CREATIVE HEALING

GROUP THERAPY CONSENT, POLICIES AND AGREEMENT

All persons participating in group counseling MUST read and sign this agreement. If you do not understand any part of this agreement, please ask any questions prior to signing the agreement. You may also receive a copy of this agreement, please ask your therapist if you would like to have one. All persons must also sign the HIPAA form as well.

I hereby grant my permission for Creative Healing, to provide group psychotherapy services in the form of weekly self-expression, support and skill-building groups.

Group counseling & therapeutic process:
Participating in group counseling can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek group counseling. Working toward these benefits, however, requires active involvement, honesty and openness on your part.

Moreover, while group counseling is effective for many people and often leads to significant and lasting changes, there are some risks involved. Many people report discomfort during group counseling as they begin to look at areas in their life that aren't working or not working as well as they would like them to. Sometimes undesirable feelings can emerge as one considers unpleasant, difficult or embarrassing subjects. The facilitator or group may suggest new and different ways of handling situations that may trigger upsets for you. Attempting to resolves tensions between yourself and others may lead to changes that were not originally intended. Moreover, a decision that is positive for one person can be viewed quite negatively by another. Change can happen quickly; but more often it can be slow, and even frustrating. For some people, problems may get worse before they get better. It is also possible that group counseling may not work for you. Even so, many people find that group counseling is worth the difficulty it may entail leading them to the intended results they are seeking.

Confidentiality:

- Anything said between any two or more group members at any time is part of the group and is confidential. I understand that everything said in this group is confidential and not to be shared with anyone outside of the group, except as may be otherwise required by law.

- I agree to keep confidential the names of other members of the group and what is said in the group. As a member of this group, I agree to not disclose to anyone outside the group any information that may identify another group member. This includes, but is not limited to, names, physical descriptions, biological information, and specifics to the content of interactions with other group members.
- I agree to indemnify and hold Creative Healing harmless for any loss or damages, including costs and attorney's fees, incurred by Creative Healing as a result of my breach of another's confidentiality.
- Further information regarding these situations and my privacy rights has been provided in the Notice of Privacy Practices for Protected Health Information

I also understand that anything said in therapy is confidential, *except* for the following limitations:

- Child abuse and/or neglect (which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out, physical abuse, etc)
- Vulnerable adult abuse or neglect
- Threats to harm oneself
- Threats regarding harm to another person
- A court subpoena
- My specific request, in writing, to disclose information regarding my psychotherapy to a third party

Please note that if you choose to send communications through text or email these communications are not protected and confidentiality cannot be assured.

Group Counseling Structure, Frequency & Guidelines:

DAY AND TIME: You are expected to attend group weekly on the day and time agreed upon with your therapist at your group intake session or in your confirmation email.

LENGTH OF GROUP: Groups at Creative Healing are typically open and ongoing. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine how much longer group therapy is recommended and encourage your communication about how helpful the process is for you to inform the treatment plan.

At times we will offer one-time workshops and time-limited groups. Should this consent form be provided to you for such a workshop or group, you will receive a schedule of dates and times for your specific offering in addition to this agreement.

ATTENDANCE: Group is a weekly commitment and your attendance is expected weekly, unless prior a prior obligation has been discussed with your group therapist. *If you are prevented attending group for any reason, you MUST notify your therapist (directly to their email address or by phone) 24 hours in advance. If we do not receive a 24-hour advance notice, you will be responsible for paying the full fee for the session you missed, and that such fee cannot be billed to your insurance company.*

Discipline Management Procedures:
Group members are expected to demonstrate appropriate behavior and to meet the expectations and agreements as outlined in group.

In the event that a group member is continually being disruptive, see the discipline procedure below.

- Immediate behavioral problems will be managed by the group leader speaking with your teen and working together to find resolution that will allow them to re-engage in the group. Should the teen need a break, they will be permitted to sit out from the current activity, but must remain in the room where supervision is present.
- Recurring behavior problems will result in the group leader notifying a parent/guardian and developing a behavior plan to help the group member be more successful in the group setting.
- Behaviors such as physical or verbal aggression, inability to remain in the group room, blatant disregard for rules and expectations will be given a “three-strikes” policy. After one verbal warning/discussion with teen and one discussion with family, the third behavior infraction will result in dismissal from the group. Refunds will not be granted for any payments made if a group member is dismissed due to disciplinary actions.
- Self-harm of any kind while on the premises, or any kind of drug and alcohol use while on the premises will result in immediately contacting a parent and will be terms for automatic dismissal from the group. Refunds will not be granted if a group member is dismissed due to disciplinary actions.

Payment/Fees:
The cost of group is $175 per month, paid by recurring credit card charge on the same day each month as your initial payment was made. You may also opt to pay $50 weekly for group by submitting exact-amount cash or check (made payable to Creative Healing) at the start of each weekly group session. Should you choose to pay weekly and fail to submit payment at the time of service, your credit card or debit card on file will be automatically charged.

Emergencies:
It is necessary that Creative Healing has someone to contact on your behalf. In case of an emergency who should we contact?

____

Full Name   Relationship   Phone Number

- ▫ I agree to allow Creative Healing to contact my emergency contact on my behalf should an emergency arise.

I understand that the therapist/facilitator is not available 24 hours a day and that in a crisis situation, I should call 911. All participants, 14 years of age or older, are required to sign this agreement prior to attending a therapy/group counseling session. Your signature on this agreement signifies that you have read, understood and are consenting to services provided by Creative Healing.

By my signature below, I indicate that I have read carefully and understand the Group Consent, Policy and Agreements, and I agree to its terms and conditions. I have asked and had answered any questions I have concerning the Group, Consent, Policy and Agreements.

I am aware signing the Agreement is required for my admission to the group. I am also aware that my refusal to sign this Agreement will exclude me from participating in the group.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Parent	*Signature of Parent*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*

** Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. Since you initially received this paperwork through email it will be considered that you have an electronic copy.*

Client Demographic Form

Client Name: ____ Age: __________

Date of Birth: ____________School: ________________________ Grade: _______

Address: ____

City: ________________________ State: ___________ Zip Code: _____________

Teen Cell Phone Number: ____

Parent Name: ____

Parent Phone Number: ____

Parent Email: ____

Legal Guardian Name: ____

Legal Guardian Phone Number: ____

Legal Guardian Email: ____

Credit Card Authorization
By completing the information below, you authorize Creative Healing to charge your credit card at the completion of each session if you do not submit cash or check at the time of service. You agree that no prior-notification will be provided unless the amount changes, in which case you will receive notice from Creative Healing at least 30 days prior to the new payment amount being collected.

Please complete the information below:

I ______________________________ authorize Creative Healing to charge my credit card indicated below for the agreed upon session fee at the completion of services being provided. I also understand that cancellations charges as outlined in the cancellation policy will be automatically charged to my card on the date of a missed appointment if I do not provide 24 hours prior notice for cancellations.

Credit Card Number: ____

Expiration Date: ____________________ CVV # (Security Code) _____________

SIGNATURE_________________________________ DATE________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Creative Healing in writing of any changes in my account information or termination of this authorization at least 24 hours prior to my next scheduled session. I certify that I am an authorized user of this credit card/bank account and will not dispute these authorized transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in my signed agreement with Creative Healing.

Insurance Information (Optional)

Insurance:____

Policy/ID #: ______________________________Group #:_______________________

Effective Date: ____________________

Address on Insurance Card: ____

City: ________________________ State: __________ Zip Code: __________________

Mental Health Phone Number: ____

Insured's Name: ____

Insured's Date of Birth: ________________ Relationship to Client: ____________________

Insured's Address: ____

City: ________________________ State: ____________ Zip Code: ________________

Insured's Employer:____

Insured's Phone Number: ____

Creative Healing will initiate billing procedures with your insurance company. All professional fees are billed to the appropriate insurance provider shortly after services are provided. Fees generally cover individual, group and family sessions. Your insurance provider may send you a statement, an Explanation of Medical Benefits, for all of services. All client information is kept confidential in accordance with privacy policies. Legal and ethical requirements specify certain conditions when it is necessary to share information about the patient with other professionals. The client's insurance provider sometime requests clinical information to support payment. Insurance companies are responsible for keeping this information confidential as well.

I authorize Creative Healing to furnish information to my insurance carrier concerning my professional services rendered, and I understand that I am responsible for paying the amount not covered.

This assignment covers any and all benefits under private insurance and other health plans for services rendered. If services are out-of-network with my insurance company, I understand that I am responsible for the full fee of services provided up-front and that my insurance company will reimburse me directly for these services. I acknowledge that it is my responsibility to contact my insurance company and determine how much, if any, of these services will be reimbursed.

I authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed.

I have read, understood, agree, and consent to Creative Healing submitting claims to my insurance company on my behalf as stated in this agreement. I also understand that this agreement will remain in effect unless revoked by me in writing or will expire when treatment is discontinued.

Legal Guardian: ____Date: __________

If you do not see a therapist at Creative Healing, please complete so that we may coordinate care with your INDIVIDUAL THERAPIST..

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,____ DOB:____________________
hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

This information will be released/requested upon request to the following:

____

First and last name and phone of person or organization

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Creative Healing

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): ________________

To Be Requested * *from third parties*

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): ________________

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Creative Healing

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Creative Healing will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Creative Healing will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that Creative Healing will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Please complete so that we may coordinate care with your PSYCHIATRIST.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,____ DOB:___________________
hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

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First and last name and phone of person or organization

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Creative Healing
_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): ________________

To Be Requested * *from third parties*
_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): ________________

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This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Please complete so that we may coordinate care with your PRIMARY CARE DOCTOR.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,____ DOB:___________________
hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

This information will be released/requested upon request to the following:

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First and last name and phone of person or organization

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Creative Healing

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
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_____Other (Specify): ________________

To Be Requested * *from third parties*

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): ________________

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Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Please complete so that we may coordinate care with your SCHOOL COUNSELOR.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,____ DOB:____________________
hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

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To Be Requested * *from third parties*

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This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where your therapist is permitted or required to disclose information without either your consent or authorization. If such a situation arises, your therapist will limit their disclosure to what is necessary. Reasons they may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if they receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order your therapist to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, your therapist may be required to provide it for them.
3. If a client files a complaint or lawsuit against your therapist, they may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and your therapist is providing necessary treatment related to that claim, they must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. Creative Healing may disclose the minimum necessary health information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which your therapist is legally obligated to take actions, which they believe are necessary to attempt to protect others from harm, and they may have to reveal some information about a client's treatment:

1. If they know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires

that I file a report with the Pennsylvania Abuse Hotline. Once such a report is filed, your therapist may be required to provide additional information.

2. If they know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that your therapist file a report with the Pennsylvania Abuse Hotline. Once such a report is filed, they may be required to provide additional information.
3. If they believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, your therapist may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** – We may use and disclose your health information within Creative Healing as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Client's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, your therapist will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with your therapist. If you wish, Creative Healing will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with your therapist at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with your therapist in session before terminating or at least contact them by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI. They reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we am required to abide by the terms currently in effect. If we revise practice policies and procedures, we will provide you with a revised notice in office during session.

COMPLAINTS

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision they made about access to your records, you may contact Creative Healing, the State of Pennsylvania Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*