1801 East Fifth Street Suite 110
Charlotte, NC 28204-2472
704.375.5354 / 704.375.3069 fax
sanctuarycounselinggroup.org

INFORMED CONSENT TO RECEIVE SERVICES

I am the _____ patient _____ parent or legal guardian

Pastoral Counseling Covenant

Pastoral Counseling and psychotherapy are most helpful when they take place in a framework of trust, clarity, and understanding. This covenant is between SCG and you with your therapist being the direct provider of care as the representative of SCG. This covenant is intended to clarify and aid this relationship. Should you have any questions concerning this covenant, please discuss them with your therapist.

Confidentiality

A copy of our Privacy Practices contains a complete explanation of confidentiality. It is included with this packet of documents.

- Sanctuary Counseling Group (SCG) complies with HIPAA guidelines relevant to the delivery of all our services and your Patient Health Information (PHI) will be accessed only by your providers and by other SCG staff only to the extent that it is necessary to schedule, provide, record, and bill for services.
- PHI may be released if you are judged by a clinician to be a credible and imminent danger to yourself or others.
- If you choose to use insurance to help pay provider fees, some PHI will be released to the insurance company as required by that company.
- SCG may release PHI if it is subpoenaed properly under applicable state or federal rules.
- SCG clinicians meet weekly to discuss our clinical work. When clinical work is presented, all identifying data of the patient is disguised to protect confidentiality.
- Some PHI may be used for research, training, grant applications, or in professional journal articles or presentations. In these cases, PHI is altered to thoroughly disguise the patient.
- In accordance with federal regulations, we are required to make and keep a copy of your driver's license and health insurance card at the time of your first visit to make certain that your identity is protected.

_____ please initial

Ethics

- Your provider is required by law to adhere to a code of ethic governing conduct for his/her particular discipline. A copy of the code applicable to your provider is available upon your request.

Clinical Processes and Disclosures

- **Clinical Emergencies**: It is not always possible for your provider or another SCG provider to respond to you in an emergency situation. If you cannot reach your therapist and experiencing an emergency, you are to call 911 or proceed to your nearest hospital Emergency Room.
- **Risks Associated with Treatment**: In the course of receiving services, additional psychological material may surface which increases your level of distress for some period of time.
- **Treatment Outcomes**: While the services provided by SCG are intended to benefit the patient, no particular treatment outcomes can be guaranteed.
- **Right to Discontinue Treatment**: You have the right to discontinue treatment at any time. We recommend, however, that you discuss these plans with your provider before making the decision to terminate.
- **Complaints/Concerns**: If you have complaints or concerns about the services being provided to you, please contact our Executive Director, Dr. John V. Arey, Jr., at 704.375.5354 x-303

_____ please initial

Child Care

- SCG cannot provide child care. If a child is not part of a scheduled counseling session and there is not an adult to care for the child, the provider may cancel the session and you will be responsible for the fee for the canceled session.

Financial Policies

Fee for a 50-60 minute session with an SCG provider is $125.00 with the fee for the initial intake visit being $150.00.

- **Payment is due at the time of service**. We ask that you leave your credit card information (Visa or Mastercard) on file for automatic payment by completing the form included in our documents. Otherwise, you may pay on the day of service by cash or check.
- **Missed Appointment//Late Cancellations**: You may be responsible for the full fee ($125) for any session cancelled less than 24 hours in advance. Missed or cancelled appointments cannot be charged to insurance and are your responsibility. This may be discussed with your therapist should there be special circumstances.
- **Returned Checks**: If a check is returned on your account for NSF, we will no longer accept checks from you. Payments on the day of service must be made by cash or a credit card provided.
- **Delinquent Accounts**: If you are repeatedly delinquent in paying for services provided to you, you will be required to pay in advance for further services. Extended delinquency hinders our ability to provide services at a competitive rate.
- **Divorced or Separated Parents**: Please in make arrangements in advance for who will be responsible for your child's charges. We ask that a credit card be placed on file from each parent and the therapist will designate which card to be charge for each session.

NOTE: Should you desire to utilize your personal healthcare insurance, we will be happy to file on behalf your primary insurance. PLEASE NOTE THAT WE ARE NOT MEDICARE NOR MEDICAID PROVIDERS. Insurers require that we charge our regular fee, and you will be responsible for your copay amount, again payable at time of service. In some cases, a deductible amount may apply, in which case you will be responsible for that amount until it has been met; at which time your benefits will then be able to be utilized. Filing insurance does mean that you will be responsible for whatever portion of the fee is not covered by your insurance benefit. Please make certain that you understand your benefits for Mental Health in an office setting. You may do this by contacting your insurance provider. A copy of your primary insurance card (front and back) must be on file along with a signed Insurance Authorization form (below).

_____ please initial

Social Media Policy

The governance of electronic communication and provision of services through e-mail, text, Skype or other electronic means is still being discussed by professional bodies of legislative groups.

Risks of Using Electronic Communications:

- SCG cannot guarantee the same security, confidentiality and privacy as is provided in face-to-face therapy sessions.
- There is an undeterminable risk that electronic communications may be intercepted by a third party and shared with others without your permission or the permission of SCG.
- E-mails or texts should not be used for emergencies or urgent issues.
- PHI that is particularly sensitive should not be sent by e-mail, text, ie. HIV, drug abuse, sexual activity, pregnancy test results
- Your employer may be able to view e-mails or texts sent or received at work.
- E-mails or texts may not be delivered correctly or in a timely manner.

Conditions of Use of E-mail, Text, Skype or Other Electronic Communications:

_____ I do **NOT** want to communicate with my provider or anyone at SCG via e-mail, text, Skype, or other electronic communications and do **NOT** grant permission to my provider or anyone at SCG to do so with me.

_____ I **DO** want to communicate with my provider via electronic communications and **DO** give my provider permission to do so with me.

- SCG will save all e-mails addressing clinical issues that are sent by SCG or are received by SCG. They become part of your permanent medical record, just like a clinical phone discussion would. Skype sessions will be documented in the same way face-to-face sessions are.
- SCG is not responsible for breaches of privacy that occur if you allow a third party to access your e-mail or text.

Consent to Counseling

By signing below, I indicate that I have had the opportunity to read and ask questions before giving my consent for services. I have now read and understand the above Sanctuary Counseling Group policies and give my informed consent to counseling with

_____and Sanctuary Counseling Group.

Signed_____Date_____

Signed_____Date_____

CLIENT INTAKE INFORMATION

PLEASE PRINT LEGIBLY & COMPLETE FULLY **Date of Initial Visit**_____/_____/_____

First Name/ Middle Initial_____ Last Name _____

Preferred Name_____ Date of Birth_____/_____/_____

Address_____

City_____ State_____ Zip Code _____

Preferred Phone _____ ☐Cell ☐Work ☐Home

Alternate Phone _____ ☐Cell ☐Work ☐Home

Email Address _____

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Racial/Ethnic Identity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other _____

Religious Preference_____ Local Congregation _____

Who Referred you to Sanctuary Counseling Group? _____

Emergency Contact _____

Relationship_____ Telephone_____

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Relationship Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

If married, year married _____Spouse's Name _____

Names/Ages of Children _____

Names/Ages of Siblings _____

_____

Recent Transitions:

☐Family Death(s) ☐ Other Death(s) ☐ Marriage ☐ Child Left Home ☐ Job Loss

☐ Serious Illness/Surgery (Self) ☐ Serious Illness/Surgery (Family Member)

☐Marital Separation/Divorce ☐ Significant Financial Changes ☐ Home Loss ☐ Move

☐Birth of Child ☐ Other _____

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College Education _____ Degree _____

Graduate School_____ Field of Study _____

Business/Technical School_____ Field of Study_____

Employer_____ Length of Employment _____

Type of Work You Do _____

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List current illness(es) or symptom(s) _____

_____

List any major surgeries, serious crises, losses, or disabilities (with dates) _____

_____

Last medical exam (date) _____Reason_____

Name of Physician_____ Telephone _____

Have you ever received counseling or other treatments for personal, marital, or family problems?

☐ Yes ☐ No If yes, date(s)_____Name of doctor, agency, pastor, etc._____

Current medications (and doses):

Prescription Date Physician Medication Dosage ` Directions

_____

_____

_____

_____

_____

_____

_____

Substances used_____

Please describe your reason(s) for seeking help_____

_____

_____

What would you like to have happen for you as a result of pastoral counseling? _____

_____

_____

CLIENT SATISFACTION SURVEY CONSENT

Dear Valued Patron of Sanctuary Counseling Group:

At Sanctuary Counseling Group, we are committed to providing you with the best possible care. We value feedback, however, in this particular type of service, obtaining feedback as to "How We Are Doing" is not an easy task. To that end, we have devised an anonymous survey instrument that we would like to provide for you to give us that feedback.

This is a voluntary process and we do not want anyone to feel obligated in any way that they must respond. If you are willing, then a link to our survey (powered by Survey Monkey) would be emailed to you. We anticipate that it will take someone approximately one to two minutes to complete the survey. As stressed above, participation is voluntary and your answers are anonymous, unless you so indicate at the end of survey.

We greatly appreciate your willingness to consider participating in this process. If you could please let us know your preference below, we would greatly appreciate it. Thank you for your response.

With gratitude,

John V. Arey, Jr., D.Min.
Executive Director

Your Printed Name: _____

☐ I am willing to participate in this ongoing Anonymous Satisfaction Survey. Here is my email address : _____

Signature _____

☐ No thank you. I do not wish to participate in this Anonymous Satisfaction Survey. Please **DO NOT** send a survey to my email address.

Signature _____

INSURANCE AUTHORIZATION OF BENEFITS

Sanctuary Counseling Group is NOT a Medicare or Medicaid provider and will file ONLY primary Insurance provider claims.

Date _____SCG Therapist _____

Patient Name _____ (as appears on insurance card)

Phone number _____Date of Birth_____

Insurance Company for Mental/Behavioral Health Benefits:

Name of Insurance Company _____
Address _____
Phone number _____Effective Date_____
Subscriber Name (if different from above) _____
Relation to Patient _____Date of Birth _____
Subscriber ID# _____Group number_____

Please attach a copy of your insurance card (front and back)

I authorize payment of medical benefits to Sanctuary Counseling Group (SCG). SCG will file your claim for you, and re-file if necessary, but will not assume responsibility for collecting on your insurance claim or negotiating settlement on a disputed claim. It is SCG policy that all persons filing insurance must pay per session either the allowable amount of your plan until the deductible is met and the respective insurance company begins making payments, or the designated copay amount per session. SCG will then make any necessary account adjustments. If your insurance does NOT PAY your claim, full fee payment will be your responsibility.

Signed _____Date_____

CREDIT CARD AGREEMENT

WE ACCEPT VISA & MASTERCARD ONLY

With this consent, your credit card will be kept securely on file and fees will be applied under the following conditions. Please initial the following:

_____I authorize Sanctuary Counseling Group (hereafter called SCG) to apply fees or co-payment following the receipt of services rendered.

_____I authorize SCG to apply a fee to be designated by the therapist (not to exceed the full fee amount) for any services missed and not cancelled within 24 hours of its scheduled time.

_____I authorize SCG to apply any fees that are unpaid after 45 days. I understand that I may revoke this agreement in writing at any time.

_____It is my responsibility to provide a valid card. In the event this card expires or has been reissued please contact our business office at 704.375.5354.

PLEASE PRINT LEGIBLY

Date_____

Names (as appears on card) _____

Signature_____

to be used for the following client(s)...

_____

Card type_____Card #_____

Expiration date_____/_____ Security code (three digits on back) _____

Address_____City _____

State_____Zip Code_____Phone number _____