L & B Counseling
Landbcounseling.net
10700 Sikes Pl, Suite 325
Charlotte NC 28277
(704) 955-7312

Please create a new signature for each signature line

Professional Disclosure Statement

Thank you for choosing L & B Counseling. Your appointment today will take approximately 50-55 minutes. The step to start counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws, and some of your rights. If you have other questions or concerns, please do not hesitate to ask.

Professional Credentials

All of the therapists that work at L & B Counseling are licensed Master level therapist. Their education and experience has prepared them to counsel individuals, groups, parents, families, children, adolescents, couples, and adults.

Trent Morrow is a LCSW licensed through the North Carolina Social Work Board.
Kevin King is a LPCA, licensed through Licensed Professional Counselors Associate of North Carolina.
Minh Bui is a LPC, licensed through Licensed Professional Counselors Associate of North Carolina.
Sade Massiah is a LPCA, licensed through Licensed Professional Counselors Associate of North Carolina.
Michael Borenstein is a LPC, licensed through Licensed Professional Counselors Associate of North Carolina.

Services Offered and Theoretical Approach

We believe counseling is a collaborative effort in which you work together with your therapist to help you change the thoughts, feelings, and behaviors that are interfering with your being able to live a fulfilling life. We take an eclectic approach to counseling and will use the approaches that will best facilitate your arriving at answers to your questions and finding solutions to your problems. We do not attempt to impose any values on you. We may use counseling methods based on theories grounded in humanism, solution focused and cognitive behaviorism. We are qualified to provide therapy for a variety of problems.

Counseling Relationship

We usually will meet weekly or bi-weekly (depending upon your need) for sessions lasting approximately 30-60 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange except in the case of an emergency. The number of times we will meet will depend on the presenting issues.

Informed Consent

Consent for Treatment and Authorization to Disclose Health Information

I consent to the Mental Health Treatment provided by any of the therapists at L & B Counseling. I understand and authorize L & B Counseling to release any and all records pertaining to my treatment to any applicable insurance company, primary care physician, psychiatrist or to the referring professional. The release of any and all records may be done electronically or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment or utilization for review purposes. I understand that I have the right to refuse any treatment.

Client Rights

I understand that I have the following client rights:

1. The right to be treated with respect and recognition of my dignity and right to privacy.
2. The right to refuse services.

3. The right to request and receive a copy of medical records subject to therapeutic privilege set forth in NC G.S. 122C-53(c).
4. The right to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164 and the provisions of NC G.S. 122C-53(c). If the doctor or therapist determines that this would be detrimental to their physical or mental wellbeing, the consumer can request that the medical records be sent to a physician or professional of their choice. If they disagree with what is written in their medical records, consumers have the right to write a statement to be placed in their file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SAS retention schedule. T
5. The right to participate in the development of a written person-centered treatment plans and individualized crisis plan that builds on individual needs, strengths, and preferences. Their treatment plan must be implemented within fifteen (15) days of their starting service.
6. The right to take part in the development and periodic review of their treatment plan and to consent to treatment goals in it.
7. The right to treatment in the most normal, age-appropriate and least restrictive environment possible.
8. The right to ask questions when they do not understand their care or what they are expected to do.
9. The right to treatment of medical care and habilitation regardless of age or degree of disability.

The protection and promotion of recipient rights is a crucial component of the service delivery system. All consumers are assured rights by law and it is expected that Providers will respect these rights at all times and provide consumers continual education regarding their rights as well as support them in exercising their rights to the fullest extent. North Carolina General Statutes (GS 122C 51-67) and the North Carolina Administrative Code (APSM 95-2) outline specific requirements for notification of individuals regarding their rights as well as operational policies and procedures that ensures the protection of rights.

Fee Schedule

We will provide therapy sessions and other professional services associated with therapy session to an individual, adult, children, families, and groups.

The fee will be $150.00 for an intake assessment and $150.00 per hour for any therapy sessions. The fees are due at the beginning of each session. The fee for other professional services you request, which include, but is not limited to, report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings you have authorized with other professionals, preparation of records, preparation of treatment summaries, is billed to you at $150.00 per hour.

If you do not provide 24-hour notice prior to canceling an appointment, you will be billed in full the contracted rate for a missed appointment fee. The contracted rate for BCBS is $100.52, Medcost $102 and Self Pay $150. You have one unexcused cancellation prior to the cancellation policy being applied if it is a cancellation after the 24-hour period. If you No Show an appointment, which means you did not call prior to the appointment to give notice, you will be charged the contracted rate as mentioned above. You are allowed a five-minute grace period after your appointment was scheduled to start. If you are able to reschedule your appointment for later in the week, if there is availability, you will not be assessed a late cancelation charge. There is no exception to the No Show charge. You are not responsible for this fee if you have Medicaid. If you miss two (3) or more appointments, your case may be terminated at the discretion of this therapist. There is a $3 dollar service charge to use your credit/debt card. You may pay with cash or check at time of service to avoid the service charge. There is a $5 dollar charge for a declined form of payment i.e. credit card, HSA, check etc. If at any time by insurance policy is terminated and services were rendered during that time you are responsible for the full rate of the service rendered including if you lose Medicaid.

L& B Counseling accepts cash, credit card or personal checks as methods of payment. All copayments will be accepted before service begins. A receipt for any payment will be provided for tax purposes. L& B Counseling will file insurance claims on your behalf but you must contact your insurance provided and authorize payment of medical benefits directly to L & B Counseling. If your insurance plan has an unmet deductible or the claim is denied, you are

responsible for payment. Please contact your insurance company to answer questions about the extent to which fees are reimbursable or can be paid by the insurance company.

L & B Counseling may use and disclose medical information about you in order that services received may be billed and payment may be collected. L & B Counseling may also tell your health or insurance plan about the treatment you will receive in order to obtain prior approval and determine whether your plan will cover the proposed treatment.

Legal Proceedings and Court Appearances

Our responsibility to your child may require involvement in conflicts between the parents and other parties. You agree that our involvement will be strictly limited to that which will benefit your child as determined by the therapist. This includes, but is not limited to, keeping anything said by any person, during a therapy session as strictly confidential. You further agree, that you will not attempt to gain an advantage in any legal proceeding with any other person as a result of our involvement and treatment with your child or children. Furthermore, you specifically agree that you, personally, or through a third party, including, but not limited to any attorney, will not require that any therapist treating your child is asked, by request, subpoena or court order, to testify in court, provide treatment records of any kind, or complete, execute an affidavit. You also agree to instruct your attorneys not to subpoena any therapist or to refer in any court filing to anything our therapists have said or done.

If one of our therapists is required to testify, we are ethically bound not to give an opinion about custody or visitation suitability and we will not make any recommendations about a final decision on custody and visitation. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator we can provide information only if the appropriate releases are signed or there is a specific court order. If you require, my any means, that any therapist from L&B Counseling must appear or participate in any way with a legal proceeding, you agree to reimburse us at a rate of $150.00 per hour for all time devoted to that request. This includes, but is not limited to, traveling, preparing reports, testifying, being in attendance, and any other case-related costs. If there is a court order for custody please provide this in writing in the event that the other party contacts us.

Confidentiality

The confidentiality of the information you share with any therapist in our practice is protected by law and by professional ethics. Information may be disclosed only if the following criteria are met or it is necessary:

- Diagnosis and date of service shared with your insurance company (if insurance is billed for treatment purposes)
- Mandated reporting of physical or sexual abuse of children
- Threats of suicide or homicide
- Cases where you have signed a release of information for information to be disclosed
- Information released as outlined in the HIPPA Notice of Privacy Practice
- Coordination of care with Medicaid/NC Healthchoice clients

Emergency Situations

If a mental health emergency should arise, you are instructed to call your therapist 24/7. If it is an immediate crisis call 911, contact your local mental health emergency room at 704-358-2700 or go to the nearest emergency department. In the event that we are unable to continue providing therapy, either temporarily or permanently, we will contact you in order to offer continued services with another therapist or provide a referral. A crisis plan will be developed as needed for a client that is at risk for decompensation. We will do our best to accommodate a client that needs an earlier appointment due to a crisis by trying to schedule them within forty-eight (48) hours.

Dual Relationships

The counseling relationship is a psychologically intimate but professional one. Our contact will be strictly limited to our sessions together and necessary phone contact. Please do not offer gifts or ask any therapist to engage in any social activities with you, including, but not limited to social media interaction.

Grievances

If you are dissatisfied with any aspect of our work, please talk with your therapist about it or Trent Marrow. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you can contact the North Carolina Social Work Certification and Licensure Board, PO Box 1043, Asheboro, North Carolina 27204, for clarification of clients' rights or to lodge a complaint or contact or NC Disability Rights 877 235 4210, Cardinal Innovations Anonymous Concern Line 1-888-213-9687, North Carolina Bar Association Lawyer Referral Service 1-800-662-7660,

and Pro Bono Project of the North Carolina Bar Association 1-800-662-7407. A copy will be returned to you and L & B Counseling will retain a copy for their confidential files.

Appointment Reminders

We may use and share health information to contact you as a reminder that you have an appointment for treatment.

Third Party Employment

At times, we will employ third parties, who are not affiliated with L&B Counseling, to help us perform our services or administrative duties. We may share your health information with them so that they can perform their function. They are required to protect your health information and keep it confidential.

Ways To Be Contacted

By checking below, I consent to be contacted through the specific electronic medium

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❑ Phone

❑ Email (Email is used to gather measurement of progress and create reviews for the business)

❑ Text (Text is used for appointment reminders and communicating with the client)

Data Breach

In the event of a data breach you will be contacted immediately. L & B Counseling puts your PHI at the highest priority and take every available step to make sure your PHI is protected. We use encryption and HIPPA technology with all forms of communication.

L& B Counseling Social Media Policy

This document outlines our policy relating to the use of Social Media. If you have any questions or concerns regarding this policy, please address them with your therapist or Trent Marrow. As new technology develops and the Internet changes, there may be times when this policy must be updated. If it is, you will be provided notice, in writing, of the update and we will provide you a copy of the updated policy. The two primary concerns driving this policy is privacy/confidentiality and maintaining the boundaries of the therapeutic relationship.

Professional Social Media Accounts and professional: L&B Counseling maintains professional social media pages and produces and posts professional articles and blogs. There is no expectation that clients will " follow", "like" or endorse in any way, any blog, post, or comment on any of our professional social media sites. If we recognize a client or former client name, "following", "liking" or endorsing in any way, we may briefly discuss it and its potential impact on our working relationship.

Professional Facebook page: L& B Counseling maintains a professional Facebook Page to allow people to share our blog posts and practice updates with other Facebook users. All information shared on this page is available on our website. We do not accept clients as "Fans" of this page because it creates a greater likelihood of compromised client confidentiality and it is best to be explicit to all who may view my list of "Fans" to know that they will not find client names on that list.

Client Testimonials: The American Psychological Association's Ethics Code prohibits us from soliciting testimonials from clients. I feel that the term "Fan" comes too close to an implied request for a public endorsement of my practice.

Business Review Web Sites: L&B Counseling may be listed on web sites that encourage customers/patients to rate providers and/or provide reviews and recommendations. These sites include, but are not limited to, Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses and accept ratings and reviews. L&B Counseling has not paid any fee to be included on these sites and it is NOT a request by L&B Counseling for a testimonial, rating, or endorsement from you as a client. Please be aware that these business review web sites pull data from the public record to include on their web pages and L&B Counseling cannot legally prevent its public data (name, address, telephone number) from appearing on these web sites.

"Friending", "Liking" and "Following": We do not accept friend requests, contact requests, and follow in any way current or former clients on any social networking site, including, but not limited to, Facebook, Instagram, Twitter and LinkedIn. We believe that adding clients as friends or contacts on these sites can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

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Messages via Social Media Sites: We do not accept or respond to any messages, questions, concerns from any current or former client via any SMS (mobile phone text messaging) or messaging on Social Media sites, such as Twitter, Facebook, or LinkedIn. These sites are not secure and not read in a timely fashion.

Use of Search Engines: It is **not** a regular part of our practice to search for clients on Google, Facebook or other search engines. The extremely rare exception may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with your therapist by usual and customary means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. If this unusual circumstance shall arise, it shall be fully documented and discussed with you at the next available meeting.
Location-Based Services: If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place L&B Counseling as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at the office on a weekly basis.
Email: We prefer using email only to arrange or modify appointments. Please do not email a therapist content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate by email, be aware that all emails are retained in the logs of the Internet Service Providers that we use. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Provider. You should also know that any emails received from you and any responses become a part of your legal record.

Tele-Counseling Policy

TELECOUNSELING AGREEMENT
I understand that the service provided is telecounseling, which is counseling delivered either by audio and video communication via the internet. Telecounseling can bring deeper insight and awareness, better ways of understanding and coping with problems, as well as improved relationships. I understand that telecounseling sometimes requires that I be willing to examine difficult topics or times in my life, to experience stronger than usual emotions, and to try out new and different behaviors.
Documentation and Access I understand that during the provision of telecounseling services, L & B Counseling will need to securely collect and record personal information such as my name, address, and contact details as well as some on-going notes to document what happens during sessions.. My Identity and Contact Information In all communications with my counselor I agree to honestly represent my identity and personal information. I also agree to regularly update my address, telephone number, and e-mail address, as well as any contact information for my emergency contacts. Failure to do so releases my counselor from any and all ethical and/or legal obligation to warn of life threatening situations.
Use of Technology and Limits of Communication Any communication by unsecured means (i.e., non-encrypted email, text messaging, instant messaging, etc.) will only be used for scheduling or for clarifying questions related to the services being provided. If I send any messages involving personal information to my counselor without encryption, I agree to waive my privilege to confidentiality. In addition, I must assume full responsibility for the risks inherent in insecure Internet transmissions, including any losses or damages. I also agree not to post transcripts or any other recording of my counseling sessions online or to distribute them in any way. I have read and understood the section below on confidentiality. Finally, I understand my counselor will not accept requests to participate in any online social networks, discussion forums, or blogs with current or past clients.
Telecounseling Precautions I understand that telecounseling and face-to-face counseling involve important differences that limit the responsibilities assumed by my counselor. Unlike in face-to-face counseling, my counselor cannot guarantee the same degree of confidentiality since telecounseling partially takes place in a space outside of my counselor's control (i.e., the internet and my physical location). Because telecounseling takes place at a distance and possibly across jurisdictions my counselor cannot reliably intervene in situations that may involve risk to my emotional or physical well-being (e.g., if I am in crisis, suicidal, or require hospitalization). This means I agree to take full responsibility for making the following treatment decisions: · Whether and where I decide to initiate the teleconference · Whether and how I will protect the confidentiality of my conversation from my side of the teleconference · Planning in advance what I will do if I become in need of emergency emotional support, including knowing how to contact my local crisis or emergency hot-line. E-Counseling (Text-Based Messaging) Counseling will take place via audio+video

connection only. Text based communication will not be used for counseling, however it can be used as a support for arranging the logistics of counseling.

Emergency Contact Information In case of emergency or clear imminent harm to myself or another person, my counselor is legally and ethically bound to contact the appropriate authority. My counselor has my permission to contact my family doctor, a friend/family member, or appropriate authority, in such cases.

I understand that my counselor will not agree to provide counseling unless this form is completed in full. I also understand that falsification of this information releases my counselor from all legal responsibility and repercussions related to notifying appropriate authorities in the case of an emergency.

CONFIDENTIALITY Importance of the Agreement The following statements are intended to explain confidentiality as it applies to discussions between counselor and client. The common limits placed on the confidentiality of disclosures made to a counselor by professional ethics and legal systems are also described. This information is important to you, so please read it carefully and make sure you understand it. I am happy to discuss this further with you if you wish. Without this agreement counseling cannot ethically proceed, so make sure that you really do understand it and that you are comfortable with it.

Unintentional Breaches of Confidentiality Telecounseling has certain aspects to it which present challenges to confidentiality that do not exist in conventional, face-to-face counseling. There are breaches of confidentiality that a conventional counselor has control over that a telecounselor does not and you need to be aware of areas where your confidentiality might unknowingly be breached. 1. E-mail Any e-mail that you send from conventional online e-mail services like HoTMaiL, Gmail, Yahoo or other similar agencies are not secure. These organizations reserve the right search the content of your letters. Similarly, private nonweb-based e-mail messages (such as ones you may send from a program on your own computer, such as Eudora, Outlook Express or the Macintosh Mail program) may be intercepted by others once sent. Finally, if you are using a work provided e-mail your employer almost always has the right to access the information in e-mails that you send. In many locations those messages are considered to be the property of the employer. In order to overcome this breach of security you might consider setting up an online, encrypted and secure e-mail address that you use for sending and receiving messages from me. Any message that you send to me from a non-encrypted source, or that you send to a landbcounseling e-mail account represents a possible breach of security that I cannot secure. 2. Conversational privacy. In conventional counseling it is the responsibility of the counselor to ensure that no one can over hear the counseling conversation. During telecounseling I will ensure that no one will be able to hear my side of the conversation. I counsel from a secure office. However, I cannot assure the privacy of your location. If you are somewhere where a family member, co-worker or even a stranger might be able to hear or see you then our conversation cannot be kept secure. I strongly encourage you to find a private location to have our conversation. I also cannot ensure that your computer is free of malicious software that might record your end of the conversation. If you have any concerns about this, you should have your computer examined by a qualified IT professional. This is important not only for confidentiality, but for the process of counseling. It is very difficult to be attentive and focused on the process if there are constant interruptions, or if you feel others can see or hear you. For this reason, and for your sake, I will refuse to begin or might possibly end a counseling session if I realize that you are not in a private location. Similarly, it is important that we create a counseling environment free of interruptions. Please do not schedule sessions while you are ‘on call’. We must be sure that the therapy hour will be uninterrupted.

Limits on Confidentiality There are certain situations which can arise in which disclosures made to me cannot be kept strictly private due to professional ethics or law. The following information describes these situations. 1. If you indicate that you are in serious and immediate risk of harming yourself or someone else. The most typical situation would be when the threat of suicide is such that I cannot be assured of your safety once you leave the session. It is important to note that this does not apply to talking about thoughts of harming yourself that you may be experiencing. Many people who are feeling discouraged and hopeless think about harming themselves, and it is very important to talk openly about this in psychotherapy. Talking about suicide or other thoughts of self-harm would not automatically lead to a breach confidentiality. However, in the event that you intended to act on your thought to kill or harm yourself, I would be required to act to protect you even if that involved breaching confidentiality. Your life is more important than your right to privacy! In the event that you reveal a serious intention to harm someone else, I would be required to take the same action to protect that person as I would to prevent you from harming yourself. 2. If you indicate that you are involved in the abuse of a minor child, an elderly adult, or a disabled person. In these cases I am ethically and legally required to file a report about these activities with the appropriate authorities in your location. Once filed, I would be unable to safeguard the privacy of the information that those authorities would then have. 3. If I am ordered to release information by subpoena. If you should become involved in a court proceeding, the court may use the power of subpoena to gain

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access to information that you have shared with me. Although it is my policy to limit my involvement in legal proceedings as much as possible, under court order I may be required by law to provide written or verbal testimony to the court. 4. If you indicate that you were sexually abused by another licensed mental health professional. If you indicate that you were sexually violated by another licensed mental health professional, I am ethically required to report this information to the authorities where the incident took place, as well as to the licensing board governing that person's license. Please note: this does not apply to disclosures of sexual misconduct by anyone other than a licensed mental health professional from whom you were receiving treatment.

Assurance of Intent Be assured that your right to confidentiality is very important to me. In the unlikely event that I must breach confidentiality, I will make every effort to use care and discretion while meeting my legal and ethical obligations.

By signing this document you have read and understand the foregoing regarding your rights, fee schedule and office policy and are **consenting** to treatment under these terms. You have the right to refuse treatment.

Client Name: _____

Signature: _____ Date: _____

Legal Guardian: _____

Signature: _____ Date: _____

Therapist: _____

Signature: _____ Date:_____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

WE ARE COMMITTED TO PROTECTING YOUR HEALTH INFORMATION

We understand that information about you and your health is personal and private. We are committed to protecting your privacy and your health information. We are required by law to:

- Make sure that your protected health information (PHI) is kept private. We will protect PHI we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- Give you this Notice explaining our legal duties and privacy practices with respect to your PHI.
- Follow the terms of the Notice currently in effect and only use and/or disclose PHI as we have described in this Notice.

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI that we maintain. If we do so, we will provide you with the new Notice by:

- Posting the revised Notice in our offices;
- Making copies of the revised Notice available upon request

This Notice tells you about the ways we may use and disclose your PHI, as well as gives you some examples. We also describe your rights and our obligations for the use and disclosure of your PHI.

WHO WILL FOLLOW THIS NOTICE

This Notice applies to all records containing your PHI which are generated by L & B Counseling PLLC.

WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

1. To obtain payment for services. Generally we may use and give your medical information to others to bill and collect payment for the treatment of services we provide to you. Before you receive scheduled services, we may share information about these services with your health plan for pre-approval of services. We may also share portions of your medical information with our billing department and collection department, insurance companies, health plans and their agents which provide you coverage; consumer reporting agencies (e.g. credit bureaus).

2. To remind you about your appointment. We may use and disclose your PHI to remind you about an appointment you have for treatment or medical care.

3. To give you information about treatment alternatives, services, products or other health care benefits.

We may use and disclose your PHI to manage or coordinate your health care. This may include telling you about treatment alternatives, services, products or other health care benefits that may be of interest to you.

4. Disclosures to others involved in your care or payment for that care. We may share with a family member, personal representatives or other person identified by you, your PHI which is directly related to that person's involvement in your care or payment for your care.

5. When the use and/or disclosure is required by law.

6. When the use and/or disclosure is necessary for public health activities. We may disclose your PHI to the health department if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading ad disease or condition.

7. When the disclosure relates to victims of abuse or neglect. We are required to report suspected child/elder abuse and/or neglect.

8. When the disclosure is for judicial and administrative proceedings. We may disclose your PHI in response to an order of a court or administrative tribunal, including a subpoena, court order or a warrant.

9. When the use and/or disclosure is to avert or lessen a serious and imminent threat to health or safety. For example, if you threaten to kill someone while you are in our care, we can notify the proper parties to protect the potential victim.

10. When the use and/or disclosure relates to worker's compensation. For example, we may disclose your PHI as

required by law to provide benefits for work-related injuries.

ANY OTHER USE OR DISCLOSURE OF YOUR PHI REQUIRES YOUR AUTHORIZATION

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose your PHI. If you sign a written authorization allowing us to disclose your PHI in a specific situation, you can later cancel your authorization in writing by contacting the person listed at the beginning of this Notice. If you cancel the person listed at the beginning of this Notice. If you cancel your authorization in writing, we will not disclose your PHI after we receive your cancellation, except for disclosures being processed before we received your cancellation.

YOU HAVE CERTAIN RIGHTS

1. Receive a copy of this Notice.
2. Request confidential communications.
3. Inspect and copy.
4. Request amendment.
5. An accounting of disclosures.
6. Request restrictions on uses and disclosures of your protected health information.
7. File a Complaint.
8. Receive information about the handling of your information.
9. You have the right to a copy of this notice.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights have been violated by us, or you want to complain to us about our privacy practices, you may send a written statement of your complaint to the person listed on the front of this Notice or call (704) 965-2364. You may also send a written complaint to the US Secretary of the Department of Health and Human Services at Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909 or call them at 1-877-696-6775. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

North Carolina Law

Some North Carolina laws give you additional protection and rights over federal laws and we will follow them whenever they apply. A few examples of North Carolina law are: North Carolina protects your discussions with a mental health provider about your mental health treatment. Any request by you for treatment and rehabilitation for drug dependence will be treated as confidential, even if we refer you to someone else.

In general, you must consent before we disclose information about your mental health, developmental disabilities, or substance abuse services. However, we can disclose this information without your consent to help us care for you, for our health care operations, for your emergency care, and to others when necessary to coordinate your care. We are also allowed, and sometimes required, to disclose your information in the same situations which do not require your authorization. If we believe it is in your best interest, we may disclose your information to start a guardianship or involuntary commitment proceeding. We can disclose to your next of kin when you are admitted or discharged from a mental health, developmental disabilities, or substance abuse facility, if we believe it is in your best interest, but only if you do not object. If you are a minor, you have the right to consent to certain treatments without consent of your parent or guardian: (1) for pregnancy, (2) for abuse of controlled substances or alcohol; and (3) emotional disturbance. North Carolina has certain requirements for parental or guardian consent for abortions.

Initial_____

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Privacy Notice Acknowledgement Form

Client Name: _____

The notice of Privacy Practices provides information about how I may use and disclose protected health information about you. You have the right to review the notice before signing this consent. As provided in the notice, the terms of the notice may change. If I change my notice, you may obtain a revised copy in my office.

- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for L & B Counseling.
- I understand how and where I may file privacy related complaint.
- I understand that I have the right to request how protected health information about me is used or disclosed for treatment, payment or health care operations. I understand that L & B Counseling is not required to agree to this request but if they agree, they are bound by our agreement.
- By signing this form, you consent to L & B Counseling to use and disclose protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on my prior consent.

Signature of Client _____

Date Signed _____

Signature of legally responsible person, if required _____

Date Signed _____

Office Use Only:
Explanation if signature of client or legally responsible person is not obtained:
_____

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Client Referral Form

Last Name:_____ First:_____ Middle:_____ Sex:___

Date of Birth: ____/____/_____ Age:_____ Email address:_____

Home Address:_____ City:_____ State:____

Zip code:_____ Home phone number:_____ Cell phone:_____

Referral source:_____

Primary Care Physician:_____ PCP Practice:_____

Responsible Party:

Last Name:_____ First:_____

Email address for receipts of payment:_____

Telephone #:_____

Race: ❑ White ❑ African American ❑ Hispanic ❑ Asian ❑ Indian ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employment Status: ❑ Unemployed ❑ Employed ❑ Student ❑ Retired ❑ Homemaker

Primary Language: ❑ English ❑ Spanish ❑ Other

Living Arrangement: ❑ Private Residence ❑ Homeless ❑ Foster Home ❑ Other

Insurance:

Insurance carrier:_____ ID:_____

Payment Information: Credit Card#:_____

Expiration date:_____ CVC #_____

L & B Counseling
Landbcounseling.net

10700 Sikes Pl, Suite 325
Charlotte NC 28277
(704) 955-7312

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the release information may no longer be protected by federal privacy regulations once it is disclosed.

Purpose of Release: ☒Ongoing Communication ❑Copy of Record ❑Legal or Insurance Review ❑Authorized Representative's Request ❑ Other _____

Release From: L & B Counseling is authorized to release the requested health information for the following date:
From: (MM/DD/YY)_____ To: (MM/DD/YY)_____
The authorization will expire when the requested health information, for the requested date(s) of service, range of time or events(s), is released to the recipient named in this document and the purpose of the release is satisfied.

Check the specific information to be released:
☒ All Records & Details ❑ Other (Please Specify)_____

Name of client whose information is to be released:
Last name:_____ First:_____ Date of Birth_____

Address:_____

Release To: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

_____
Name

Patient's rights and signature:

- I understand that I have a right to revoke this authorization at any time by notifying the provider of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third part can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.
- This is a full release including information related to behavioral/mental health, drug or alcohol treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

If the client is a minor or is clinically unable to sign, an authorized representative may sign this authorization.
Print Name:_____

Signature:_____ Date _____
Refusal to sign: ☐ Yes ☐ No

Therapist Name:
Signature:_____ Date_____

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Date/Time	Signature/Credentials	Date/Time	I have had input into this plan and I agree with this plan. (Client/Legally Responsible Person Signature)

You have a right to a copy of this treatment plan. If you would like a copy of this plan please ask or submit a written request to L & B Counseling 10700 Sikes Place Charlotte NC 28277, Suite 325.

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FEE AGREEMENT AND PAYMENT TERMS

I _____ agree to pay L&B Counseling, LLC for professional services rendered by one of its licensed therapists. Professionals services include, but are not limited to, individual and family sessions, assessments, report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals, preparation of records, preparation of treatment summaries, any other service you may request, or services that are deemed reasonable and necessary by the therapist.
I agree to pay L&B Counseling, LLC according to the following fee schedule:

a. $150.00 for an intake assessment.
b. $150.00 per hour for individual and family sessions and other related professional services.
c. $150.00 per hour to participate in any way related to a legal proceedings of any kind, this includes, but is not limited to, appearing in court as a witness, waiting in court, traveling, preparing reports, testifying, responding to emails, and any other related costs and expenses.
d. Or in the case of in network insurance I agree to pay the remaining member's expense as stated in the explanation of benefits by my insurance company. It is my responsibility to understand my policy and therefore my financial obligation. Payment is due at the time the Remittance Advice is delivered by my insurance company.
e. There is a $5 dollar charge for a declined form of payment i.e. credit card, HSA, check etc
f. There is a $3 dollar service charge to use your credit/debt card. You may pay with cash or check at time of service to avoid the service charge.
g. I agree if my insurance policy is terminated I am responsible for the full rate of the charge including Medicaid.

I agree that fees are due at the beginning of each session. **If you do not provide 24-hour notice prior to canceling an appointment, you will be billed in full the contracted rate for a missed appointment fee.** The contracted rate for BCBS is $100.52, Medcost $102 and Self Pay $150. You have one unexcused cancellation prior to the cancellation policy being applied if it is a cancellation after the 24-hour period. If you No Show an appointment, which means you did not call prior to the appointment to give notice, you will be charged the contracted rate as mentioned above. You are allowed a five-minute grace period after your appointment was scheduled to start. If you are able to reschedule your appointment for later in the week, if there is availability, you will not be assessed a late cancelation charge. There is no exception to the No Show charge. You are not responsible for this fee if you have Medicaid. If you miss two (2) or more appointments, your case may be terminated at the discretion of this therapist.
I agree that all fees, costs and expenses are due 30 days after an invoice for services are presented to me and that any balance owed beyond 30 days, will incur a late fee and interest rate equal to 2.5% of any outstanding balance.
L&B Counseling, LLC will file an insurance claim for any fees incurred except those relating to participating in legal proceedings or professional services not typically covered by any form of insurance. I understand that if any form of insurance, for any reason whatsoever, does not pay the invoiced cost for the professional services rendered, I will be personally responsible to pay whatever balance is owed.
I agree that L & B Counseling, LLC may use and disclose medical information about me so that the services received may be billed and payment may be collected.
I further also agree, that if L&B Counseling, LLC, must acquire the services of an attorney to collect any outstanding balance on my account, I will be responsible for paying the actual costs in filing any legal action, any out of pocket expenses relating to the filing of a legal action and attorney fees equal to fifteen percent (15%) of any outstanding balance.
Date:_____

Signature: _____

Printed Full Name: _____

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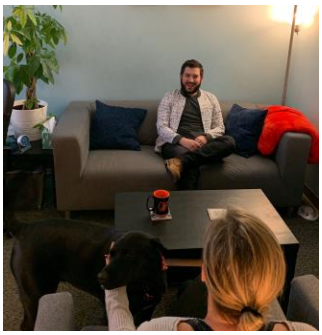
Permission to use Images

At L & B Counseling we try to show our customers and prospective customers how we are Outside The Box when it comes to therapy. One way we try to do that is showing pictures of what and how we do therapy. This authorization is giving us permission to use photographs as a way to show how we live one of our Core Values. By signing this authorization you have right of first refusal which means the picture that we intend to use will be proofed by you first. Only if the signee agrees that the picture is appropriate we will then use it. At any time the signee wants the picture to not be used it will immediately be taken down. The intent of the picture is to show how the therapist thinks Outside The Box. L & B Counseling will never use a picture that uses identifying information i.e. birth marks, tattoos, etc. The picture being used will have the person in the background, with their back turned towards the camera.



If you agree to this you will be sent an email with the picture proof for the signee's approval.

Name of client whose information is to be released:
Last name:_____ First:_____ Date of Birth_____

Address:_____

Patient's rights and signature:

- I understand that I have a right to revoke this authorization at any time by notifying the provider of the above named organization in writing, phone, text, or email. I understand that revocation will not apply to information that has already been released in response to this authorization.

If the client is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

Print Name:_____

Signature:_____ Date _____

Therapist Name:

Signature:_____ Date_____