SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

CLIENT INFORMATION

First Name_____ Middle _____ First Visit _____

Last Name_____ Gender _____

Address _____ Date of birth _____

City, State & Zip _____ Employer _____

Primary Phone _____ Martial Status _____

Email _____

Can we leave a text/email for appointment reminders? ☐ Yes ☐ No

Can we leave a voice message? ☐ Yes ☐ No

Can we email you? ☐ Yes ☐ No

How were you referred? ☐ Website ☐ Google ☐ Psychology Today ☐ Social Media (i.e., Facebook)

☐ Friend/Family _____ ☐ Other _____

Would you like to receive our FREE monthly e-newsletter? Yes _____ No _____

EMERGENCY CONTACT

Per Santos Counseling PLLC ethical code and guidelines, we will contact the legal guardian and/or emergency contact if the patient is in danger to themselves or someone else. Parents/legal guardians are required to remain on premises during each session for adolescents.

First Name_____ Middle _____ Last Name _____

Relationship to Client_____ Contact # _____

First Name_____ Middle _____ Last Name _____

Relationship to Client_____ Contact # _____

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

EDUCATION

Level of education:

☐ None ☐ Elementary School ☐ Middle School ☐ High School ☐ GED ☐ Vocational Training
☐ Some College ☐ College Degree ☐ Graduate/Professional School

ETHNICITY

☐ Other ☐ American Indian or Alaskan Native ☐ Black ☐ African American ☐ Hispanic
☐ Multiracial ☐ Pacific Islander ☐ White

SEXUAL ORIENTATION

☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgendered ☐ Other ☐ Heterosexual ☐ Unknown

CLIENT HISTORY

The following questions are for gathering initial background information to save time for your first session. Please feel welcome to skip questions that do not apply to your situation or that you are not comfortable answering. Please note that the more information you provide, the better your counselor will understand your situation. You will be able to discuss questions in more detail during your session(s). Thank you.

Primary Concern:

SYMPTOM CHECK-LIST

☐ Poor Concentration	☐ Impulsive	☐ Negative Thoughts	☐ Aggressive
☐ Angry	☐ Headaches	☐ Recurring Thoughts	☐ Inferior Feelings
☐ Anti-Social	☐ Sick Often	☐ Regretful	☐ Lonely
☐ Anxious	☐ Worry	☐ Sexual Addiction	☐ Body Image
☐ Dizziness/Light headed	☐ Restless	☐ Internet Addiction	☐ Unattractive
☐ Inferior	☐ Guilty	☐ Drug Addiction	☐ Sexual Difficulties
☐ Incompetent	☐ Tired	☐ Alcohol Addiction	☐ Empty
☐ Alcohol Dependency	☐ Hateful	☐ Sleep Problems	☐ Irritable
☐ Avoid People	☐ Restless	☐ Other Addiction	☐ Withdrawal

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

If you are experiencing symptoms not listed above, please explain:

What are your counseling goals (things you would like to achieve/change)?

Please list strengths/positive influences in your life:

MEDICAL HISTORY

Personal History of Counseling/Therapy? ☐ Yes ☐ No

If so, please provide details (with whom, dates, purpose, etc.):

Family History of Counseling/Therapy? ☐ Yes ☐ No

If so, please provide details (with whom, dates, purpose, etc.):

Are you currently under the care of a Psychiatrist? ☐ Yes ☐ No

If, so, details?

Doctors Name:

Address:

Phone Number:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

Are you taking medication? ☐ Yes ☐ No

If, so please provide medication details:

Medication	Dose	Start Date	Who Prescribes?	Purpose

Anything else we should know about your medications (side effects, other supplements, etc.)

If so, please explain:

Have you ever attempted suicide or had a plan to harm yourself? ☐ Yes ☐ No

If so, details:

Current thoughts/feelings/ideations of wanting to physically harm yourself? ☐ Yes ☐ No

If so, details:

Previous treatment for alcohol/drug abuse? ☐ Yes ☐ No

If so, details:

Have you ever experienced any of the following forms of abuse?

☐ Verbal ☐ Emotional ☐ Sexual ☐ Other

If so, please explain:

Do you have a previous (formal) diagnosis from a mental health professional? ☐ Yes ☐ No

If so, please explain:

LEGAL

Are you involved in any active legal cases (traffic, civil, criminal)? ☐ Yes ☐ No

If so, please explain:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

Primary Insurance Information

Having insurance is not a substitute for payment. Many insurance carriers have fixed allowances or percentages based upon your contract with them, not our office. It is your responsibility to pay the deductible, co-insurance and any other balances not paid by your insurance.

Insurance Carrier_____ Insured's Name_____

Policy ID _____ Insured's date of birth _____ Gender _____

Group # _____ Address _____

Claims Address _____ City, State & Zip _____

_____ Employer _____

Patient relationship to insured: Phone _____

Self _____ Spouse _____ Child_____ Domestic Partner _____ Other _____

My signature below indicates that I am consenting to treatment/services at Santos Counseling, PLLC. I have received and understand the contents of the professional disclosure, Notice of Privacy Practices (HIPAA), Electronic Communications Agreement and specific policies of Santos Counseling, PLLC. This information has been explained or summarized for me and any question or concerns have been addressed.

Signature:

Printed name:

Date:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician, psychiatrist, and/or other service providers. Your consent is valid for the term of treatment. If you prefer to decline consent, no information will be shared.

____You may inform my physician(s) ___ I decline to inform my physician.

Physician Name _____ Clinic Name, if applicable _____

Address: _____

Phone: _____

Signature:

Date:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Santos Counseling for your health care needs. We are committed to providing you the highest quality of care. The service that you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. We ask that you read this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of the provided care and treatment.
- We will bill your insurance carrier on your behalf. However, the patient is required to provide the most correct and up to date information regarding insurance.
- It is the responsibility of the patient, prior to the first appointment, to verify your plan's limitations, deductibles, coinsurance, and exclusions.
- Patients are responsible for payments of co-payments, coinsurance, deductibles, out of network and all other procedures or treatment not covered by their insurance plan.
- Coinsurance, copays, deductibles, out of network, and non-covered charges are due within 30 days from receipt of billing.
- Payments can be made in cash, check or by all major credit cards.
- There is a $35 fee for returned checks. Thereafter only cash or credit card will be accepted.
- Please remember that your appointment time has been reserved for you alone. Please provide at least a 24 hour notice for missed or cancelled appointments. Our policy is to charge a $50.00 "no show" fee for any appointment not cancelled or rescheduled within 24 hours.
- For missed appointments (not cancelled/rescheduled within 24 hours), you will receive an electronic invoice and/or mailed invoice that is due upon receipt.

I have read the above policy regarding my financial responsibility to Santos Counseling, PLLC. I understand that if I should default on any payment obligations as called for in this agreement, Santos Counseling, PLLC will have the right to forward my information to a collection agency. By my signature below, I hereby understand that I am financially responsible for charges not covered by this assignment.

Signature:

Printed name:

Date:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

Professional Disclosure Statement

Juan Santos, MS., CRC, LPC
Cell: (336) 707-1723
Fax: (336) 907-3461

THERAPY AGREEMENT

This document is part of the standards of practice of the North Carolina Board of Licensed Professional Counselors. Please read this statement:

This document contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

QUALIFICATIONS & LICENSURE

I have a Master's of Science in Rehabilitation Counseling from Winston Salem State University. The degree was awarded May 2014. I am a Certification Rehabilitation Counselor (CRC, #00118930) and a Licensed Professional Counselor (LPC in NC # 11154). I have been working in the counseling field for going on five years with the following populations, developmental disabililities, intellectual disabilities, mental health, and behavioral health.

COUNSELING BACKGROUND

I have been in the counseling realm since childhood due to having a sister with Autism and a family member who received mental health counseling. Counseling has always defined my personal and character as a person and a professional in the field. Within the counseling field there are numerous approaches to working with diverse clienteles. I am trained to work with youth, adults, couples, and families from diverse cultural backgrounds. As a professional in this field I continue to immerse myself within various settings in order to gain competence and awareness on persons from different backgrounds. I have been working in the counseling field for over five years with the following populations, development disabilities, intellectual disabilities, mental health, mental health evaluations and behavioral health.

I have conducted individual, group and family counseling sessions with students, adults, couples, and families experiencing issues related to depression, anxiety, grief, relationship troubles, trauma, immigration evaluations, and alcohol or substance abuse. In addition, I counsel individuals that suffered with relationship issues, financial struggles, depression, domestic abuse, etc. I continue to remain open and eager to work with all populations.

My primary theoretical orientation is Cognitive-Behavior Therapy, but I find myself using an eclectic approach due to its diverse and broad approach in counseling. I am trained in Cognitive-Behavior Therapy, Motivational Interviewing, and Person Centered Thinking. In the sessions, I ask that you involve yourself as much as possible in order to gain as much as possible from sessions.

COUNSELING SERVICES

Counseling is a process by which we work together to identify and work on any issues you bring to our sessions. I provide mental health services for children, adolescents, adults, couples, and families, with a specialty in diverse populations. I am fluent in Spanish, and provide culturally sensitive individual psychotherapy, marital counseling, and topic-focused interventions (e.g., ADHD management, divorce, depression, anxiety, parenting issues, and disability management). If you are seeking an evaluation, please note that the nature of our relationship is for evaluation and is not therapeutic in nature. During he intake will discuss the nature of the evaluation relationship. Your signature at the end of the document validates your knowledge of understanding the nature of the relationship and consent for evaluation. I use a variety of techniques to meet the individual needs of each client. However, you should be aware that while counseling interventions offer potential benefits, they also present possible risks. Such risks might include uncomfortable feelings of sadness, guilt, anxiety, anger or frustrations as you discuss unpleasant aspects of your life, or experience difficulties with other people as you change.

SESSION FEES/LENGTH OF SERVICES/PAYMENT OPTIONS

My fees are as follows unless billing at Health Insurance Carrier's contracted rate:

- Initial Intake/Assessment Session (60 minutes) $140.00
- Regular Sessions (55-60 minutes) $110.00; Extended Sessions (75 minutes) $120.00
- Couples Therapy (55-60 minutes) $110.00; Extended Sessions (75 minutes) $120.00
- Family Therapy (55-60 minutes) $110.00; Extended Sessions (75 minutes) $120.00
- Full Time Students $100.00
- Evaluations (dependent on type)

I agree to provide counseling services in return for the aforementioned fees per session. Payment must be made prior to any services. You will be charged $50.00 for missed appointments unless you cancel 24 hours prior to your scheduled appointment. Cash or major credit/debit cards are acceptable methods of payment, and I will provide a receipt for all fees paid. A fee of $35.00 will be charged for returned checks.

As a courtesy to you, we will attempt to obtain authorization from your insurance company, HMO, or responsible party. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. We ask that every client authorize payment of insurance benefits directly to Juan Santos. Accepted insurance benefits will be verified in advance of initiating services.

SANTOS COUNSELING P.L.L.C
3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

USE OF DIAGNOSIS

Any diagnosis made will become part of your permanent insurance record. In addition, when it comes to diagnosis in respect to insurance companies we need to abide by regulations in order to support both the client and the insurance company. The majority of insurance companies require that a diagnosis of a mental health condition and indicate that one must have an "illness" before they agree to reimburse. Please be aware that some counseling seeking conditions do not qualify for reimbursement. I will inform you of the diagnosis before we submit the diagnosis to the health insurance company.

CONTACTING ME

I am available by phone but do not answer the phone when I am in sessions with clients. Calls go to my voicemail when I am unavailable, which I check regularly, and on weekdays. I will return your call as soon as possible (usually within a few hours or always within 24 hours). If you are difficult to reach, please leave times you will be available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance. At times when I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary. If you are in an emergency situation call your local emergency services at 911 or go to your nearest hospital emergency department.

EXPLANATION OF DUAL RELATIONSHIPS

Contact will be limited to only counseling sessions and will be held within the counseling office only. For your best interests and to protect your personal rights, our counselor-client relationship must remain professional at all times; this means that even though our relationship may seem very intimate, you must remember that I am only sharing with you as a professional and focusing on the goals you have indicated you desire to reach. This is the primary purpose of our relationship. During initial sessions I will provide you with educational resources catered towards education on boundaries and our distinct rules.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to examine and/or receive a copy of your records. Please make request in writing to Juan Santos, 3300 Battleground Avenue, Suite 303, Greensboro, NC 27410 or email at juansantos@santoscounseling.com

CONFIDENTIALITY

All information shared will be kept *confidential* with the following *exceptions*;

a) If I believe you are a *danger* to yourself or someone else
b) If you give me *written permission* to disclose information
c) In the case of *abuse* to a child or an elderly person confidentiality will be waived
d) If the information is court ordered
e) If you desire to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement

f) In case of a *Medical Emergency*
g) These rights are waived if accusations of misconduct are brought

Even under these circumstances only essential information will be revealed and as much as possible you will be informed before confidentiality is broken. In the event the client is a minor, parents or legal guardians may be included in the counseling process as is appropriate, however measures will be taken to safeguard confidentiality, always acting in the best interest of the client. Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

REGISTERING COMPLAINTS

If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective, or whether referral would be appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact the North Carolina Board of Licensed Professional Counselors. Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

CONCLUSION

I reserve the right to change the policies, practices and procedures described in this document. I will notify you in writing of any significant changes. By signing the attached form you are indicating that you have received and read the information in this document, you have discussed the contents with me to your satisfaction, and you agree to abide by its terms during the course of our professional relationship. You have the right to consent to treatment and or refuse treatment.

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

Juan Santos, MS., CRC, LPC
Cell: (336) 707-1723
Fax: (336) 907-3461

Permission to Treat:

I hereby acknowledge I have received and been given the opportunity to read a copy of Juan Santos's Therapy Agreement.

I have been given the opportunity to ask any questions and to retain a copy for my regarding missed appointments and aware of the methods I may contact Mr. Juan Santos in an emergency.

Client Name, please print:
_____

Client Signature: _____ Date: _____

Guardian Name, print_____

Guardian Signature: _____ Date: _____

_____ Date: _____
Juan Santos, M.S., CRC, LPC

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

NORTH CAROLINA NOTICE FORM
Notice of Mental Health Provider's Policies and Practices
To Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment and Health Care Operations

We may *use* or *disclose* your *protected health information (PHI) for treatment and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *"Treatment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example or treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Health Care Operations* are activities that related to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, or health care operations, we will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

- You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing.
- You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* - If we have reasonable cause to believe that a child has been abused we must report that belief to the appropriate authority.
- *Adult and Domestic Abuse* – If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we much report that belief to the appropriate authority.
- *Heath Oversight Activities* - If we are the subjects of an inquiry by our NC Professional Licensing Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advanced if this is the case.
- *Serious Threat to Health or Safety* - If we determine, or pursuant to the standards of our profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide

protection against such danger for you or the intended victim.

- *Worker's Compensation* - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Client's Rights and Licensed Clinician's Duties

Client's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us).
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of our mental health records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Licensed Mental Health Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, you may obtain a revised notice at our offices.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact us at (336) 707-1723 to discuss your concerns.

If you believe that your privacy have been violated and wish to file a complaint with us, you may send your written complaint to Juan B. Santos, 3300 Battleground Ave, Suite 303 Greensboro, NC 27410.

You may also send a written complaint to the North Carolina Board of Licensed Professional Counselors:

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Dates, Restrictions, and Changes to Privacy Policy

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

This notice is effective as of January 1, 2013.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we change the terms of this notice, you may obtain a revised notice at our office.

Your signature below indicates that you have read the foregoing North Carolina Notice Form and that you have received a copy.

Patient/Legally Responsible Person's Printed Name:

Patient/Legally Responsible Person's Signature:

Date:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

Enrollee/Consumer Rights and Responsibilities

If you receive services from a provider, you have certain rights and responsibilities. Your rights are defined by and protected by federal and state laws. These rights include, but are not limited to the following:

- The right to receive information about the Licensed Independent Practitioner (LIP), its services, its providers/practitioners, and member rights and responsibilities presented in a manner appropriate to their ability to understand;
- The right to be treated with respect and recognition of your dignity and right to privacy;
- The right to participate with providers/practitioners in making decisions about your health care;
- The right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse;
- The right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities;
- The right to a candid discussion with service providers/practitioners on appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
    - They may need to decide among relevant treatment options, the risks, benefits, and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitation;
- The right to voice complaints or appeals about the LIP or the care it provides;
- If you are seeking an evaluation, please note that the nature of our relationship is for evaluation and is not therapeutic in nature. During the intake will discuss the nature of the evaluation relationship. Your signature at the end of the document validates your knowledge of understanding the nature of the relationship and consent for evaluation.
- The right to make recommendations regarding the LIP's member rights and responsibilities policy;
- The responsibility to supply information (to the extent possible) that LIP and its practitioners and providers need in order to provide care;
- The responsibility to follow plans and instructions for care that they have agreed to with their provider(s)/practitioner(s);
- The responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- The right to request and receive a copy of his or her medical record subject to therapeutic privilege set forth in NC G.S. §122C-53©, and 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 well-being, they can request that the information be sent to a physician or professional of their choice;

- The right to participate in the development of a written Person-Centered Plan that builds on individual needs, strengths and preferences. Their treatment plan must be implemented within thirty (30) days of their starting service;

Enrollee Rights and Responsibilities
Page 2

- The right to take part in the development and periodic review of their treatment plan and to consent to the treatment goals in it;
- The right to freedom of speech and freedom of religious expression;
- The right to equal employment and educational opportunity;
- The right to treatment in the most normal, age-appropriate and least restrictive environment;
- The right to consent to treatment and or refuse treatment.
- The right to ask questions when they do not understand their care or what the expectations are; and
- LIP uses and discloses member protected Individually Identifiable Health Information (IIHI) appropriately in order to protect member privacy. Members can request restrictions on use and disclosure of PHI. Members can request a report of disclosures of PHI. If at any time a member believes that their member rights have been violated, they may contact the LIP directly at (336) 707-1723. Clients can also file a complaint with Cardinal Innovations at 1-888-581-9988 or NCBLPC (844)-622-3572 or 336-217-6007

Your signature below indicates that you have read the foregoing Enrollee Rights and Responsibilities Form and that you have received a copy.

Patient/Legally Responsible Person's Printed Name:

Patient/Legally Responsible Person's Signature:

Date:

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

CONSUMER AUTHORIZATION

To Permit Use and Disclosure of Health Information

This authorization form implements the requirements for consumer authorization to use and disclose Health Information protected by the Federal Privacy Law, (HIPAA) 45 C.F.R. parts 160- 164; the Federal Confidentially Law, 42 C.F.R. part 2, and State Confidentially Law governing Mental Health, Developmental Disabilities, Substance Abuse Services G.S. 122C, and Confidentiality of Medical Records G.S. 130A-143.

Patient Name_____ Record Number_____
DOB_____ SSN_____
Requests and authorizes_____to use or disclose

(Name of agency/person/facility/or program authorized to make disclosure)

the Protected Health Information indicated below (including HIV & Substance Abuse related information if applicable)

to _____

(Agency/person/facility or program to whom the requested use or disclosure will be made)

*Please indicate information to be disclosed.

____Admission/Screening Assessment	____Service Plan	____Service Notes
____Medication Hx/Physicians Orders	____Psychological testing	____HIV Related Info.*
____Discharge Information	____Substance Abuse Information	____Psychiatric Evaluation
___ 3rd Party Information *	____Accounting of Disclosure	__508 DWI Form

Purpose of disclosure: ____Continuity of Care _____Referral _____Legal ____Service Delivery _____Other

Other information (if not listed):_____

*(HIV or other communicable disease related information may be a part of multiple documents in the record)

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will not be protected by state and federal privacy and confidentially laws and that it could be redisclosed by the person or agency that receives it.

* I understand that by indicating I authorize 3rd Party Information to be disclosed, any Protected Health Information (PHI) from other treatment facilities contained in this medical record will be shared pursuant to this authorization; including information related to HIV infection, AIDS or AIDS-related conditions, substance abuse information, psychological or psychiatric conditions, or genetic testing.

I understand that with certain exceptions, I have the right to revoke this authorization at any time. The procedure for revoking authorizations as well as the exceptions to my right to revoke is explained in Notice of Privacy Practices. If you do not have the Notice of Privacy Practices you may request one.

The meaning of this authorization form has been explained to me. I understand that I may refuse to sign this authorization form. I understand that Services will not condition treatment on receiving my signature on this authorization. I understand this authorization is made freely, voluntarily and without coercion. I understand the health information indicated will be disclosed per my instructions.

Signature:
Date:

Witness: _____ Date: _____ Expiration Date: _____

SANTOS COUNSELING P.L.L.C

3300 Battleground Avenue Ste 303 | Greensboro, NC | 27410 | 336.707.1723
3410 Healy Drive Ste 203 | Winston-Salem, NC | 27103 | 336.707.1723
www.santoscounseling.com | juansantos@santoscounseling.com | @santoscounseling

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

Only needed for patients under 18 years of age*

It is important and essential to the treatment process that Mr. Juan Santos maintain a confidential relationship with your child(ren) and/or adolescents. Although the parents/guardians have a legal right to information from therapy session, I ask that parents/guardians agree to the same confidentiality that would be offered if the client were an adult. I understand that I have the right to consent to treatment or to refuse treatment. I have the right to consent for treatment in accordance with 10A NCAC 27 D .0303 and the right to refuse treatment without threat or termination of services. Consent for treatment may be withdrawn at any time.

I/We consent for _____ to receive treatment as a client with a confidential
Child/adolescent name

therapeutic relationship with Mr. Juan B. Santos.

Per Santos Counseling PLLC guideline, please provide full contact information and have a copy of the custody order/agreement by the third session if shared custody exists. Per Santos Counseling PLLC ethical code and guidelines, we will notify you (legal guardian) and/or emergency contact if your child is in danger to themselves or someone else. Parents (legal guardian) are required to remain on premises during each session.

By signing below, you are giving permission to Santos Counseling PLLC to provide treatment to your child (minor) for mental health counseling services and agree to the statement and policies regarding minor's in the Counselor Client Agreement, HIPPA and Confidentiality.

Signature (Legal Guardian):

Date: