as well as the ***North Carolina Addictions Specialists Professional Practice Board*** (NCASPPB) ***Ethics Rules*** (2013), that shape & govern the mental health & addiction counseling professions, so as to best protect & preserve your personal information, your best interest & welfare, & that of the public as a whole. At Safe Haven Counseling, PLLC, we consider your private information, an essential part of ***promoting your welfare***, ***ensuring you the best possible quality of care*** & ***advocating for your best interest*** & our top priority. Therefore, your PHI is carefully used, handled & disclosed so as to:

- Inform & shape our case conceptualization, treatment planning & service delivery (i.e. face-to-face/remotely; individual/couple/family/group; during/in-between scheduled sessions/crisis situations…) which become part of your clinical records which you may access at any time.
- Determine how referrals to & from the appropriate licensed, certified or qualified community, legal, career, social or healthcare service provider(s) whom you agree should become involved in your treatment(s), should be handled.
- Determine how we conduct case consultations with other licensed, certified, qualified, competent or expert peer or mentor clinician(s), bound by the same legal & ethical standards as listed above & to whom we ***only*** disclose therapeutically relevant information that cannot be used to identify you for the purpose of identifying treatment barriers, treatment options, treatment effectiveness, treatment outcomes & available resources,
- Determine how we coordinate your care with tertiary service provider(s), as deemed necessary or potentially beneficial adjunct services to the treatment(s) & service(s) you receive at Safe Haven Counseling, PLLC.
- Verify insurance coverage information, file claims for reimbursement & collect payment from your insurance provider or third-party payer (i.e. Health Saving's Account; family member…) for the treatments & services rendered to you.
- Determine how we conduct all other business operations, including: 1) staff trainings; 2) National & State Licensure & Certification Board requirements compliance; 3) administrative duties; 4) accounting & 5) marketing activities, deemed necessary to continue providing you with the best possible quality care.
- Determine how we involve the appropriately licensed, certified or qualified healthcare professional(s), protective services or law enforcement agencies during times of severe or imminent risk(s) of domestic violence, medical, mental health or substance use ***crisis*** or life-threatening ***emergencies***, at which time: **Step 1**: An attempt is first made to inform you of the medical, legal &/or ethical necessity & the purpose of the disclosure & the mean(s) by which the disclosure will take place, prior to proceeding with the disclosure of your PHI. | **Step 2**: an opportunity for further discussion is also be provided to you at the first possible occasion, as needed &/or requested, regarding the appropriateness of the disclosure, determining its scope & therefore the greatest possible extent to which your PHI will remain protected & omitted from the disclosure(s).
- ***Except if***: 1) ***Ethical Necessity***: you report imminent ***risks of harm to self*** or ***others***; 2) ***Ethical & Legal Necessity***: I suspect ***child, elderly*** or ***disabled person abuse***; 3) ***Legal Necessity***: I must comply with court-ordered testimony &/or subpoenaed release of all or parts of your clinical records, as deemed relevant to the purpose of the court proceeding(s) & mandated by Federal & State laws with/out prior consent.

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career
163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone**: 336-396-7834 ~ **Fax**: 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CLIENT RIGHTS

As Safe Haven Counseling, PLLC client, you &/or your legal guardian have the rights to:

- Access to any of the domestic violence, mental health, addiction, grief & career treatments & services offered at Safe Haven Counseling, PLLC, as deemed medically necessary, therapeutically appropriate & mutually agreed upon as in your best interest &/or that of other concerned parties.
- Consent to & play an active part in all parts of your treatment planning, decisions, adjustments & discharge.
- Inspect & amend your clinical records by providing the information to be amended in writing.
- Request a copy of your clinical records, in full or in part, for a fee.
- Request how to be contacted by us: ☐ Home ☐ Work ☒ Cell ☒ Email ☐ Other: _____.
- Refer to the American Counseling Association ***Code of Ethics*** at: http://www.counseling.org/Resources/aca-code-of-ethics.pdf &/or to the North Carolina Addictions Specialists Professional Practice Board (NCASPPB) ***Ethics Rules*** at: https://www.ncsappb.org/wp-content/uploads/2013/02/NCSAPPB-ethics-rules.pdf so as to address any issues or concerns you may encounter with your service provider(s) directly in person, via phone or in writing using the contact information provided to you.
- File an official complaint with the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC) via Mail: P.O. Box 77819, Greensboro NC 27417 | Phone: 844-622-3572 or 336-217-6007 | Fax: 336-217-9450 | Email: <complaints@ncblcmhc.org> &/or by submitting your compliant form with the North Carolina Addictions Specialists Professional Practice Board (NCASPPB) Online: https://www.ncsappb.org/ethical-complaint-form/
- Decline or withdraw from any & all treatments or services recommended to you at Safe Haven Counseling, PLLC, whether you initially sought such services voluntarily, were ordered to by a court of law, or urged by a guardian or enforcement agency (i.e. Law Enforcement; Child Protective Services…) & to seek similar or different treatment(s) & service(s) from another service provider at any time & for any reason.
- Receive notices of Safe Haven Counseling, PLLC's policy changes.

CLIENT RESPONSIBILITIES

I, *(&/or my legal guardian)*_____ **agree to**:

____ Assume the **risks &/or benefits associated with my voluntarily decision(s) to consent to, decline or withdraw from any & all recommended treatments & services**, including if my treatments are court-ordered &/or strongly encouraged by my guardian &/or a third-party agency &/or authority.

____ Understand that **treatment outcome(s)** may be predicted but **not guaranteed**, as contingent but not limited to: 1) the complexity my presenting concerns; 2) nature & severity of certain intrapersonal &/or environmental factors; & 3) the un/availability of treatment options, resources &/or support system(s).

____ Understand that **my therapeutic experience** may only be **as rewarding as** it may be **challenging** contingent on, but not limited to my active engagement, cooperation, transparency, motivation, readiness & genuine **desire to learn, change, grow & self-improve**, as well as to my open-mindedness, flexibility & willingness to make difficult changes to achieve significant progress & desirable outcome(s).

____ Actively participate in my assessments, treatment planning, treatment decisions, changes & commit to my treatment goals; actively & genuinely engage in session activities & complete my homework to the best of my ability.

____ **Pay**: 1) $_____ for _____; 2) $_____ for _____ _____; 3) $_____ for _____ prior to the start of my appointment, or by 6:00PM on the date the service was received & according to my insurance mental health/substance abuse benefits, or otherwise convened, as: _____.

____ Attend all scheduled appointments, cancel, or reschedule **at least 24 hours in advance** or pay a ***$75.00 Missed Appointment Fee*** within 30 days, or prior to my next scheduled appointment, unless I am able to reschedule my appointment within the same week, or I missed my appointment & was unable to notify my counseling office in a timely manner due to unavoidable circumstances, & at the discretion of my therapist on a case-by-case basis.

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone**: 336-396-7834 ~ **Fax**: 336-217-8708

Client Name:	**DOB:**	**Phone #:**
Payer/Insurance Provider:	**Policy #:**	**Group #:**

____ I understand that a **$25.00 Late Fee** will accrue on any unpaid balance under $100.00 & a **Late Fee of 25%** of any unpaid balance larger than $100.00 after 30 days from the date of my invoice.

____ I understand if I have an unpaid balance to Safe Haven Counseling, PLLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts. In order for Safe Haven Counseling, PLLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Safe Haven Counseling, PLLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

SAFE HAVEN COUNSELING, PLLC
Mental Health | Addictions | Domestic Violence | Grief | Career
163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

Consent for Treatment

I _____, client &/or legal guardian, agree to receive treatments & services, as recommended by Safe Haven Counseling, PLLC & described in my plan of care, & I understand that this consent is valid for 1 year, upon discharge or until I provide my written request to withdraw from my treatments & services, whichever comes first.

_____ ____/____/ 2024
Client / Legally Responsible Person's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ____/____/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT TO BILL INSURANCE

(INITIAL & CHECK all that Applies)

_____ **I understand** that the treatments & services provided by Safe Haven Counseling, PLLC, as described in my treatment plan of care, will be billed to my insurance.

_____ **I attest that I was explained my rights** to be informed of the contents to be released & for which purpose(s) according to Federal (HIPAA, 1996) & NC General Statutes (NCGS), the NC Board of Licensed Clinical Mental Health Counselors (NCLCMHC) & NC Addictions Specialists Professional Practice Board (NCASPPB) Rules, Regulations & Ethical Codes (i.e. American Counseling Association, 2014) that serve to protect my Protected Health Information before I consent to its release, including my **rights to revoke my voluntary consents to treatment &/or to release my PHI at any time**, except to the extent that action based on this consent has been taken. I hereby acknowledge that this consent is truly voluntary and will otherwise be valid until such request is fulfilled for 1 year after the date of the consent.

_____ **I currently have Active Insurance coverage with Blue Cross Blue Shields**: ☐ of NC ☐ Out-of-State **Select Your Plan**: ☐ PPO; ☐ Indemnity; ☐ Blue Advantage; ☐ Blue Options; ☐ Blue Select; ☐ Classic Blue; ☐ Blue Care; ☐ NC State Health Plan (YPY); ☐ Blue Home w/ Novant Health; ☐ Other: _____ & agree to provide Safe Haven Counseling, PLLC with the necessary information & documentation (i.e. copy of BCBS eligibility card) so that *certain* treatments & services may be claimed & reimbursed to me &/or to Safe Haven Counseling, PLLC, according to my plan coverage.

_____ **Release of my PHI**: I hereby authorize Safe Haven Counseling, PLLC to release the necessary Personal Health Information (PHI) to my insurance provider so that all or some of the treatments & services I receive may be billed to my insurance provider(s) &/or other third-party payer(s) & reimbursed directly to Safe Haven Counseling, PLLC.

_____ **I currently have Active Insurance coverage with Blue Cross Blue Shields Limited Network Plan**: ☐ Blue Value; ☐ Blue Local with Atrium Health ☐ Blue Local with Wake Forest Baptist Health; ☐ Blue Home with UNC Alliance, & I understand that Safe Haven Counseling, PLLC is considered an **out-of-network provider** with regards to any of the hereby BCBS limited network plans.

_____ **I currently have other active insurance coverage with**: ☐ Cigna; NC Medicaid / NC Health Choice ☐ Medicare; ☐ Aetna; ☐ United Healthcare; ☐ MedCost; ☐ Tricare; ☐ Trillium; ☐ Optum; ☐ Other:

_____ **I agree to be Responsible for the FULL &/or MY Portion of the Total Fees charged for the treatments & services received** at Safe Haven Counseling, PLLC, according to my insurance plan (i.e. deductible; fixed copay amount; co-insurance percentage…), &/or **for the full rate(s) of services received** not covered by my insurance provider, &/or in the event that my insurance denies financial responsibility &/or **according to my reduced fee contract**, as agreed upon & signed below. I hereby authorize payments to be made directly to Safe Haven Counseling, PLLC, otherwise payable to me, & agree to forward any such payments owed to Safe Haven Counseling, PLLC by my insurance, if paid directly to me.

_____ _____

Client / Legal Guardian's Signature & Date

Stephanie Jimenez MA, NCC, LCMHC

Staff / Witness Signature & Date

Valid Through: ____/____/ 2025

CONSENT REVOCATION

I, hereby, withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI to my insurance provider for the purpose of filing claims for reimbursement & therefore agree to be responsible for my own cost(s) of care effective: ___/___/_____. _____ _____

Client / Legal Guardian's Signature(s) & Date Staff's Signature

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	**DOB:**	**Phone #:**
Payer/Insurance Provider:	**Policy #:**	**Group #:**

Release of PHI Log

Date	What	To Whom	Method	Purpose	Signature

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between

Safe Haven Counseling, PLLC **&** FORSYTH MEDICAL CTR. **pertaining to (INITIAL ALL that applies)**:

_____ Demographic _____ Financial Information _____ Insurance Information
_____ Medical Information _____ Assessments _____ Treatment Plan & Diagnosis
_____ Progress Notes _____Substance Abuse Information _____ Discharge Summary
_____ Other: _____

Purpose of disclosure: *Diagnostic, referral & care coordination in the event of medical &/or mental health emergency.*

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stephanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between *Safe Haven Counseling, PLLC* **&** ATRIUM HEALTH WAKE FOREST BAPTIST **pertaining to** (INITIAL ALL that applies):

_____ Demographic _____ Financial Information _____ Insurance Information
_____ Medical Information _____ Assessments _____ Treatment Plan & Diagnosis
_____ Progress Notes _____Substance Abuse Information _____ Discharge Summary
_____ Other: _____

Purpose of disclosure: *Diagnostic, referral & care coordination in the event of medical &/or mental health emergency.*

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	**DOB:**	**Phone #:**
Payer/Insurance Provider:	**Policy #:**	**Group #:**

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between

Safe Haven Counseling, PLLC **&** Emergency Contact: _____ **pertaining to** (INITIAL ALL that applies):

_____ Demographic _____ Financial Information _____ Insurance Information
_____ Medical Information _____ Assessments _____ Treatment Plan & Diagnosis
_____ Progress Notes _____Substance Abuse Information _____ Discharge Summary
_____ Other: *Basic emergency information (i.e. nature of emergency; treatment location…) ONLY.*

Purpose of disclosure: *Safety Planning & care coordination in the event of medical &/or mental health emergency.*

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stephanie Gimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between

Safe Haven Counseling, PLLC **&** Primary Care Physician: _____ **pertaining to**:

_____ Demographic _____ Financial Information _____ Insurance Information
_____ Medical Information _____ Assessments _____ Treatment Plan & Diagnosis
_____ Progress Notes _____Substance Abuse Information _____ Discharge Summary
_____ Other: _____

Purpose of disclosure: *Diagnostic, referral & care coordination, as clinically appropriate & previously convened.*

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between

Safe Haven Counseling, PLLC **&** _____ **pertaining to** (INITIAL ALL that applies):

_____ Demographic _____ Financial Information _____ Insurance Information
_____ Medical Information _____ Assessments _____ Treatment Plan & Diagnosis
_____ Progress Notes _____Substance Abuse Information _____ Discharge Summary
_____ Other: _____

Purpose of disclosure: *Continuity of Care* .

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC

Mental Health | Addictions | Domestic Violence | Grief | Career

163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT FOR THE RECIPROCAL EXCHANGE OF MY "*PHI*"

I, hereby, consent to the reciprocal exchange of my therapeutically &/or medically relevant PHI between

Safe Haven Counseling, PLLC **&** _____ **pertaining to** (INITIAL ALL that applies):

_____ Demographic	_____ Financial Information	_____ Insurance Information
_____ Medical Information	_____ Assessments	_____ Treatment Plan & Diagnosis
_____ Progress Notes	_____Substance Abuse Information	_____ Discharge Summary

_____ Other: _____

Purpose of disclosure: *Continuity of Care* .

Re-disclosure of Protected Health Information (PHI) is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" and under NC State Law G.S. 122C for Mental Health (MH), for Substance Abuse (SA) and Developmental Disabilities (DD) treatments. I understand that if my record contains HIV infection, AIDS or related conditions information, it can only be disclosed in accordance with the NC Communicable Disease Law GS 130A-143. Safe Haven Counseling, PLLC will only disclose information when you sign specifically for the release of your HIV/AID-related information. I understand that I may revoke this authorization verbally or in writing at any time and that this authorization will be legal and binding prior to revocation. I certify that this authorization is made freely, voluntarily and without coercion, and I understand that I may refuse to sign this authorization form as Safe Haven Counseling, PLLC will not condition my treatment upon receiving my signature on this Authorization.

_____ ____/____/ 2024

Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024

Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____

Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC
Mental Health | Addictions | Domestic Violence | Grief | Career
163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

CONSENT TO RECORD Treatment Information

_____ I hereby authorize Safe Haven Counseling, PLLC to **audio record** session contents, in their entirety or in part, as needed & at my provider's discretion, as a mean to monitor my progress, treatment effectiveness, & maintain my clinical records accordingly.

_____ I hereby authorize my Safe Haven Counseling, PLLC provider to **verbally share** clinically relevant information ***only***, as needed & at my provider's discretion, as a mean to obtain reliable, sound & helpful second &/or third opinions through otherwise confidential case consultation, & to ensure the best possible care, as I understand that *my personal & identifiable information will remain protected & privileged from any such third parties* involved (i.e. licensed &/or certified peers/colleagues, mentors and/or supervisors) in clinical peer consultation.

_____ I hereby authorize Safe Haven Counseling, PLLC to **video/audio record** session contents, in their entirety or in part, as needed & at my provider's discretion, as a mean to meet licensure(s) & certification(s) requirements (i.e. State Board Licensure; National Certification(s); Specialty Certification(s)…), & to maintain all relevant licensure(s) & certification(s) active and in good standing, as deemed necessary for the continuity of my care.

_____ I hereby authorize Safe Haven Counseling, PLLC to **photo record** &/or **share in writing** general case information (i.e. significant therapeutic progress; treatment effectiveness; success story…), as measured by formal &/or informal assessments (i.e. Provider observation; Client/family member &/or third party's report(s); Satisfaction surveys…), or other anonymous treatment outcome measures, in their entirety or in part, as needed & at my provider's discretion, as a mean to accurately represent the quality of the therapeutic services, treatments & care provided at Safe Haven Counseling, PLLC in marketing materials (i.e. brochures; website; online media…), as I understand that *my personal & identifiable information will remain protected & privileged* from the public; that my welfare will remain Safe Haven Counseling, PLLC's top priority above all other purposes, and that ***only*** my clinically relevant information will be shared, & ***only*** once I am notified of Safe Haven Counseling, PLLC's intent to do so ahead of time, am explained & understand the full & true purpose of my clinically relevant PHI release, feel sufficiently informed, & am given a sufficient time to decide whether to verbally confirm this written consent, prior to any potential release of my PHI.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**

Valid Through: ___/___/ 2025

CONSENT REVOCATION

I have withdrawn my consent for Safe Haven Counseling, PLLC to disclose my Protected Health Information verbally on: ___/___/_____, &/or now withdraw my consent for Safe Haven Counseling, PLLC to disclose my PHI per this written request, effective: ___/___/_____.

_____ _____
Client / Legal Guardian's Signature(s) & Date Staff Signature & Date

SAFE HAVEN COUNSELING, PLLC
Mental Health | Addictions | Domestic Violence | Grief | Career
163 Stratford Court, Suite 225, Winston-Salem, NC 27103 | **Phone:** 336-396-7834 ~ **Fax:** 336-217-8708

Client Name:	DOB:	Phone #:
Payer/Insurance Provider:	Policy #:	Group #:

INTAKE CHECKLIST

I was provided, understand & voluntarily consented to (Please, INITIAL ALL that applies)**:**

_____ **Confidentiality / Privacy Practices** (HIPAA), as explained in my provider's Professional Disclosure Statement (PDS) & this Consent Packet.

_____ My **Rights & Responsibilities** to co-create my Treatment Goals, as explained in my provider's Professional Disclosure Statement (PDS) & this Consent Packet.

_____ Safe Haven Counseling, PLLC Crisis Procedures, as explained in my provider's **Professional Disclosure Statement** (PDS) & this **Consent Packet**.

_____ My **Consent for Treatment**.

_____ My **Consents** for the reciprocal release of my clinically &/or medically relevant &/or necessary information between Safe Haven Counseling, PLLC & all third parties relevant &/or necessarily involved in **coordinating for my care** in the events of a medical, mental health, substance abuse, natural disaster or any other type of crisis or emergency requiring additional care for myself, or to facilitate necessary adjunct services.

_____ I was given the opportunity to review **Safe Haven Counseling, PLLC HIPAA Policies & Procedures** Handbook for Outpatient Behavioral Health, Mental Health, Substance Abuse and Domestic Violence Treatments, Targeted Case Management, Advocacy and other related Services, which I am currently seeking and which Safe Haven Counseling, PLLC currently offers.

PARTICIPATION AGREEMENT

_____ I agree to participate in the treatment process by having input/consultation with staff, as needed, either by phone, written correspondence, and/or face-to-face meetings. I also agree to be an active part of my treatment team and to be active and engaged in creating, developing and working with my care provider(s) to reach the treatment goals agreed upon according to my treatment plan of care. I also agree to provide important information that would be relevant and/or that would affect my care at Safe Haven Counseling, PLLC's staff in an effective and timely manner. I understand that this consent is valid until the time of my discharge from Safe Haven Counseling, PLLC, until I revoke this consent orally or in writing, OR until this consent's expiration date, which is not to exceed 1 year.

_____ I understand all the information discussed with me and agree to follow Safe Haven Counseling, PLLC's rules, policies and procedures aforementioned in this consent packet.

_____ ____/____/ 2024
Client / Legal Guardian's Signature **Date**

Stéphanie Jimenez MA, NCC, LCMHC _____ ____/____/ 2024
Witness / Staff Signature **Date**