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Welcome to Art It Out. Please bring completed intake packet to your initial intake session. Please know that your intake appointment will begin when completed intake information is received.

- ☐ Client Information, pages 1-4
- ☐ Information, Authorization & Consent to Treatment, pages 5-11
- ☐ Parent Collateral Participation, pages 12-13
- ☐ Health Insurance Portability & Accountability Act (HIPAA), pages 14-17
- ☐ Release of Information, page 18
- ☐ Credit Card Form, page 19
- ☐ If divorced, attached Parenting Plan (or both parents sign pages 11, 13 & 17)

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VININGS: 4300 PACES FERRY RD, SUITE 357, ATLANTA, GA 30339

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CHILD CLIENT INFORMATION FORM

**This Form is Confidential*

Child's Name:_____ **Today's date:** _____
Last **First** **MI**

Date of birth: ____/____/____ **Gender:** _____ **Age:** _____

Home street address: _____

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

Current School:_____ **Grade:** _____

Teacher's Name:_____

Parent/Guardian 1 Name: _____
Name of Employer/Occupation:_____
Age: _____ **Does this parent live with the child? Yes No**
Home Phone: _____**Work Phone:** _____
Cell Phone: _____ **Email:** _____

Parent/Guardian 2 Name: _____
Name of Employer/Occupation: _____
Age: _____ **Does this parent live with the child? Yes No**
Home Phone: _____**Work Phone:** _____
Cell Phone: _____ **Email:** _____

Parent(s) are: ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Single ( ) Living together ( ) Other
**** If divorced, please bring a copy of Parenting Plan OR have both parents sign the Informed Consent Document***
Child's legal custodian/guardian is: _____

Is the child adopted? Yes No
If yes, is this the knowledge of the child? Yes No

How did you hear about Art It Out Therapy Center? _____
If referred by another clinician, would you like for us to communicate with one another? Yes No

Who else lives in the home with the child?
_____

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Please describe your current concerns about your child.

_____

_____

_____

_____

How long have you had these concerns?

_____

_____

MEDICAL HISTORY:

Please list all current medications the child is taking.

Name of medication	Dosage	Prescribing Physician/Psychiatrist	Time of day taken

Please list any past medications.

_____

List all childhood illnesses, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____

Previous *medical* or *psychiatric* hospitalizations (Approximate dates and reasons):

_____

_____

Have you and your child ever talked with a counselor, psychiatrist, psychologist, or other mental health professional? YES NO (Please list approximate dates and reasons):

_____

Has the child been given a diagnosis with respect to psychological or developmental concerns? (If yes, please identify and/or describe)?

_____

*** If your child has had a psychological evaluation, please bring a copy of the report.**

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Have you ever received concerning feedback from a teacher regarding your child? If so, what was said?

_____

_____

PLEASE CIRCLE ALL THAT APPLY AND CHECK "NOW" AND/OR "PAST":

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Anxiety			Concentration			Headaches		
Depression			Loss of memory			Nausea		
Mood Changes			Organization			Fainting		
Anger or Temper			Trusting Others			Abdominal Distress		
Panic Attacks			Thoughts of Hurting Others			Shortness of Breath		
Fears			Thoughts of hurting Self			Bed Wetting		
Irritability			Compulsive Behaviors			Sweating		
Excessive Worry			Hyperactivity			Muscle Tension		
Nightmares			Night Terrors			Allergies		
History of Physical Abuse			History of Sexual Abuse			Eating Disorder(s)		

FAMILY HISTORY (check all that apply):

Difficulty with:	Relationship	Difficulty with:	Relationship	Difficulty with:	Relationship
Drug/Alcohol Problems		Physical Abuse		Depression	
Domestic Violence		Sexual Abuse		Anxiety	
Suicide		Hyperactivity		Bipolar Disorder	
Anger or Aggression		Learning Disabilities		Autism	

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BEHAVIOR:

Please list any concerns you have about your child's behavior.

How does your child get along with peers and/or siblings?

List any current stressful events in the family or in the child's life.

DEVELOPMENT:

Please fill in any information you have on the areas listed below. *Only indicate if outside of normal limits.*

Any prenatal (before birth) problems or birth complications?

Please list any problems during infancy or early childhood AND any speech, hearing, or language difficulties.

Any additional information you would like to include:

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INFORMATION, AUTHORIZATION & CONSENT TO TREATMENT

Welcome to Art It Out Therapy Center, LLC. We are very pleased that you selected our facility for your child's therapy, and we sincerely look forward to assisting you. This document is designed to inform you about what you can expect from your child's therapist, policies regarding confidentiality and emergencies, and several other details regarding your child's treatment here at Art It Out Therapy Center. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your child's therapeutic experience. Please know that your relationship with your child's therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding the course of therapy at any time.

THEORETICAL VIEWS & CLIENT PARTICIPATION

The process and duration of therapy is individualized and not the same for everyone. Factors, such as: treatment goals of focus, how fast a client learns and implements skills, motivation to incorporate new skills into one's routine, and the impact of external stressors, may contribute to how long you or your child will benefit from therapeutic intervention. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. Since treatment goals vary from client to client and progress is related to the client's willingness to change, we cannot guarantee results within a given period of time. As a client or client's parent, you are in control and you may end the relationship with your child's therapist at any point. In order for therapy to be most successful, it is important for your child to take an active role. This means working on the things he/she and his/her therapist talk about both during and between sessions. Generally, the more one invests in therapy, the greater the return. It is our intention to empower your child in his/her growth process to the degree that he/she is capable of facing life's challenges in the future without the therapists here at Art It Out Therapy Center**.** We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, the therapist will direct your family to other resources that may be of assistance. Your child's emotional health is our top priority.

COURT & FORENSIC WORK

There is a dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. Our passion is not in forensic work but in providing your child with the best therapeutic care possible. Therefore, by signing this document, you acknowledge that your therapist will be providing therapy only and not forensic services. You also understand that this means your therapist will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities. Furthermore, we discourage sharing confidential client information regarding specific statements by the client for use in court procedures. In our experience this devalues the therapeutic relationship and the trust that the client has in the therapist. If court appearances are required however, please note the fee below.

If you believe it is necessary to subpoena your therapist, you will be responsible for his or her expert witness fees in the amount of $1,500 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time spend over one-half (1/2) day would be billed at the hourly rate of $375 per hour including travel time. By signing this form, you attest that you understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in the therapist withdrawing as your counselor.

ETHICAL STANDARDS

Art It Out Therapy Center assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association; the National Association of Social Workers; and the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Teresa Woodruff, Practice Director, at 770.726.9589 x103. Due to the very nature of therapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you.

SAFETY

For the safety of all our clients, their accompanying family members and children, and our therapists and staff, Art It Out Therapy Center maintains a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, or anything that could be harmful to yourself or others. Art It Out Therapy Center reserves the right to contact law enforcement officials and/or terminate treatment with any client who violates our weapons policy. In addition, per our ethical guidelines, all of our therapists are mandated reporters. If your therapist has any reason to suspect possible child abuse or to suspect that you or your child may hurt him/herself or others, your therapist is required to report to the Georgia Department of Child and Family Services.

TELEMENTAL HEALTH STATEMENT

It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. TeleMental Health is defined as follows:
"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01) TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, our therapists have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

TELEPHONE VIA LANDLINE

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know. *Telephone conversations lasting longer than 10 minutes are billed at your therapist's hourly rate.*

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CELL PHONES

Cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only for purposes of setting up an appointment. Additionally, your therapist may keep your phone number in his/her cell phone, but it will be listed by your initials only and his/her phone is password protected. If this is a problem, please let your therapist know, and you he/she will be glad to discuss other options. *Telephone conversations lasting longer than 10 minutes are billed at your therapist's hourly rate.*

TEXT MESSAGING

Text messaging is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text because it is a quick way to convey information. Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality.

EMAIL

Email is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy. *Please inform your therapist if you do not wish to receive any emails regarding your child or your child's appointment information.*

SOCIAL MEDIA-FACEBOOK, TWITTER, LINKED IN, PINTEREST, ETC

It is our policy not to accept "friend" or "connection" requests from any current or former client on any of our therapist's *personal* social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of your relationship. However, Art It Out has a *professional* Facebook page, Twitter account, Linked In account. You are welcome to "follow" us on any of these *professional* pages where we post therapeutic content, parenting tips, and self-care strategies. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Art It Out, as we cannot control who views these pages. Also, please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

ELECTRONIC TRANSFER OF PHI FOR CERTAIN CREDIT CARD TRANSACTIONS

We utilize Merchant e-Solutions as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used a credit card at our facility, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill.

CONFIDENTIALITY & RECORDS

Both your and your child's communications with the therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your child's PHI will be kept in a file stored in a locked cabinet in our business office. Additionally, your therapist will always keep everything your child says to him/her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that your child is a danger to himself or to others; (3) your child reports information regarding abuse, harm, or neglect or (4) your child's therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what your child says confidential.

EXCEPTIONS TO CONFIDENTIALITY AND PRIVELEDGE

As a mandated reporter in the state of Georgia your therapist is legally obligated to violate confidentiality if he/she has reasonable cause to believe that suspected child abuse has occurred; has reason to suspect that the client is involved in abuse, harm or neglect; and/or if the child is a danger to himself/herself or others (ie. suicidal or homicidal). In the event that your therapist suspects abuse, he/she will file a report with the Department of Family & Child Services (DCFS).

COST OF SESSIONS

- $160: Intake (CPT Code 90791)
- $150: Individual or Family Therapy 50-minute Session (CPT Code 90837 or 90834 with LPC or LCSW)
- $140: Individual or Family Therapy 50-minute Session (CPT Code 90837 or 90834 with LAPC or LMSW)
- $75: Group Therapy 50-minute Weekly Session (CPT Code 90853)

PAYMENT

Payment is due at the time of session. We accept cash, check, credit cards, debit cards, and health savings/flex spending cards. Any outstanding balances over 90 days will be turned over the DCE: Debt Collection Experts: 866.624.2863. By signing this form, you are stating that you understand that your account will be turned over to DCE if your bill is over 90 days due.

Art It Out will provide you with a receipt of payment monthly, emailed to you via an encrypted, HIPAA-compliant method from a GoDaddy program. The email may say it is from "Proofpoint" or "GoDaddy". The receipt of payment may also be used as a statement for insurance if you so choose. *Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement.*

OUT-OF-SESSION SERVICES

We love working with your children and find ourselves busy keeping in touch with other professionals in your child's life. We are happy to make phone calls, emails, and communication with professionals to make sure your child has the best multi-disciplinary treatment and has a caring team of professionals who are all on the same page. The following are our fees for this communication:

- $150 per hour for any communication exceeding 10 minutes in a week between therapist and collateral contacts (including parents, teachers, psychiatrists, school counselors, guardian ad litem, or any other professionals)
- $150 per hour for phone calls, emails and letter-writing exceeding 10 minutes per week
- $200 school observations (duration 35-45 minutes plus travel time)

COURT APPEARANCES

We discourage sharing confidential client information regarding specific statements by the client for use of court procedures. In our experience this devalues the therapeutic relationship and the trust that the client has in the therapist. If you believe it is necessary to subpoena your therapist, you will be responsible for his/her expert witness fees in the amount of $1,500 for one-half (1/2) day to be paid 5 (5) days in advance of any court appearance or deposition. Any additional time spend over one-half (1/2) day would be billed at the hourly rate of $375 per hour including travel time. By signing this form, you attest that you understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in the therapist withdrawing as your counselor.

LATE ARRIVALS

- Therapy sessions are scheduled to be 50 minutes. We understand if traffic and other reasons cause you to be late; however, we still must conclude the session at the scheduled stop time (meaning if you are 10 minutes late, your session will be 40 minutes).

CANCELLATIONS

- Your appointment time is reserved exclusively for you. If you are unable to attend your appointment please notify us by phone.
- We require a full business day's notice for any cancelled appointment.
- Failure to follow cancellation policy will result in being billed full session amount for the time that was reserved for you.
- More than two cancellations (for any reason) per semester in group therapy will result in a $50 charge for additional cancellations.

GROUP THERAPY ATTENDANCE

At Art It Out Therapy Center, it is our mission to provide the highest quality services to our clients in an environment of creativity, compassion and respect. In order to do so, consistent attendance and timely cancellations are needed. For Groups, Art It Out believes that keeping the group small gives each group member the focus that is needed to achieve individual goals and group cohesion that is needed in order to meet the group goals. When you join an Art It Out Social Skills Group, you are paying for a slot in that group. Sporadic attendance, late cancellations and no-shows disrupt the group and negatively effects the other group members' experience. Non-emergency cancellations require 24-hours' notice.

- Non-emergencies include vacations, preplanned medical appointments, school functions, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency". Sessions must be cancelled no later than 24-hours before the appointment. Monday appointments must be cancelled the Friday before the scheduled session.
- Emergency cancellation require notification by 12:00 pm on the day of your scheduled appointment or group. Emergency cancellations are accepted only for illness, illness of a family member or death in the family.

- More than 2 cancellations (emergency and non-emergency) during the semester (August-December/January-May) will result in a charge for the time that was reserved for you. After your 2nd cancellation, you will be billed $50 for each missed group session.

GOING OVER THE SESSION TIME

- The 50-minute therapy session includes the parent-check in at the end (if applicable). Any additional time spent in the therapist's office will be billed at a rate of $140-150 an hour. Once the 50 minutes has been reached, a therapist will inform you and give you the option to continue the conversation (if the therapist has time available) but please note that if you choose to extend the session time, you will be billed at a prorated rate.
- Please pick up your child on time. We are not responsible for unaccompanied children after the scheduled session time.

IN CASE OF AN EMERGENCY

Art It Out Therapy Center is an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
- Call Behavioral Health Link/GCAL: 800.715.4225
- Call 911.
- Go to your nearest emergency room.

PROFESSIONAL RELATIONSHIP

Psychotherapy is a professional service we will provide to your child. Because of the nature of therapy, your relationship (and your child's relationship) with the therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If your child and his/her therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your child's) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your child's needs. This is why your and your and your child's relationship with your therapist must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their clients' secret. As much as your therapist would like to, for your confidentiality he/she will not address you in public unless you speak to him/her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always

maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

STATEMENT REGARDING ETHICS, CLIENT WELFARE & SAFETY

Art It Out Therapy Center assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately.

We are sincerely looking forward to facilitating you and/or your child on his/her journey toward healing and growth. If you have any questions about any part of this document, please ask the therapist. Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of the relationship with your child's therapist/group leader, and you are authorizing the therapist/group leader to begin treatment with your child.

_____

Client Name (Please Print)

(if divorced, separated or applicable)

_____ _____

Parent/Legal Guardian 1 Name (please print) **Parent/Legal Guardian 2 Name (please print)**

_____ _____ _____ _____

Parent/Legal Guardian Signature Date **Parent/Legal Guardian Signature Date**

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

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PARENT COLLATERAL PARTICIPATION

Thank you very much for taking the time to read this authorization form carefully. This document is to inform you about your rights, responsibilities, and risks regarding collateral participation. A "collateral participant," means that **you are here to assist another person (the designated client), but you are not the primary focus of treatment.** Please know that your relationship with us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your collateral participation.

DESCRIPTION OF COLLATERAL PARTICIPATION

The role of a collateral participant can vary greatly. For example, a parent or guardian may continuously be involved in the treatment of a minor. Whereas, a partner or friend may only come in once or twice to help the designated client. We will discuss what role you shall take in the client's treatment during our first session. As mentioned above, we are committed to providing treatment to the designated client, and your participation is adjunct to this treatment. Therefore, our legal and ethical responsibility resides strictly with the designated client. This means the following: (1) What the client tells us is confidential, but what you tell us is not. This isn't to say that we plan to divulge any information that you tell us to the public. However, we will not keep secrets from the client, and your information isn't protected by the same laws as information given by the client. (2) Although your participation as a collateral may help you psychologically, our primary concern is for the client, and treatment will focus on the client's needs. However, we will be glad to give you other resources for your own treatment if necessary. (3) We will keep a clinical record for the designated client only. Any notes taken regarding your participation will go into the client's chart. The client has the right to access her/her chart. Whereas, you do not have the right to access this chart without the client's written permission. *Parents have a legal right to a minor's chart, but not an ethical right.*

PARENTS AS COLLATERAL PARTICIPANTS

Due to the sensitive nature of counseling and the fragile stage of development that your son or daughter is currently experiencing, forming a therapeutic bond with his/her therapist is very critical at this point. It is important that he/she feel safe and comfortable discussing personal and private topics in therapy. In effort to respect the privacy and sensitive needs of your son/daughter, we will not be discussing the content of therapy sessions with you in detail. It is our hope that through the therapeutic process new skills and insights will be gained by your daughter or son so she/he can discuss these sensitive topics with you in her/his own time. If your daughter or son is too young to do this, we will definitely have family meetings to assist in this process. However, if at any time we make the assessment that your son or daughter is in danger or might be dangerous to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of your son/daughter, you will be notified immediately so that the necessary actions and precautions can be taken.

CONFIDENTIALITY & RECORDS

Your communications with us will become part of a clinical record of treatment for the designated client, and it is referred to as the client's Protected Health Information (PHI), protected by both federal and state law. The PHI of the client will be kept in a file stored in a locked cabinet. Additionally, the PHI of the client is confidential, with the following exceptions: (1) the client or guardian directs us to tell someone else and signs a “Release of Information” form; (2) we determine that the client or you are a danger to yourself or to others; (3) the client or you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) we am ordered by a judge to disclose

information. Regarding an order by a judge, our licenses provide us with the ability to uphold what is legally termed "privileged communication." Privileged communication is the client's right to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of the client's private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what the client says confidential. However, you should be aware that if a judge orders the disclosure of your information, we do not have the legal authority to maintain your confidentiality. We only maintain that authority with the designated client. Additionally, it is expected that you will maintain the confidentiality of the client in your role as a collateral participant.

If at any point we, as a team, determine that family therapy is more appropriate than collateral participation, then you will be afforded all the rights to confidentiality that currently reside with the designated client. Please feel free to discuss this with me if you have concerns.

As a parent of a client, you are a "collateral participant" and not the client. Please print, date, and sign your name below indicating that you have read and understand the contents of this document and you agree to the policies stated above.

Parent/Guardian Collateral Participant 1: _____ _____
(Name) (Signature)

Parent/Guardian Collateral Participant 2: _____ _____
(Name) (Signature)

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____
Therapist's Signature **Date**

art it out
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phone: 770-726-9589 ▫ fax: 404-996-1299

East Cobb
255 Village Pkwy, Suite 580
Marietta, GA 30067

Vinings
4300 Paces Ferry Rd, Suite 357
Atlanta, GA 30339

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

Updated 5/2018

I. COMMITMENT TO YOUR PRIVACY: Art It Out, LLC is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that Art It Out, LLC maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, Art It Out, LLC is required to ensure that your PHI is kept private. This Notice explains when, why, and how Art It Out, LLC would use and/or disclose your PHI. Use of PHI means when Art It Out, LLC shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when Art It Out, LLC releases, transfers, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, Art It Out, LLC may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, Art It Out, LLC is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by Art It Out, LLC. Please note that Art It Out, LLC reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that Art It Out, LLC has created or maintained in the past and for any of your records that Art It Out, LLC may create or maintain in the future. Art It Out, LLC will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of Art It Out, LLC's Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: Art It Out, LLC will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: Art It Out, LLC may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, Art It Out, LLC may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, Art It Out, LLC will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: Art It Out, LLC may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - Art It Out, LLC may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that Art It Out, LLC is in compliance with applicable practices and laws. It is Art It Out, LLC's practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.

3. To Obtain Payment for Treatment: Art It Out, LLC may use and disclose your PHI to bill and collect payment for the treatment and services Art It Out, LLC provided you. Example: Art It Out, LLC might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. Art It Out, LLC could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Art

It Out, LLC's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Art It Out, LLC will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to Art It Out, LLC by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use
or disclosure of your PHI, Art It Out, LLC will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of Art It Out, LLC.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – YOUR NAME may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, Art It Out, LLC may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Art It Out, LLC may make a disclosure to the appropriate officials when a law requires Art It Out, LLC to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** Art It Out, LLC may disclose information about you to respond to a court or administrative order or a search warrant. Art It Out, LLC may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. Art It Out, LLC will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** Art It Out, LLC may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** Art It Out, LLC may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** Art It Out, LLC may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if Art It Out, LLC determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Art It Out, LLC may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), Art It Out, LLC may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** Art It Out, LLC may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Art It Out, LLC has a reasonable suspicion of child abuse or neglect, Art It Out, LLC will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** Art It Out, LLC may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Art It Out, LLC may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** Art It Out, LLC may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you

identify, relevant to that person's involvement in your care or payment related to your care. In addition, Art It Out, LLC may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. **Military and Veterans:** If you are a member of the armed forces, Art It Out, LLC may release PHI about you as required by military command authorities. Art It Out, LLC may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** Art It Out, LLC may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, Art It Out, LLC may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
13. **For Research Purposes:** In certain limited circumstances, Art It Out, LLC may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**
Art It Out, LLC may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** Art It Out, LLC is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** Art It Out, LLC may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess Art It Out, LLC's compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, Art It Out, LLC will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying Art It Out, LLC in writing of your decision. You understand that Art It Out, LLC is unable to take back any disclosures it has already made with your permission, Art It Out, LLC will continue to comply with laws that require certain disclosures, and Art It Out, LLC is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in Art It Out, LLC's possession, or to get copies of it; however, you must request it in writing. If Art It Out, LLC does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from Art It Out, LLC within 30 days of receiving your written request. Under certain circumstances, Art It Out, LLC may feel it must deny your request, but if it does, Art It Out, LLC will give you, in writing, the reasons for the denial. Art It Out, LLC will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than $.25 per page and the fees associated with supplies and postage. Art It Out, LLC may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that Art It Out, LLC limit how it uses and discloses your PHI. While Art It Out, LLC will consider your request, it is not legally bound to agree. If Art It Out, LLC does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that Art It Out, LLC is legally required or permitted to make.

3. The Right to Choose How YOUR NAME Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Art It Out, LLC is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that Art It Out, LLC has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period.

Art It Out, LLC will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information

disclosed, and the reason for the disclosure. Art It Out, LLC will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that Art It Out, LLC correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of Art It Out, LLC's receipt of your request. Art It Out, LLC may deny your request, in writing, if it finds that the PHI is: (a) correct and complete,

(b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than Art It Out, LLC denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and Art It Out, LLC's denial will be attached to any future disclosures of your PHI. If Art It Out, LLC approves your request, it will make the change(s) to your PHI. Additionally, Art It Out, LLC will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to Art It Out, LLC's Director, Teresa Woodruff, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision Art It Out, LLC made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. Art It Out, LLC will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature below indicates that you Acknowledge receipt of this Notice:

Client Name	**Parent/Guardian Name**	**Parent/Guardian Signature**	**Date**

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your or your child's therapy, and you believe it would be helpful for your therapist to contact them regarding treatment, please read carefully and complete this document. The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you (or your child) as the client. Please provide the necessary information and your signature with today's date as indicated below.

****

CLIENT'S NAME: _____

I, _____ **(client's guardian),** hereby authorize Art It Out Therapy Center's therapists and the following party or parties to discuss my/my child's mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, child's diagnosis.

Stepparent(s): _____ Phone: _____

School Counselor: _____ Phone: _____

Physician/Pediatrician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Other (nanny, grandparent, etc): _____ Phone: _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please list any limits to this communication: _____

_____

Date this Release may expire (if applicable): _____

Additionally, the above-named parties, therapist & person(s) or entity (entities) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality. Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by Art It Out at 255 Village Pkwy, Suite 580, Marietta, GA 30067 to be effective.

Parent's/Legal Guardian's Signature:_____ Date: _____

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255 Village Pkwy, Suite 580
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Atlanta, GA 30339

Payment Consent Form

All Art It Out clients are required to have a credit/debit card on file. Client must designate the first and the second card for payments. Any deviation from this payment process must be handled prior to end of client session by client paying online or paying in the office. All cards on file may be used to pay outstanding balances if other card is declined. Art it Out will not take responsibility to split payments or coordinate payments between parties. In the event that a credit card is declined or we are unable to secure payment from the paying party, either parent may be notified.

Client Name _____

PAYMENT METHOD #1 Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Last *First*

Card Holder Address _____
Street *City* *State* *Zip*

Card Number _____ _____ _____ _____

Expiration Date _____/_____ **CVV** _____

IF PAYMENT METHOD #1 IS A FLEXIBLE SPENDING CARD OR HEALTH SAVINGS CARD, A SECONDARY PAYMENT METHOD MUST BE PROVIDED.

PAYMENT METHOD #2 Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Last *First*

Card Holder Address _____
Street *City* *State* *Zip*

Card Number _____ _____ _____ _____

Expiration Date _____/_____ **CVV** _____

A 24 hour notice is required for all cancellations or you will be charged for the time which was reserved for you.

_____ _____
Signature Date