Family Life Resource Center

273 Newman Ave
Harrisonburg, VA 22801

Information about Your Child

Please complete this form if you are seeking services concerning your dependent child under the age of 18.

Name and relationship of person completing form: _____
Child's Full Name: _____
Child's Age: _____
School Currently Attending: _____
Grade: _____
Age: _____ Birth date:_____ Height:_____ Weight: _____
Hair Color: _____ Eye Color: _____
Child's Social Security Number: _____
Home Address: _____

_____
Home Phone: _____ Cell Phone_____
Parents Work Phone: _____

Family Information

Father: _____Age: _____ Living In Home: Yes☐ No☐
Mother: _____Age: _____Living In Home: Yes☐ No☐
Brothers and/or sisters (Include Age):

_____
Others living in home and relationship:

_____
Has your child or any other family members received counseling or psychotherapy? If so, who received services? _____
For what reason? _____
When and with whom? _____

History About Your Child

Any Difficulties with pregnancy, delivery or birth?

_____

_____

_____

Age child talked: _____ Walked:_____
Age Toilet training Completed: _____
Any concerns or difficulty with toilet training: _____

Significant Illnesses, diseases, allergies, high fevers, head injuries or hospitilizations:

Physical, psychological, social or academic history:

Pediatrician and/or family doctor's name, address and phone number:

Do we have your permission to advise the physician that your child is receiving care?
(if information is needed from your physician we will ask for completion of a different release)

☐ ***No*** ☐ ***Yes (Coordination of Care will be sent to your Child's Physician)***

You may grant consent by signing here: _____
Parent/Guardian Signature

Significant Life events such as divorce of parents, deaths in family, moving and child's reactions to events:

Current Teachers Name & School: _____
Other Schools Attended and dates of attendance

Religious affiliation or Church attending: _____

WHAT IS YOUR MAIN CONCERN ABOUT YOUR CHILD AT THIS TIME and how long have you had this concern?

Who referred you to our services? _____

On a scale of 1 to 10, with 1 being the worst and 10 the best, how would you rate your child's behavior in comparison to other children his/her age? 1 2 3 4 5 6 7 8 9 10 (Please Circle)

Below you will find a number of statements about your child and his/her problems. Check "yes" for those that are true of your child at the PRESENT time. Check "no" for those that do not pertain to your child.

1. My child explodes under stress. Yes ☐ No ☐
2. My child cries easily. Yes ☐ No ☐
3. My child is a worrier. Yes ☐ No ☐
4. My child has many or unusual fears. Yes ☐ No ☐
5. My child is often angry. Yes ☐ No ☐
6. My child is moody or sensitive. Yes ☐ No ☐
7. My child has sleep problems. Yes ☐ No ☐
8. My child has trouble remembering things. Yes ☐ No ☐
9. My child says people don't like him/her. Yes ☐ No ☐
10. We frequently have family problems. Yes ☐ No ☐
11. One or more of my other children have problems too. Yes ☐ No ☐
12. My child has trouble making friends. Yes ☐ No ☐
13. My child does not get along with other people in household. Yes ☐ No ☐
    Specify who in Household if circled yes: _____
14. My child speaks of death or dying. Yes ☐ No ☐
15. My child has been physically or sexually abused. Yes ☐ No ☐
16. My child tells lies or often exaggerates. Yes ☐ No ☐
17. My child has learning problems at school. Yes ☐ No ☐
18. Teachers complain about my child. Yes ☐ No ☐
19. My child is a discipline problem at home or school. Yes ☐ No ☐
    If yes, specify which _____
20. My child steals. Yes ☐ No ☐
21. My child has bladder or bowel problems. Yes ☐ No ☐
22. My child is currently taking medication. Yes ☐ No ☐
    If yes, what type of medication? _____
23. My child has a visual, hearing or speech problem? Yes ☐ No ☐
    If yes. Which? _____
24. My child often complains of illness. Yes ☐ No ☐
25. My child eats to much or not enough. Yes ☐ No ☐
    If yes, which one? _____
26. List any concerns not listed above.

    _____

    _____

    _____
27. List some strengths of your child. _____

    _____
28. List your child's hobbies or interest. _____

    _____

Adolescent Informed Consent Form

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.
  - **Communicating with your parent(s) or guardian(s):**
  -
- Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.
- Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.
- Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"
- Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.
- **[You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]**

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Minor's Signature _____ Date_____

Parent Signature _____ Date_____

Parent Signature _____ Date_____

FAMILY LIFE RESOURCE CENTER

FLRC *Counseling for Hope, Health and Healing*

Separated/Divorced Parents' Consent To Mental Health Treatment for a Minor Child

As an organization, we strive to serve children and adolescents (youth) who are experiencing mental health difficulties or adjustment issues to various circumstances. We also believe it is important therapeutically to have the consent of BOTH parents to treat a child. For us to best serve your child, we ask that you complete this form and provide the necessary information **prior to your child's first appointment.**

In Virginia, regardless of the arrangements about physical custody, legal custody is either "sole" or "joint". Please place your initials next to the correct statement to identify whether you (the parent or legal guardian who is bringing the minor to counseling) have sole or joint legal custody.

_____I have sole legal custody of _____.
(Minor's Name)

_____I have joint legal custody of _____.
(Minor's Name)

If you have sole legal custody, please do one of the following:

*Provide a letter from your attorney stating that there is nothing in the custody agreement that would prevent you from seeking counseling and/or treatment for your minor.
OR
*Provide a copy of the legal custody agreement verifying that you are the sole legal guardian who has the right to make decision's for your minor's mental health treatment.

If you have joint legal custody, please do both of the following:

*Provide a copy of the legal custody agreement verifying that you have joint legal custody.
AND
*Provide the information for the child's other parent so that the person's written consent may be obtained by FLRC. (Provide below)

I share custody with _____(Name of minor's mother or father). You may contact the other parent at : _____(phone number) or
_____(address).

_____ _____
Signature Date

If there is no custody agreement established on behalf of minor, both parents need to sign below indicating you are aware an support the mental health treatment that is being provided for the minor _____(Name of Minor).

_____ _____
Mother Signature Date

_____ _____
Father Signature Date

For Office Use Only:

Additional parent's signature cannot be obtained due to the following:

☐ Parent inaccessible
☐ Unwilling to Participate
☐ Other: Explain_____

☐ abuse or neglect suspected/reported
☐ Involvement detrimental to child

Information for Parent or Guardian About Minor's Counseling

I am providing you with the information which I think will be helpful to you as you plan to bring your child for counseling with me.

ABOUT THE TIME AND DURATION OF THERAPY SESSIONS:

The first session is a clinical interview with the parent(s) and child during which I will gather relevant clinical information, including your view of the child's problems, assets and strengths, and pertinent background information.

I usually will spend the next 4 to 5 sessions with your child in play therapy (when age appropriate). I will be with your child 40 to 45 minutes in each session and will meet with you 10 minutes before or after to address any questions or concerns that you may have. I will meet with you about the 6th session to discuss the child's progress. At that point, we will decide whether or not further sessions are needed or if some other services are warranted.

HOW DOES PLAY THERAPY HELP CHILDREN?

I know that you are concerned about your child. Since you are bringing your child to therapy, I am certain you want to help your child with the difficult time he or she is having coping at school or home. In the process of growing up children can experience difficulty adjusting. Some children may need more help than others in some areas and less help in others. Children have a difficult time sitting in a counselor's chair and talking about what bothers them. They do not have the vocabulary or knowledge of words to describe what they are feeling or thinking. Therefore, sometimes they act out to cope with what they are experiencing.

In play therapy, toys are provided because children can use the toys to say what they have difficulty putting into words. When children can communicate or play out how they feel or what they are experiencing with a trained counselor, they begin to feel a sense of relief. In play therapy, children can use dolls, puppets, art materials, sand, or other toys to express what they think or feel. Therefore, how children play or what they do in the play room is very important, just like what the parent says in the counselor's room is important. In play therapy, children learn how to express their thoughts and feelings in constructive ways, to control their behavior, to make decisions, and to accept responsibility.

WHAT SHOULD YOU ASK YOUR CHILD AFTER EACH SESSION?

After the play therapy sessions, if you were to ask your child what he/she did, he/she would probably say , "I just played" in the same way you may say "I just talked" if someone ask you what you did while you were here. Children are sometimes unaware that something important has happened at the moment. Sometimes it is easier for children to explore feelings, especially their fears or anger, with someone who can be objective than it is with parents or teachers. Thus, your child may not be able to fully explain what he/she did, or what happened in the session.

Family Life Resource Center

CLIENT-CLINICIAN SERVICE AGREEMENT & INFORMED CONSENT

Thank you for choosing Family Life Resource Center (FLRC) as your mental health provider. This document contains important information about FLRC's professional services and business policies. We would like to call your attention to the information below which includes summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. It is important that you understand these documents so please do not hesitate to ask questions. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should know. Your clinician has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for many individuals who undertake it. Therapy can lead to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things you and your clinician have discussed outside of sessions.

The first 1-2 sessions will involve a comprehensive evaluation of your needs. At the end of the evaluation, you and your clinician will discuss and create an initial treatment plan that will include goals. You should evaluate and make your own assessment about whether you feel comfortable working with your clinician. If you have questions about the clinician's or organization's procedures, you should discuss such things with the clinician or Director as soon as possible. If your doubts persist, the clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in length (after the first session which is 60 minutes), typically once per week, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. Please cancel your appointment with **at least a 24 hours' notice**: There is a waiting list to see the clinician's at Family Life Resource Center and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our clients or use the appointment for a client in crisis. If less than a 24-hour cancellation notice is given, this will be documented as a "Late Cancel" appointment. In addition, you are responsible for arriving on time to your session. If you are late, your appointment will still need to end on time. If you are more than 15 minutes late, you still may be charged as a late cancel. If you do not present to the office for

your appointment, this will be documented as a "No-Show" appointment. After the "No-Show/Late Cancel" appointment, you will be charged a $50.00 fee per missed appointment if contractually applicable. Please be aware that insurance companies do not provide reimbursement for late cancel/No show sessions so you will be financially responsible for this fee. If you have three (3) "No-Show/Late Cancel" appointments within a one-year time, counseling services will be suspended for a minimum of six (6) months. The agency will provide you with a list of referrals from other mental health specialist in the community.

PROFESSIONAL FEES

Our fees for the initial evaluation and 45-50 minutes sessions thereafter differ depending on the counselor/doctor you see. You may be responsible for the full fee at the time of your appointment, if we do not bill insurance which can occur if your clinician does not determine that a mental health diagnosis is warranted or if the type of therapy (i.e., marital therapy) is not covered by your health insurance provider. If insurance is billed you will need to pay your co-payment or pay toward the deductible, if it has not been met. If you do not use insurance, you may ask the office staff about the alternatives. **Our fees are the same for all clients. Please note the clinicians are ONLY paid once fees are collected for the services rendered.**

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy, after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel they need more services after insurance benefits end. Some managed-care plans will not allow a clinician to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your therapy.

You should also be aware that most insurance companies require you to authorize a clinician to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems). Sometimes your clinician has to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, your clinician has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called the co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the client. In addition, some insurance companies also have a deductible, which is an out-of-the-pocket amount that must be paid by the client before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions at FLRC until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage

ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for FLRC services yourself to avoid problems described above, unless prohibited by a provider contract. If a provider does not participate in your insurance plan, FLRC can supply you with a receipt of payment for services that you can submit to your insurance for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

By signing this Agreement, you agree that FLRC can provide requested information to your insurance carrier if you plan to pay with insurance.

We request that you handle any payments with the office staff at the beginning of each session. If the office staff is not in, please leave your payment with your clinician. **We expect your payment at the time of each appointment.**

In addition to scheduled appointments, it is our practice to charge this amount on a prorated basis (the hourly cost will be broken down) for other professional services that you may require such as telephone conversations beyond 10 minutes, report writing, attendance to meetings or other services that are being requested of your clinician since these things cannot be billed to insurance companies. Court appearances and legal issues are billed at the rate of $100 per hour and are payable in advance.

FEE COMMITMENT

1. Remember that insurance was designed to defray the cost of treatment, not cover those costs completely. So while we accept payment from your insurance company, **you are ultimately responsible to see that the total amount of each visit is paid.**

2. In recognition of the service provided through Family Life Resource Center, I understand that I am responsible for $_____ per visit.

3. I understand that if conditions of employment, health, or other factors should warrant, I need to contact FLRC to work out a payment plan or necessary arrangements.

4. I understand that my insurance company will not pay for "no show" fees and I am responsible for payment.

5. I further agree to pay in full for services not covered by my insurance and for my portion of covered services, including any legal or other costs incurred in the collection of this amount, if it becomes delinquent.

6. Please <u>initial</u> one of the following regarding your choice of billing:

_____A. I authorize FLRC to **submit my insurance claim** for the service provided and I hereby assign all insurance payments directly to FLRC. I authorize FLRC to release my information necessary to process this claim. I understand that my insurance claim may be filed electronically by computer modem and I hereby release FLRC from any unintended use thereof by such person.

_____B. I choose to **personally pay for my counseling services**. I understand that FLRC will not bill insurance for my services nor will they bill retroactively for services rendered. I acknowledge I have been given the opportunity to use my insurance for covered services and have declined.

PROFESSIONAL RECORDS

Your clinician is required to keep appropriate records of psychological services that he/she provides. Your records are maintained in a secure location in the office. Your clinician keeps records noting the date you were here, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis (if there is one), topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others (with your permission) and your billing records. FLRC may use electronic/telephone communications including but not limited to email, fax machines, wireless, cell and digital phones, pagers, and computers. FLRC will do the very best to ensure security/privacy of your communication and records. If you do not wish FLRC to use a specific type of communication device, talk to your clinician directly.

Client records are the property of FLRC, but you may request a copy of these in writing. Access to these records will be given according to Virginia State guidelines consistent with your condition and sound therapeutic treatment. Because these are professional records, they may be misinterpreted and or upsetting to untrained readers. For this reason, we recommend that you initially review them with your clinician, or have them forwarded to another mental health professional to discuss the contents.

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and given the opportunity to discuss any issues. Please remember that you may reopen the conversation at any time during your time at FLRC.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that the clinician can share whatever information he/she considers necessary with a parent. For children 14 or older, we request an agreement between the client and the parents allowing the clinician to share general information about treatment progress and attendance. All other communication will require the child's agreement, unless the clinician feels there is a safety concern, in which case the clinician will make every effort to notify the child of the intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING YOUR CLINICIAN & EMERGENCY SERVICES

Your clinician is often NOT immediately available by telephone. Typically, clinicians do not answer the phone when they are meeting with clients or otherwise unavailable. If you need to leave a message, you may do so by asking the office staff to transfer you to the clinician's confidential voicemail. FLRC does have an answering service which answers calls after 4:30PM Monday through Thursday and all day Friday and on weekends. The answering service staff will try to contact your clinician or another FLRC clinician who may be covering for your clinician in the event of an emergency.

If you are ever suicidal or homicidal, you may call (540)434-8450 and the office staff or the answering service will try to contact your clinician. If, for any reason, a clinician cannot be contacted immediately, go to your local emergency room or call 911 so you can be evaluated.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, we want you to talk with your clinician so your concerns can be handled. Such comments will be taken seriously and handled with care and

respect. You may also request that your clinician refer you to another therapist and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your clinician's specific training and experience.

CONSENT TO THERAPY

Your signature below indicates that you have read this agreement which includes the Notice of Privacy Practices, Client-Clinician Service Agreement/Informed Consent and the Social Media Policy and agree to the terms.

Signature of Client or Personal Representative	Date
Printed Name of Client or Personal Representative	Date

Family Life Resource Center -Social Media Policy

This document outlines Family Life Resource Center's office policies related to use of Social Media. If you have any questions, please see the Administrative Director or speak to your Counselor in session.

FLRC staff does not accept friend or contact requests from current or former clients on any social networking site. The site could potentially compromise your confidentiality and our respective privacy.

Please do not use mobile text messaging or messaging on Social Media networks to contact your Counselor. These sites are not secure and messages may not be seen. Please do not use wall replies, or any other means of engaging in online publication if there has been a client/counselor relationship. It is a possibility that these exchanges may become a part of your legal medical record and will be documented and archived in your chart.

Please do not e-mail content related to your therapy sessions, as e-mail is not completely secure or confidential. If you choose to e-mail, please be aware that e-mails are retained in logs of your internet and FLRC's internet provider. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the administrator of the internet service provider. You should also be aware that any e-mails received and any responses sent become a part of your legal record.

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. FLRC is not listed on sites as a check-in location. However, if you have GPS tracking enabled on your device, it is possible that others may be aware of your location.

It is NOT a regular part of FLRC practice/staff to search for clients on websites or Social Media. Extremely rare exceptions may be made during times of crisis. If danger to yourself or someone else is suspected, and you can't be reached during usual means, there may be an instance the search becomes necessary as a part of your welfare. These are unusual situations, and if used will be fully documented and discussed in your next session.

You may see a listing of the agency on websites or business forums. Many sites comb search engines for business listings and add listings regardless of whether the business has added itself to the site. If the Agency is listed on any of these sites, please know that the listing is NOT a request for testimonials, ratings or endorsements from any of our clients. It is unethical for counselors to solicit testimonials from clients or other persons.

If you feel the Agency or any of the Counselors have done something unethical or harmful that you do not feel comfortable discussing with the Counselor or Agency management, contact the following Agency:

Virginia Department of Health Professions – (800)533-1560
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Family Life Resource Center- Notice of Privacy Practices

This notice of Privacy Practices describes how information about you, the client, may be used and disclosed and how you can access this information. PLEASE REVIEW THIS INFORMATION CAREFULLY.

We understand that information about you is personal. We are committed to protecting your information. We create a record of care and services you receive at this office. We need this record to provide you with quality care and to comply with legal requirements. This notice tells you about the ways in which we use and disclose your records. We also describe your rights and the obligations we have regarding the use and disclosure of records.

Uses and Disclosures of Information:
We use information about you for treatment, to obtain payment for treatment, and for the purposes of ensuring the quality of care you receive. We may contact you about appointments, treatment alternatives or other benefits that may be of interest to you. We will contact you according to permission granted on the intake form. **We will provide information when required by law, such as for law enforcement in specific circumstances. *Confidentiality will be waived if there is concern of harm to yourself or to others and in child abuse, elder abuse, or abuse of individuals with special needs.*** In all other situations, we will ask for you written authorization to disclose information. You can later revoke that authorization to stop any future uses and disclosures.

For the purpose of ensuring quality services, our staff is involved in ongoing training and supervision. As deemed necessary by your clinician, cases and review of case notes may be discussed confidentially in consultation with other staff members. If your clinician needs to consult other professionals in our community, a release of information is available for you to sign.

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice in the waiting area. You can also request a copy at any time. For more information, contact the office manager or your counselor. Please remember that you may reopen the conversation about these issues at any time during our work together.

Individual Rights
In most cases, you have the right to look at or get a copy of the information about you that we use to make decisions about you. If you request copies, we will charge you $0.50 for each page up to 50 pages and $.25 thereafter (fees charged are pursuant with Virginia State guidelines). You also have the right to receive a list of instances where we have disclosed information about you for reasons of treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The office staff can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices described in this notice. If you have any questions or complaints, please contact: Family Life Resource Center Administrative Director, Marie Bradley.

Family Life Resource Center

Acknowledgement of Receipt of **Notice of Privacy Practices**

By signing this form, you acknowledge that Family Life Resource Center has given you a copy of it Notice of Privacy Practices. This notice explains how your counseling information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. FLRC has given me this opportunity to ask any questions about this notice and all my questions have been answered.

_____

Client's Signature or Guardian

_____

Date Signed

Provider Use Only

If the client was not able to sign due to an emergency/health issue or refused signature, please document if the client was given the notice and the reason why the client did not sign below.

Client was given the notice ☐ Yes ☐ No

Reason signature was not obtained:

_____

_____

_____

_____

Signature of Staff Date