# Welcome to the Kellin Foundation

**(NON-VOCA Supported MINOR Client)**

The Kellin Foundation builds resilient children, families, and adults through behavioral health services, victim advocacy, and community outreach. Our goals are to assist individuals and communities with safety, restore hope, facilitate healing, and achieve holistic wellness. We believe that mental, physical, social, and spiritual well-being all contribute to the ability of individuals to reach their full potential, and thus, we use an integrated approach to our programming. Let's get started!

Please review these agreements carefully, as they set forth the understanding between you ("Client") and the Kellin, Foundation regarding the services you have requested and that we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

## Client Information

**First Name:** _____ **Middle:** _____ **Last:** _____

**Date of Birth (MM/DD/YYYY):** ___/___/_____ **Gender:** _____ **Race:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Email:** _____

**Emergency Contact Name:** _____ **Emergency Contact Ph. Number** _____ **Relationship to Client** _____

**Parent or Guardian Name(s) (if different from client):**

**First Name:** _____ **Last Name:** _____ **Relation:** _____

**First Name:** _____ **Last Name:** _____ **Relation:** _____

In the unlikely event of an emergency with you in our building and/or in session, we will call 911 and request an ambulance. We will also call the emergency contact person that you listed above. At the arrival of the ambulance, we will give them the following information:

**Hospital Preference:** _____

**Current Primary Care Physician:** _____ **Phone:** _____

**Allergies / Special Health Conditions:** _____

**Current Medications:** _____

KELLIN FOUNDATION

# Informed Consent for Services

Please review this agreement carefully, as it sets forth the understanding between you ("Client") and the Kellin, Foundation regarding the services you have requested and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

1. **Term of Agreement**. The term of this agreement will start on the Effective Date, and will continue on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide services agreed upon as set out in the Treatment Plan, which can include (but not limited to) things such as assessment, treatment, peer support, group therapy, and case management. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency.
3. **Termination**. Either "Client" or "Agency" may terminate this agreement at any time upon written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will immediately refund any prepaid fees.
4. **Governing Law.** The laws of the State of North Carolina shall govern this agreement.
5. **Agency's Responsibilities**. The Agency responsibilities are outlined on the enclosed "*Rights and Responsibilities"* form
6. **Client's Responsibilities.** Your responsibilities are outlined on the enclosed *"Rights and Responsibilities"* form. You will be required to sign it.
7. **Severe/Bad Weather.** In severe weather, we may determine it is not safe for our Clinicians to travel and provide services at our office that day and may have to cancel that day's service. When this occurs we will notify you and reschedule.
8. **Confidentiality.** There are some situations where disclose of information is required without either your consent or Authorization, including a court order, a government agency requesting the information for health oversight activities, if a client files a complaint or lawsuit against us for self-defense, and in some situations, worker's compensation claims. In addition, mandatory reporting laws require us to disclose information if we have cause to suspect that a child has been abused or neglected, or if we have cause to suspect that a disabled adult has had a physical injury or injuries inflicted upon such disabled adult, other than by accidental means, or has been neglected or exploited. Finally, if we determine that a client presents a serious danger to the client (yourself) or another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.
9. **Billing and Payments.** You will be expected to pay for each session at the time it is held, unless we agreed otherwise.
10. **General Information.** You will be provided with a list of contact names and numbers in the event you have any questions or concerns or should an emergency arise.

## *Signature(s) Required*

Your signature and/or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this agreement, including the following:

- You have read this agreement and agree to its terms
- You acknowledge that you have received a copy of the HIPAA Privacy Policy and Clients Rights and Responsibilities documents and have had the opportunity to ask any questions pertain to the contents
- You have reviewed and agree to the Financial Agreement
- You have reviewed the Client Handbook and understand its contents
- You have had the opportunity to ask any questions that you may have related to this agreement

| | |
|---|---|
| _____ | _____ |
| Print Name of Client | Date |
| _____ | _____ |
| Signature of Client | Date |
| _____ | _____ |
| Signature of Parent or Legal Guardian (if client under 18-years-old) | Date |

# Supplemental Consent to Treat a Minor
# (Only Complete If Client Is Under the Age of 18)

Welcome to the Kellin Foundation! We are excited to begin connecting with you to help you reach your goals. During our first session, we will ask to speak with you and learn more about your strengths and hopes for our time together. This is your space and time so please feel free to bring anything with you that you think you and your counselor might find helpful.

Parents/guardians, please note that in general, it is important to maintain the confidentiality of the client as the client works toward their treatment goals. During treatment, we will provide only general information about the progress of the child's treatment. However, parents/guardians, if the counselor is made aware that anyone is in danger of harming themselves or someone else, you will be notified immediately.

In addition, parents should be aware that, under N.C. General Statute 90-21.5, minors may consent for their own treatment for certain services, including medical health services for the prevention, diagnosis, and treatment of venereal and other communicable diseases, pregnancy, abuse of controlled substances, and emotional disturbance. In those situations, without the minor's permission, a provider of mental health services cannot notify a parent that the minor is receiving services.

Parents/guardians are required to stay on the premises during each session, although you may or may not participate in each session depending on the client's individualized treatment goals.

### *Signature(s) Required*

*By signing below, you give permission for the Kellin Foundation to see your minor child for counseling and agree to the stipulations outlined above and to the Consents & Agreements.*

_____ _____

Minor's Name (Print) Date

_____ _____

Minor's Signature Date

_____ _____

Parent/Guardian's Signature Date

# Notice of Privacy Practices (HIPAA)

HIPAA (Health Insurance Portability and Accountability Act) was enacted by the Federal Government in 1996. It serves a number of purposes: 1) It allows persons to qualify immediately for comparable health insurance coverage when they change employers; 2) It mandates the use of code set and format standards for the electronic exchange of healthcare data; 3) It requires the use of national identification systems for healthcare patients, providers, payers (or insurance plans), and employers (or sponsors); and 4) It mandates measures be taken to protect the security and privacy of personally identifiable healthcare information, and that patients have a right to access their healthcare information. The U.S. Department of Health and Human Services has the responsibility for oversight of these mandates.

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

*OUR LEGAL DUTY:*

***The Law Requires Us to:***

- Keep health information about you that can be identified with you (**P**rotected **H**ealth **I**nformation, or **PHI**), private.
- Make a copy of this Notice describing our legal duties, privacy practices, and your rights regarding your medical/health information available to you.
- Notify affected individuals following a breach of unsecured PHI.
- Follow the terms of this Notice of Privacy Practices that is now in effect.

***We have the Right to:***

- Change the terms of this Notice at any time, provided they are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical/mental health information that we keep, including information previously created or received before the changes.

***Notice of Change to Privacy Practices:***

- Before making an important change in our privacy practices, we will change this notice, post the revised notice in our office; and make copies of the revised notice available upon request.

*USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION:*

The following section describes different ways that we may disclose **p**rotected **h**ealth **i**nformation (**PHI**). Such information may include, but is not limited to: name of doctor providing services, summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, frequency of treatment, session dates and duration, medications, and results of clinical tests. PHI disclosed in this category does **not** include psychotherapy notes. Psychotherapy notes are separate from other PHI and are discussed in a special section below. We will not disclose your PHI for any purpose not listed below, without your specific written authorization.

**Consent for Disclosure of PHI for Treatment, Payment, Health Care Operations (TPO):**

We may disclose PHI without your specific authorization for treatment, payment, and health care operations.

- **For Treatment:** We may disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. In addition, we may disclose PHI about you when referring you to another health care provider.
- **For Payment:** Generally, we may give your PHI to others, i.e. insurance company, billing agency, or collection agency, to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services and during treatment, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment.
- **For Health Care Operations:** We may disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. Examples include 1) cooperating with outside organizations that assess the quality of the care we provide, i.e. inspections or audits, 2) assisting various people who review our activities, i.e., accountants, lawyers, and others who assist us in complying with applicable laws, 3) conducting business management and general administrative activities related to our organization and the services it provides, and 4) complying with this Notice and with applicable laws.
- **For appointment reminders, etc.**: We may contact you to provide appointment reminders or other health-related information that may be of interest to you. If you do not want to consent to this specific use of your PHI, please contact our office.

While specific authorization is not required for these uses and disclosures, we ask that you sign a general consent form for the use and disclosure of PHI for such treatment, payment, operations use as described above. You have the right to refuse to sign such a consent form; however, we may refuse treatment if such consent is not signed.

We may disclose PHI (including psychotherapy notes) under other circumstances without your authorization:

By law, we may disclose PHI about you, including psychotherapy notes, in a number of circumstances in which you do not have to consent, give authorization, or otherwise have an opportunity to agree or object. Those circumstances include:

- When required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- For health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- For judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal or to defend ourselves against a lawsuit or legal proceedings brought against us by yourself.
- For law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- Regarding a person who has been deceased for more than 50 years.
- When the disclosure is for organ donation purposes.
- For certain research purposes in an institutional setting with a Review Board.
- To avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of yourself or others.

- For specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- For workers' compensation functions.

Disclosures of PHI without your written authorization, opportunity to agree or object:
By law, we may disclose PHI about you, without written consent or authorization, if you are told in advance and are given the opportunity to agree, object or restrict, orally or in writing, the use or disclosure in the following situations: 1) Facility directories, 2) Emergency circumstances (incapacity/emergency), 3) Disaster relief efforts, 4) Family member, relative, friend, or other person identified by the yourself, 5) Family member or other person who was involved in an individual's care or payment for care prior to that individual's death.
Other disclosures of PHI require your written authorization:
Under most circumstances, including uses for marketing purposes or sale of PHI, other than those listed above, we must obtain your written authorization before we disclose PHI about you. Specific authorization obtained will include: a description of information to be used/disclosed, the name or specific identification of person authorized to make the disclosure; the name or specific identification to whom the information is to be disclosed; the purpose of the disclosure; the expiration date or event of the disclosure; and the signature of the client authorizing disclosure along with the date of the authorization. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not make further disclosures after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.
Psychotherapy Notes:
Specific written authorization will be obtained from the client for the release of psychotherapy notes except: 1) for treatment, 2) payment, 3) health care operations; 4) our own training programs), 5) to defend ourselves in a legal action, and 6) in special situations noted above. Psychotherapy notes are defined as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session, and that are separated from the rest of the individual's medical record. Excluded from this definition of psychotherapy notes includes, but is not limited to: frequency, dates, and duration of treatment, summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, results of clinical tests, and medication prescriptions and monitoring.

*YOUR INDIVIDUAL RIGHTS:*

1. You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions unless the disclosure is for payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a healthcare care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described above. Such request for restriction must be submitted to our office in writing.
2. You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by e-mail. Your request must be submitted in writing to our office. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact.
3. You have the right to inspect and/or receive a copy of your PHI (excluding psychotherapy notes). Your request must be submitted in writing to our office. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. We will inform you of our decision to grant or deny access to your PHI within 30 days of receipt of the request.
4. You may request to inspect and/or receive a summary of your psychotherapy notes; however, your request may be denied. If your request is denied, we will respond to you in writing, stating why we will not grant your request. You do not have any rights for a review of our denial. We will inform you of our decision to grant or deny access to your psychotherapy notes within 30 days of receipt of the request.
5. You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We will act upon your request within 60 days of receipt of the request. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amended information.
6. You have the right to request in writing a written list of our disclosures of PHI about you other than for treatment, payment, and health care operations, disclosures to yourself, and disclosures for which you previously provided written authorization. You may ask for disclosures made up to six (6) years prior to your request (not including disclosures made prior to April 14, 2003). If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

**You have the right to request an additional paper copy of this Notice at any time by contacting our office.**

*QUESTIONS AND COMPLAINTS:*

If you have questions about this notice, you think your privacy rights have been violated by us, or you want to complain to us about our privacy practices, you can contact our Security Officer at the address and telephone number listed below. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any retaliatory action against you or change our treatment of you in any way. You can reach us at: Kellin Foundation, 2110 Golden Gate Drive, Suite B, Greensboro, NC 27405, 336-429-5600.

# Consent to Disclose Information for Treatment, Payment, or Health Care Operations & Acknowledgment of Privacy Practices

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by the Kellin Foundation in order to carry out payment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official". A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TPO and those for which I provided authorization. I may submit a written privacy complaint to the address below or to the U.S. Secretary of the Dept. of Health and Human Services, without any action being taken by the Provider against me and without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions unless the disclosure is for payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a healthcare care item or service for which I, or a person other than the health plan on behalf of me, has paid the Provider in full; however, if the Provider does agree to by requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

***Signature(s) Required***

***By signing below, I consent to the release of protected health information for treatment, payment, and health care operations. I have had the opportunity to review the provider's notice of privacy practices and answer any questions.***

_____
Print Name of Client

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date
(if client under 18-years-old)

KELLIN FOUNDATION

# Financial Agreement

You are responsible for all service fees and understand that the Kellin Foundation does not participate with any insurance companies and does not file insurance. The Kellin Foundation will provide you with a receipt for your services that you can submit to your insurance company should you choose to do so.

Payment is due at the time services are rendered unless other arrangements are approved in advance. Acceptable forms of payment in American Express, Discover, Mastercard, Visa, PayPal, check, cash and money order.

If I fail to uphold my payment arrangements, the Kellin Foundation can pursue collection of any unpaid balance for services received. I hereby agree to reimburse the Kellin Foundation for the costs of pursuing collection, including attorney fees. It is my responsibility to inform the Kellin Foundation of any changes that might affect the billing or charges to my account. In cases of divorce or separation, the parent authorizing treatment for the child will be the parent responsible for charges. If the divorce decree requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

I understand that:

- My rate per session will be $_____.
- I may be charged a $25.00 no-show fee for scheduled appointments that are not canceled 24 hours in advance.
- Any returned checks shall incur a $25.00 fee in addition to any outstanding balance for services rendered, due immediately.
- Additionally, checks will no longer be accepted as a future method of payment.
- Should I request medical records, fees will be incurred consistent with North Carolina Statute 90-411 at the following rates: Page 1-25: $0.75 per page; Pages 26-100: $0.50 per page; Pages 100=:$0.25 per page; Minimum charge: $10.00
- If a Clinician is required to appear in a legal proceeding for a current or former client there will be a $200.00 minimum scheduling fee which is payable at the time the subpoena is delivered. Additional fees may be incurred that will be provided the client at the time of the subpoena.
- We reserve the right to charge a fee for the compilation of other types of paperwork that is requested by the client (i.e., work-related forms, school forms, etc). This fee will be assessed and agreed upon prior to the completion of the forms.

I have read and understand this financial policy and all of its elements. These statements are true and complete to the best of my knowledge. I understand all the financial information obtained will be treated as confidential.

***Signature(s) Required***

**Client Name (Printed):**

**Name of Responsible Party for Payment:**

**Signature of Responsible Party for Payment:** Date:

# Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request. I hereby authorize the Kellin Foundation to use my credit card information to charge my credit card for any balances as outlined in this agreement.

Type of Card: Card Number:

Verification/Security Code: Exp. Date: _____/_____ Billing Zip Code:

By signing below, I am authorizing the Kellin Foundation to charge my credit card per the above guidelines.

**Signature of Responsible Party for Payment:** **Date:**

KELLIN FOUNDATION

# Consent to Contact and Electronic Transmittal

We are sensitive to your privacy and the confidentiality of services. For rescheduling or appointment confirmation purposes, it may occasionally be necessary for our office to contact you.

***Check each method of communication approved to send information.***

| | |
|---|---|
| O **Phone / Voicemail Communication at HOME/CELL**<br><br>**Provide phone number:** _____ | O **Phone / Voicemail Communication at WORK**<br><br>**Provide phone number:** _____ |
| O **Email Communication – Provide email address:**<br><br>**Email:** _____<br><br>**Email communication will mainly be used for appointment reminders and scheduling and should not be a method of trying to reach your therapist.* | O **Text Communication – Provide phone number:**<br><br>**Provide phone number:** _____<br><br>**Text communication will mainly be used for appointment reminders and should not be a method of trying to reach your therapist.* |

I give my consent for the Kellin Foundation to send by electronic transmittal (fax or email) or communicate by cellular phone, with appropriate release of information, confidential information concerning my or my child's diagnosis, care, testing records, treatment plan and goals. I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective moving forward.

I give my consent for the Kellin Foundation to use a web-based scheduling calendar. I understand that while the web-based scheduling calendar may not meet all of HIPAA's stringent requirements, it does use the secure https protocol in which the data between computers and the server is encrypted and that access to computers and the calendar are password protected.
I am fully aware that electronic transmittal, wireless telephone communication and web based systems are subject to difficulties and that the Kellin Foundation cannot and does not guarantee confidentiality of such technology.

I understand the Kellin Foundation will exercise all reasonable precautions and I will in no way hold the Agency liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of cellular phone, fax, email or web-based scheduling systems. I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

***Signature(s) Required***

_____
Print Name of Client

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date
(if client under 18-years-old)

# Client Attendance and No Show Policy

We want you to be successful and reach your treatment goals. Your success in treatment is strongly influenced by your regular attendance to your appointments. Our structured attendance and no show policy is to ensure that clients regularly attend their scheduled appointments for an overall successful experience. This is not to punish anyone but to ensure all those in need of services are able to be seen and get the most out of the therapeutic process. Your appointment dates and times are important and session times fill fast. If you are unable to attend your scheduled appointment, providing notice may ensure someone else can be seen instead.

1. Clients must:
    - Attend all scheduled appointments.
    - Provide at least 24 hour notice of cancellation.
    - Arrive to all appointments within 15 minutes of their scheduled time.
        - If you have called ahead to advise of your tardiness, it will be up to the assigned Clinician to allow a shortened session.
        - If you have not called ahead to advise of your tardiness your appointment will be canceled.
2. Multiple no showed appointments, late cancellations or late arrivals will lead to being discharged from services.
3. The Kellin Foundation can (but is not required) to take into consideration sickness or emergencies when implementing the attendance and no show policy.
4. All discharges due to attendance and no show policy shall be approved by the Deputy Director.
5. All clients who have been discharged are welcome to request services at the Kellin Foundation six months after discharge. All returning clients will be treated as new client to the agency and will need to complete the screening and intake process again.

**********

***Signature(s) Required***

My signature below indicates that you have read the above Client Attendance and No Show Policy and understand my obligation to attend all scheduled appointments. I understand it is my/my guardian's responsibility to remember my scheduled appointment date and time. I understand that the Kellin Foundation will attempt a reminder call, text and/or email of my preference the business day prior to my scheduled appointment but that it is a courtesy and not guaranteed.

_____
Print Name of Client

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date
(if client under 18-years-old)

# Teletherapy Consent Form (Optional)

Telehealth and Teletherapy is the use of electronic transmissions to treat the needs of a patient. In this case, we offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, may occur from different locations geographically in order to assist with delivery of care when access to care may not be possible by face-to-face visits.

You understand that Teletherapy occurs in the state of North Carolina, and is governed by the laws of the state where the client resides. Teletherapy may also be governed by the laws of the state in which the providers are located at the time of service delivery, if that state is other than NC. All providers are licensed in the states in which you reside, as well as the state the provider may be located in at the time of a Teletherapy session.

While Teletherapy is an effective way to obtain assistance when geographic distance or scheduling conflicts prevent face to face care, in the event that Teletherapy is determined to not be in your best interests, your provider will explain that to you and suggest some alternative options better suited to your needs. In most cases this will likely include a recommendation for face-to-face psychiatric consultation or psychotherapy, or a referral to a facility or an agency that may provide a higher level of care. Teletherapy is not intended for emergency services, and if emergencies arise you will be required to seek face to face consultation and evaluation, and by signing this consent, you agree in advance to seek such care if you or your provider deem this necessary. In the event of an imminent emergency, clients should consult the nearest emergency room or psychiatric facility to provide emergent care.

You are responsible for information security on your computer. If you decide to keep copies of our emails or other communication on your computer, it's up to you to keep that information secure. Unfortunately, we cannot guarantee the security of emails as they travel between computers. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails. Even if someone were to intercept an encrypted e-mail, they would not be able to read the encoded message.

Teletherapy via an online secure platform is considered to be secure because it is reported by the manufacturer to be encrypted and therefore confidential so that it meets HIPAA acceptable privacy guidelines. Despite the manufacturer's representation, we do not independently certify that it meets encryption criteria for HIPAA compliance, and therefore you release the Kellin Foundation from any liability in the event that teletherapy is not secure and confidential as reported by the manufacturer. The software of choice by the Kellin Foundation is preferred due to HIPAA compliance and encryption ensuring security of transmission while Skype's fundamental security is not documented as clearly rendering Skype's degree of security uncertain at this point. Skype may be an alternative when VSee or other platforms are unavailable as a means of conducting Teletherapy.

Teletherapy may be received either from your chosen environment (e.g., home or work) or from another location of your choice. You understand that you are responsible for (1) providing the necessary computer, telecommunications equipment and internet access for Teletherapy sessions; (2) the information security on your computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions, and sufficient for privacy to protect your personal health information.

I understand that there are risks and consequences from Teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Other risks include Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, with Teletherapy, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and protected from other's intrusion. You maintain sole responsibility for ensuring the privacy of your surroundings if participating in Teletherapy. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my provider's efforts, my condition may not improve, and in some rare cases may even get worse.

***Signature(s) Required***

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of the Teletherapy Consent Form, including the following:

- You have read this agreement and agree to its terms
- You acknowledge that you have received the HIPAA Privacy Policy and Clients Rights and Responsibilities documents
- You have had the opportunity to ask any questions that you may have related to this agreement

_____
Print Name of Client

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date
(if client under 18-years-old)

# Client Rights and Responsibilities

Client Rights

Clients have the right to:

1. be cared for by a qualified, competent and trained clinician;
2. be treated with courtesy, dignity and respect;
3. be spoken to or communicated with in a manner or language they can understand;
4. receive privacy and confidentiality in regards to their health, social, and financial circumstances, in accordance with laws and Agency policies;
5. be informed of the laws, rules and policies affecting the operation of the Agency;
6. be informed of procedures for initiating complaints about the delivery of service, without fear of reprisal or retaliation;
7. be informed of the Agency's *Code of Ethics* policy;
8. be informed of the Agency's policy on *Withdrawal/Termination of Services*.
9. have their property treated with respect;
10. participate in the development of a plan for their care;
11. provide input on which clinician they want and to be informed of who the clinician is accountable to. e.g. which Behavioral Health Agency oversees their work;
12. be briefed on any procedure/treatment before it is carried out in order that they can give informed consent or refuse the service/treatment;
13. expect that the Agency will only release information about them if they have given authorization and/or if it is a requirement of law; or it is for treatment or payment purposes.
14. receive notice of any changes in their service, within an agreed upon amount of time, prior to the changes place;
15. receive services, including access to medical care, without regard to race, color, age, sex, sexual orientation, creed, religion, linguistics, disability and/or familial/cultural factors;
16. be free from any actions that would be deemed to be abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;
17. report instances of potential abuse, neglect, exploitation, involving any employee of the Agency.
18. be dealt with in a manner that recognizes their individuality and is sensitive to and responds to their needs and preferences;
19. be informed, within a reasonable amount of time, of the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency.

Client Responsibilities: Clients are responsible for:

1. providing complete information about matters relating to their mental health and abilities when it could influence the care they are being given;
2. reporting any potential risks that might exist to the clinician such as the possibility that a client/family member might have a contagious illness or condition;
3. reporting unexpected changes in their condition;
4. requesting information about anything that they do not understand;
5. contacting the office with any concerns or problems regarding services;
6. following service plans and/or expressing any concerns they have about the *Service Plan*;
7. accepting the consequences, if the *Service Plan* is not followed;
8. following the terms and conditions of the *Service Plan*;
9. notifying the Agency, in advance, of any changes to scheduled appointments;
10. being considerate of property/equipment belonging to the Agency and/or clinician;
11. notifying the Agency of any changes being made to their contact information such as address or phone number;
12. advising the Agency of any changes being made to their Health Care Professionals. e.g. Primary Physician, Psychiatrist, Occupational Therapist, Nurse, etc.
13. advising the Agency if they are not satisfied with the care or services being delivered;
14. giving reasonable notice, when possible, if service is going to be cancelled;
15. treating clinicians in a courteous and respectful manner, and,
16. ensuring that clinicians are free from any actions that could be deemed to be abusive such as intimidation, physical/ sexual/ verbal/ mental/ emotional/material/ financial abuse, etc.

Agency Responsibilities: We shall be responsible for:

1. providing competent employees;
2. carrying liability and other insurances;
3. meeting the standards of *Worker's Compensation*;
4. ensuring behavioral health service delivery standards are met;
5. ensuring federal, state, county & municipal legalities are researched and applied;
6. adhering to labor regulations;
7. developing contingency plans;
8. making deductions for social security, Medicare and other taxes;
9. conducting needs assessments, with client's/family's input;
10. developing service plans with client's/family's input;
11. consulting with relative professionals regarding the service plan (as required)
12. being part of, or coordinating, a treatment team to provide for the client's needs, as indicated;
13. establishing goals with client/client's representative's input and striving to meet these goals;
14. maintaining the client's/family's confidentiality, privacy and dignity;
15. maintaining professionalism and a code of ethics;
16. avoiding inflicting its personal values and standards onto clients;
17. being alert for and reporting signs of abuse or neglect.

This *Rights and Responsibilities* form has been reviewed with, and a copy given to, the named client/client's representative.

KELLIN FOUNDATION

Congratulations! You have qualified for one of our grant funded programs. As a result, Kellin Foundation offers the following services to you at a free or reduced cost as outlined in your Financial Agreement:

1. A total of 26 outpatient individual, family, or couples counseling sessions over the course of one calendar year from the time of your first assessment appointment.
2. Ongoing access to any of the group offerings through the Kellin Foundation that are appropriate for you and your service plan. Your clinician will inform you of group offerings and discuss with you how these can be incorporated into your service plan.

We are glad that we can provide this level of service to you and look forward to working with you to help you achieve your goals!

Your signature below indicates that you understand the limits of the free or reduced cost services available to you and have had the opportunity to ask any questions about the range of services available.

_____ _____

Signature Date