Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

WELCOME

Healing Waters Counseling Center, LLC is an outpatient mental health private practice that was established in May 2010. Outpatient mental health services (including counseling and psychiatric services) are provided in a warm, confidential, and professional environment. For additional information, please visit: www.healingwaterscc.com

OFFICE LOCATIONS

Healing Waters Counseling Center has four service locations:

Cedar Bluff (1113 Cedar Valley Drive, Cedar Bluff, VA 24609)

Wytheville (510 West Main Street, Wytheville, VA 24382)

Wise (106 Spring Avenue Northeast, Wise, VA 24293)

Abingdon (112 East Main Street, Abingdon, VA 24210)

OFFICE HOURS

All offices of Healing Waters Counseling Center are open from 8:30a.m. until 5:00p.m. Monday through Friday unless otherwise indicated. Offices are closed for lunch from 12:00 noon until 1:00pm.

CLINICAL SERVICES

Services are provided by Licensed Clinical Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, Psychiatric Mental Health Nurse Practitioners, Supervisees in Social Work, Residents in Counseling, and/or Residents in Marriage and Family Therapy.

FEES AND PAYMENTS

Information regarding our fee schedule, insurance, and payments is attached. All financial arrangements are made through the practice manager (276-963-0111).

MISSED APPOINTMENTS

Information regarding missed appointments is attached.

INCLEMENT WEATHER

Attempts will be made to notify individuals with scheduled appointments if the office must be closed due to inclement weather. These notifications may occur by phone, text, or email. This may not always be possible. Closing due to weather conditions will be announced on the Healing Waters Counseling Center Facebook page.

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

FEE SCHEDULE

Diagnostic Interview (Clinical Assessment)	$140.00
Individual Therapy	$100.00
Family Therapy	$115.00
Group Therapy	$45.00 per person per group session
Psychological Evaluation	$1200.00
Record Requests	$10.00 retrieval fee and $0.50 per page
Forms for Disability Claims *(Other than Social Security)	$20.00 per form
Subpoena (court-half day)	$500.00
Subpoena (court-full day)	$1000.00
Minimal phone consultation or correspondence	no charge
Extensive phone consultation or correspondence more than 15 minutes	$50.00 per hour
Missed appointment- hourly rate (Therapy)	$45.00
Missed appointment-hourly rate (Psychiatric Mental Health Nurse Practitioner)	$70.00
Missed appointment-(Psychological Evaluation)	$250.00

Insurance will not reimburse for review of records, extensive phone consultation or missed appointments. The client or guardian is responsible for those charges.

NOTICE: 24 hours prior notification is required for cancellation of any appointment with Healing Waters Counseling Center, LLC. Missed appointment fees shall be due and payable upon receipt of the invoice for the same. Failure to pay the missed appointment fee, deductible, co-pay, or other amount due may result in referral of your account for outside collection at which time you will also be responsible for any fee amounts due and owing as well as all collection costs, including but not limited to, court costs, filing fees, service fees, and reasonable attorney’s fees.

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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

Healing Waters Counseling Center, LLC has been and will always be totally committed to maintaining the confidentiality of clients. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Virginia State Law, we are obligated to report this to the Department of Social Services. If you provide information that informs us that you are in danger of harming yourself or others, we are obligated to report this. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Patient Name: ____________________________________

Address: ____ Referred By: ___________________

City:____________________State:________Zip:______________ Phone: _________________

Email:_____________________________________ Cell: __________________________

Sex:________ Age:_______ Marital Status:__________________ Date of Birth: ____________

Patient's Social Security #: ____

Please describe the reason for seeking services through Healing Waters Counseling

Center:____

____

____

____

If the patient is a minor, please list the names of the patient's parent(s) or guardian(s) and their best contact number(s):

____

____

____

____

Are services being sought for the purposes of filing a disability claim? ☐ Yes ☐ No

Insurance Information: (Please complete thoroughly)

Insured:______________________________ Sex:__________ Date of Birth: ____________

Relationship to patient:________________________________

Policy Number:_______________________________ Group Number: ______________________

Please sign and date the release/assignment below:

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Healing Waters Counseling Center.

______________________________ ___________________

Client (18 or over) or Guardian Date

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

CANCELLATION/NO-SHOW POLICY, NOTICE, AND AUTHORIZATION TO BILL CREDIT CARD

EXPLANATION: Healing Waters Counseling Center, LLC, is a very busy counseling practice, and appointment openings are very important to our patients. In an effort to deliver only the highest quality services in the most efficient way possible, it has become necessary to implement our "NO-SHOW" Policy. This policy is not designed to penalize, but to ensure that we can make the best use of all staffing resources and deliver quality, timely services to our clients.

POLICY: All patients of Healing Waters Counseling Center, LLC, must notify the practice of cancellation a minimum of twenty-four (24) hours prior to any scheduled appointment. This notification can be done via telephone to our main office line at **(276) 963-0111**.
Failure to provide the mandatory minimum twenty-four (24) hour notice of cancellation shall result in automatic billing to the client's credit card. This fee shall be designated as a "No-Show Fee." This fee is charged to the patient, not the insurance company. If the cancellation fee cannot be billed to the credit/debit card on file, then it will be due at the time of the patient’s next office visit

Fees billed shall be as follows: 1.) Therapist Appointment: $45.00; 2.) Psychiatric Mental Health Nurse Practitioner Appointment: $70.00.

The policy of Healing Waters Counseling Center is that if a patient misses an appointment (or fails to cancel an appointment with less than 24-hour notice) three (3) separate times, that may result in the termination of our professional relationship. We do realize circumstances can change at the last minute. If you were unable to make a scheduled appointment due to extenuating circumstances, please contact our Practice Manager immediately.

AUTHORIZATION: By my signature hereon, I do hereby acknowledge the above policy of Healing Waters Counseling Center, and I do further authorize billing of the requisite fee for failure to notify the practice of cancellation within the required timeframe.

I have read and understand this policy. I have had an opportunity to ask questions, which have been addressed to my satisfaction. I understand that failure to comply with the 24-hour notice required by the cancellation policy will result in automatic charges to my debit/credit card, and I specifically authorize the charges.

Name:	*Signature:*

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

MEDICAL RECORDS REQUEST FEE

Patient Name:____Patient DOB: ________________

The office of Healing Waters Counseling Center, LLC will provide your records to you once you have completed the Authorization for Disclosure/Exchange of Information form. You can find this form on our website or you can contact our office.

Your request will be processed and fulfilled within 30 business/working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20:	**$15.00**
Pages 21-50:	**$25.00**
Pages 51+	**$40.00**

FORM AND LETTER FEE

This is to notify you that the office of Healing Waters Counseling Center, LLC will apply a fee of $20.00 to your account for patient, companies, family members, insurance carriers or other person requesting forms and/or letters to be completed (unless the requesting entity pays for the records request).

Forms include, but are not limited to FMLA, disability, motor vehicle division, continuation of pay, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, etc.

In order to comply with federal laws including HIPAA, as well as, Virginia state and federal statues, this office must have a signed authorization (Authorization for Disclosure/Exchange of Information form) from the patient/responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office. Please be sure to sign the form. Unsigned request cannot be processed.

_________________________________ ____________________
Signature of patient or responsible party Date

INFORMED CONSENT

Thank you for choosing Healing Waters Counseling Center, LLC. We realize that beginning outpatient mental health services is a major decision and that you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask, and we will try our best to give you all the information you need. There are various mental health professionals employed by Healing Waters Counseling Center, LLC. Our providers are independently licensed (i.e., Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Clinical Psychologist, or Psychiatric Mental Health Nurse Practitioner) or are working under the license of a Licensed Clinical Supervisor. If applicable, this will also be discussed with you today, and you will be provided with written correspondence with the supervisor's contact information. Cognitive Behavioral Therapy is used for most conditions, although other treatment approaches may be used depending on the person or condition. Treatment practices, philosophy, and plan limitations and risks will be discussed with you. Not all items will necessarily apply to your specific situation.

Psychotherapy services: Psychotherapy cannot be easily summarized in general terms. It varies based on factors related to the provider, the client, and the specific issues being addressed. The staff of Healing Waters Counseling Center utilizes various approaches to address the problem(s) you bring forth. Psychotherapy is an active process that requires your active participation. To maximize the effectiveness of therapy, you will need to work on the issues discussed during sessions both in therapy and at home.

• Psychotherapy entails both benefits and risks. Since therapy often involves exploring unpleasant aspects of your life, you may experience uncomfortable emotions like sadness, guilt, anger, frustration, loneliness, and helplessness. However, psychotherapy has also demonstrated positive outcomes for individuals who undergo it. Therapy frequently leads to improved relationships, resolution of specific problems, and a significant reduction in distress. Nevertheless, there are no guarantees regarding the experiences you will have. While you can anticipate benefits from treatment, it is essential to understand that specific outcomes cannot be guaranteed.

• The initial sessions will involve a comprehensive assessment of your needs. After the diagnostic interview is completed, a potential treatment plan will be discussed, and you will have the choice to continue with the proposed plan. If you have any concerns about your treatment or progress, it is important to communicate these as they arise. If your doubts persist, you can request a meeting with another professional for a second opinion. Healing Waters is a group practice, and if you do not perceive that you are connecting with your assigned provider, then we will be happy to transfer you to another provider in the practice. If you would like a referral outside of the practice, we are happy to arrange that as well.

Psychological Evaluation: In general, the objective of "psychological assessment" or "testing" is to address inquiries related to your intellectual, academic, social, and/or emotional functioning. This is commonly accomplished through standardized tests (such as intelligence and academic tests), informal tests, interviews, questionnaires, observation, and examination of previous evaluation records or reports.

• Assessment involves multiple sessions to discuss your background, administer specific tests, and evaluate your results. In the case of child clients, there may also be a visit to the student's school to observe them in the classroom.

• The assessment results include a description of the current level of functioning in the evaluated areas, along with recommendations and, if necessary, referrals for additional services. Feedback is provided through both meetings and written reports.

• Psychological assessment provides an opportunity to identify unique strengths and challenges, which can inform interventions aimed at nurturing strengths and supporting/remediating challenges. However, it's important to note that psychological assessments only provide a snapshot of the client's functioning at the time of evaluation. Therefore, while the evaluation can assist in establishing a diagnosis and making treatment recommendations, the results should never be the sole measure of a client's functioning.

• Psychological assessment typically poses a relatively low risk to participants. Clients may potentially experience discomfort, anxiety, or fatigue during the testing process.

• Completing a psychological assessment can offer potential benefits, including a detailed description of strengths and challenges in the evaluated areas, as well as specific recommendations for addressing areas of difficulty.

Confidentiality and Emergency Situations: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Virginia State Law, Healing Waters Counseling Center is obligated to report this to the Virginia Department of Social Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) when required by law, or e) for the purpose of billing and/or collections.

I understand that Healing Waters Counseling Center, LLC does not provide emergency services. If you believe you are experiencing an emergency situation, you should call 911 or go to the nearest hospital emergency room.

Minors: If a client is below 18 years old, the law grants parents the right to access treatment information. Our clinic has a policy to seek parental agreement to allow for some level of confidentiality between the child and the provider, when appropriate. If the parent agrees, the provider will share general information about their work together, unless there is a concern that the client may pose a risk of harm to themselves or others. In such cases, the provider will notify the parents (and potentially other relevant parties) about their concerns. Whenever possible, before disclosing any information to a parent, it will be discussed with the client, and the provider will make efforts to address any client concerns.

• Treatment for children and adolescents under 18 years old requires the consent of a parent or legal guardian. In the context of divorce, the consenting parent must be the one with legal custody. In cases of joint custody, you will be requested to provide a copy of the most recent court documents and furnish information about each parent who is legally entitled to be informed about and involved in the child's services. Additionally, in cases of joint custody, the consent of both parents or legal guardians will be required before beginning services.

• I acknowledge that I may be contacted via phone, text, or email by a third-party company on behalf of Healing Waters Counseling Center to complete a patient satisfaction survey regarding the care and services I receive as a patient. I understand that the contact information I provided may also be used to invite me to register for the Healing Waters Counseling Center patient portal. Additionally, I may receive calls and other communications from Healing Waters Counseling Center staff for the purpose of following up on my care and treatment.

My signature below documents that I have read the information provided in the Informed Consent section of this document and have had the opportunity to discuss anything that I did not understand and have had all my questions fully answered. Also, my signature below indicates that I agree to abide by the policies and terms outlined in the informed consent. I understand that no particular outcome can be guaranteed, and I give my consent for Healing Waters Counseling Center to provide counseling, psychiatric, and/or psychological services to me or my child.

***Signature(s)*____*Date:*________________**

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. If applicable, we ask that at each session you pay your co-pay, co-insurance, or 100% of the allowable charge if your deductible is not met. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover outpatient mental health (behavioral health) services, we request that you pay the balance due at that time. For clients with commercial insurance, or clients with insurances that requires that patient (insured) to pay a copay, co-insurance, and/or unmet deductible, it is the policy of HWCC to store your debit/credit card information on file. The financial information is kept securely on file through a Payment Card Industry Data Security Standard (PCI) compliant company, Complete Merchant Solutions, Inc., whose software is integrated with our electronic health record, Valant Medical Solutions, Inc. Regarding clients with an unpaid balance, after 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Healing Waters Counseling Center, LLC.*

I have received a copy of my fee schedule

***Signature(s)*____*Date*__________**

Lastly, if you need to cancel or reschedule an appointment, 24 business hours advance notice is required, otherwise you will be billed a no-show fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

***Signature(s)*____*Date*__________**

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

COORDINATION OF TREATMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*

____You may inform my physician(s) **____I decline to inform my physician(s)**

PHYSICIAN NAME:____

CLINIC:____

ADDRESS:____

PHONE:__________________________________

Signature(s)____Date_______

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s)____Date_______________

May we contact you at home ☐***YES*** ☐***NO****?* *May we contact you at work* ☐***YES*** ☐***NO?***
May we contact you by cell phone ☐***YES*** ☐***NO?***
Where may we contact you_______________________________________?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that_____________________________________may be treated as a client by Healing Waters Counseling Center, LLC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.*

Signature(s)_______________________________________Date__________

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

May we contact you at home (circle one) ☐**YES** ☐**NO**? May we contact you at work ☐**YES** ☐**NO?**

May we contact you by cell phone ☐**YES** ☐**NO?** Where may we contact you? ___________________

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy. You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

PSYCHIATRIC MEDICATION CONSENT AND POLICIES

PATIENT NAME: ____

PATIENT DOB: ______________________

TODAY'S DATE: _______________________

GUARDIAN NAME (IF APPLICABLE): _______________________________________

_____________ By **initialing here**, I certify the following:

1. The nature of my condition and the reason for prescribing the specific medication have been explained to me.
2. Alternative treatments and their benefits and disadvantages have been explained to me.
3. The type of medication, dosage, and range of frequency, the route of administration, and the anticipated length of treatment have been explained to me.
4. I understand and accept the possible side effects of the prescribed specific types of psychotropic medication.
5. I understand and accept additional possible side effects that may occur when specific psychotropic medications are taken for extended periods include persistent, involuntary movements of the face, mouth, or extremities (hand/feet). These symptoms are potentially irreversible and may appear after the medications have been discontinued.
6. I understand and accept possible side effects may occur in adolescents and/or children when taking specific psychotropic medications including stunting of growth, sudden cardiac death, and suicidal ideations.
7. I have informed the prescriber of all medications I am currently taking, including prescription, over the counter, herbal, or recreational.
8. I have been advised whether I should avoid drinking alcohol or consuming any or all of said medications while taking the psychotropic medications.

9. I have been advised of the probable consequences of declining recommended or alternative therapies.
10. I have informed the prescriber of all my known allergies.
11. I will not hesitate to ask my provider any questions I may have regarding my treatment.
12. I understand that psychotropic medication therapy may include lab tests, random pill counts, random drug screens (Note: if drug testing is mandated in the office, there will be a $20 fee). Refusal to cooperate may lead to dismissal from the practice.
13. I understand that controlled substances, such as benzodiazepines, stimulants, hypnotics, or gabapentin, are generally not prescribed at this facility.
14. I understand therapy services are generally a requirement for medication management. I understand failure to attend scheduled therapy sessions may delay appointment with a prescriber and result in delay of medication refills.
15. When asking the forms be completed by the provider, they will be brought at the time of the next scheduled appointment and will be done so at the provider's discretion. The provider will be allowed no less than one week to complete if choosing to do so.
16. Our commitment to patient safety and the provision of high-quality care necessitates regular attendance at scheduled appointments, particularly for those requiring prescription medications. Regular visits allow for ongoing monitoring to ensure the effectiveness and safety of your prescribed treatment. Medications will be prescribed during your appointment, with a quantity sufficient to last until your next scheduled visit. Therefore, it is generally unnecessary to request prescription refills outside of your appointments. In the event that you miss an appointment and run out of medication, you will be required to schedule a follow-up appointment within one week. A limited supply of medication will be provided to last until this follow-up visit. Should you miss the rescheduled appointment, no further prescriptions will be issued until you attend a subsequent appointment. For any prescription refill requests made to our office, please allow up to 48 hours (two business days) for processing.

I,____, understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments.
- I will participate in all other types of treatment that I am asked to participate in.
- I will keep the medicine safe, secure and out of reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it.

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Tele-Health Policies and Procedures:

PATIENT NAME:____

PATIENT DOB:________________________

TODAY'S DATE:________________________

PATIENT GUARDIAN (IF APPLICIABLE):______________________________

My healthcare provider has explained the use of video conferencing technology for my telehealth visit. I understand that during this visit, I will be able to see and hear my provider, and they will be able to see and hear me. I acknowledge that this consultation differs from a traditional in-person visit, as I will not be physically present in the same room as my provider. The information exchanged during the visit may be used for diagnosis, treatment, follow-up, or educational purposes.

1. Understanding of Risks and Benefits:
   - I am aware of the potential risks and benefits associated with telehealth services. Benefits may include enhanced access to care, allowing me to remain at my current location, and reducing the need for travel. While I may experience these benefits, I understand that there are no guaranteed outcomes.
   - Potential risks may include, but are not limited to, technological issues that could disrupt or delay the consultation, the possibility that the telehealth visit may not provide sufficient information for an accurate clinical decision, and, in rare instances, security breaches that could compromise the privacy of my personal medical information.
2. Alternative Options:
   - I have been informed of the alternatives to a telehealth visit. By choosing telehealth, I understand that some physical aspects of the examination may be conducted by individuals at my location under the guidance of the consulting healthcare provider.
3. Consultation Responsibilities:
   - In emergency or inpatient scenarios, I understand that the role of the telehealth consulting specialist is to provide advice to my local practitioner. The specialist's responsibility ends once the video conference concludes.
4. Privacy and Confidentiality:
   - I understand that the same laws protecting the privacy and confidentiality of medical information apply to telehealth services. No identifying information or images obtained during the telehealth visit will be shared with other entities without my written consent. I acknowledge that my healthcare information may be shared with other healthcare providers or insurers for treatment, payment, and healthcare operations purposes.

5. Right to Withdraw Consent:
    - I understand that I have the right to withdraw my consent to telehealth services at any time without impacting my right to future care or treatment.
6. Provider's Discretion:
    - I acknowledge that if the provider determines that an in-person consultation is more appropriate, they may terminate the telehealth session and arrange a face-to-face visit.
7. Financial Responsibility:
    - I accept responsibility for all charges and fees associated with the telehealth services and understand that billing will occur accordingly.

I acknowledge that I will be in a quiet, private environment at the time of the appointment. I will be signed onto Wi-Fi internet with an adequate connection. I will not be operating machinery at the time of appointment (including driving a car). I will alert my provider of all other persons within the room during the appointment. I will not record (audio or video) an appointment without verbal or written agreement from my provider. If the patient is a minor (under 18 years of age), the parent or guardian will be present at the time of medication-focused appointments. If vital signs (blood pressure, heart rate, height, and weight) are requested from my provider, this will be collected and presented to the provider at the time of or before the appointment. I will assume responsibility for calling the office accordingly if experiencing technical difficulties.

By signing below, I confirm that I have read and understood the information provided regarding telehealth services, and all my questions have been answered to my satisfaction. I hereby authorize the use of telehealth services in my diagnosis and treatment.

___________________________________ ____________________
Signature of patient or responsible party **Date**

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Client Screening Form

1. Are you (or the minor child) currently, or are you expecting to be, involved in any legal proceedings?
   a. Yes b. No

2. Are you (or the minor child) currently prescribed any benzodiazepines (Xanax, Klonopin, Ativan), Neurontin/Gabapentin, or other controlled medications?
   a. Yes b. No

3. Are you currently involved in a child custody battle?
   a. Yes b. No

4. Do you anticipate being involved in a child custody battle within the next year?
   a. Yes b. No

5. Have you (or someone on behalf of the minor child) recently applied for Disability?
   a. Yes b. No

6. Have you (or someone on behalf of the minor child) applied for Disability within the past year?
   a. Yes b. No

7. Do you (or someone on behalf of the minor child) expect to apply for Disability within the next year?
   a. Yes b. No

8. Are you (or someone on behalf of the minor child) in the process of applying for Disability?
   a. Yes b. No

9. Do you (or the minor child) have any pending legal charges?
   a. Yes b. No

10. We charge $500 for a half day or $1000 for a full day to come to court. Should your legal, child custody, or disability case require court involvement from HWCC, do you agree to prepay our indicated rates for each provider that is subpoenaed?
    a. Yes b. No

11. If you are a legal custodial parent of a client being seen at HWCC, do you share custody with anyone else outside of your home?
    a. Yes b. No

If yes, please provide the following information:

What is the relationship of the client to the outside custodial individual?____

What is the name of the individual that shares custody of the client?____

What is the address of the individual that shares custody of the client?____

What is the phone number of the individual that shares custody of the client?____

12. If you (or your minor child) are involved in legal/court related matters, please indicate the names of all attorneys involved.____
    ____

_______________________________ _______________________________

Client (18 or over) or Guardian Date

Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Authorization for Disclosure/Exchange of Information

Client Name		DOB		SSN	

I hereby authorize Healing Waters Counseling Services, LLC and ________________________________, at
(Person or Agency – one per page)

____
Telephone/Address

to exchange information. The type of information to be disclosed:

☐ **Evaluations** [including Diagnostic Interviews and/or Psychological Evaluations]
☐ **Diagnoses**
☐ **Treatment Plan**
☐ **Psychological Test Results**
☐ **Substance Abuse Records/Treatment**
☐ **Course of Treatment** [including progress notes]
☐ **Other** ________________

The purpose of such disclosure:

☐**Ongoing Treatment** ☐ **Transfer** ☐**Legal Issues**
☐**Evaluation** ☐**Coordination of Care** ☐**Other**

Exceptions: ____

The designated information about me ☐**may** ☐**may not** be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Healing Waters Counseling Center, LLC and the above designated person ☐**may** ☐**may not** discuss by telephone the content of the information released.

This consent is in effect until ____________________, or for **one year if not specified**. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential, except as provided in § 32.1-127.1:03 of the Virginia State Code and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information and that it may no longer be protected under the HIPAA privacy regulations. This is to certify that I have given consent freely and voluntarily and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____________________ ____
Date Signature of Client (13 or older)

____________________ ____
Date Signature of Parent/Guardian/Authorized Representative