Shirley Shani Ben-Zvi, MFT Intern
1755 Woodstock Road Suite 200
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

Today's Date _____

Client's Name _____ Date of Birth _____

Parent/Guardian's Name (if applicable) _____ Relationship _____

Home Address _____ City _____ Zip Code _____

May I send information to this address? ❑Yes ❑ No

If No, please provide an address where information can be mailed: _____

_____

Home Phone Number _____ May I contact you at this number? Yes ❑ No ❑ Disguised

Cell Phone Number _____ May I contact you at this number? Yes ❑ No ❑ Disguised

Work Phone Number _____ May I contact you at this number? Yes ❑ No ❑ Disguised

Education Level Completed _____ Occupation _____

Person to notify in case of emergency _____ Phone _____

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: _____

Referred by _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

How many sessions do you anticipate to address these concerns?

1-5 6-10 11-20 20+ I don't know

FAMILY INFORMATION

Are you currently in a relationship? ❑ Yes ❑ No If yes: ❑ Married ❑ Partnered

How long in current relationship? _____ Any previous significant relationships? ❑ Yes ❑ No

Please list all the people that live in your household and your relationship to them:

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Please list any family members who do not live in your house, but are important to you:

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered from the following:

❑ Depression Who? _____

❑ Anxiety Who? _____

❑ ADHD Who? _____

❑ Bipolar Disorder Who? _____

❑ Schizophrenia Who? _____

❑ Other Who/What? _____

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

_____

Current Medications	Indication	Dosage	Frequency	Side Effects

Please include over-the –counter medications and vitamins

_____

_____

_____

_____

Past Medications	Date(s)	Indication	Dosage	Side Effects

_____

_____

_____

_____

Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how much per day? _____

Do you consume caffeine? ❑ Yes ❑ No If yes, how much per day? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much per day/week/month? _____

Do you use any illicit drugs? ❑ Yes ❑ No If yes, which? _____

Do you exercise? ❑ Yes ❑ No If yes, how often? _____

PSYCHIATRIC HISTORY

Have you ever talked with a mental health professional before today? ❑ Yes ❑ No

If yes: Date(s) Type of Treatment Reason Professional Seen

_____

_____

_____

Would you like me to contact any of your previous providers? ❑ Yes ❑ No

If yes, please provide their contact information _____

_____

_____

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues? ❑ Yes ❑ No

If yes, please describe briefly: _____

_____

Are you currently involved in any lawsuits, custody battles, or other legal battles? ❑ Yes ❑ No

Is therapy part of any court mandated requirement that you are required to complete? ❑ Yes ❑ No

BEHAVIOR CHECKLIST

Please mark if you have had difficulty with any of the following currently or in the past:

Mental Health Symptoms

Anxiety	current	past	Time of first onset _____
Depression	current	past	Time of first onset _____
Mood Changes	current	past	Time of first onset _____
Anger/Temper	current	past	Time of first onset _____
Panic	current	past	Time of first onset _____
Fears	current	past	Time of first onset _____
Irritability	current	past	Time of first onset _____
Concentration	current	past	Time of first onset _____
Loss of Memory	current	past	Time of first onset _____
Excessive Worry	current	past	Time of first onset _____
Feeling Manic	current	past	Time of first onset _____

Trusting Others	current	past	Time of first onset _____
Drugs	current	past	Time of first onset _____
Alcohol	current	past	Time of first onset _____
Frequent Vomiting	current	past	Time of first onset _____
Eating Problems	current	past	Time of first onset _____
Severe Weight Gain	current	past	Time of first onset _____
Severe Weight Loss	current	past	Time of first onset _____
Sleeping Too Much	current	past	Time of first onset _____
Sleeping Too Little	current	past	Time of first onset _____
Nightmares	current	past	Time of first onset _____
Head Injury	current	past	Time of first onset _____
Speaking w/o Thinking	current	past	Time of first onset _____
Completing Tasks	current	past	Time of first onset _____
Waiting your turn	current	past	Time of first onset _____
Paying Attention	current	past	Time of first onset _____
Easily Distracted	current	past	Time of first onset _____
Hyperactivity	current	past	Time of first onset _____
Making Careless Mistakes	current	past	Time of first onset _____
Fidgeting	current	past	Time of first onset _____

Relationships

With people in general	current	past	Time of first onset _____
Parents	current	past	Time of first onset _____
Current relationship	current	past	Time of first onset _____
Friends	current	past	Time of first onset _____
Coworkers	current	past	Time of first onset _____
Employer	current	past	Time of first onset _____
Finances	current	past	Time of first onset _____
Legal Problems	current	past	Time of first onset _____
Sexual Problems	current	past	Time of first onset _____

History of Child Abuse	current	past	Time of first onset _____
History of Sexual Abuse	current	past	Time of first onset _____
Domestic Violence	current	past	Time of first onset _____
Homicidal Thoughts	current	past	Time of first onset _____
Suicidal Thoughts	current	past	Time of first onset _____

Physical Symptoms

Increased Stress	current	past	Time of first onset _____
Fainting	current	past	Time of first onset _____
Dizziness	current	past	Time of first onset _____
Diarrhea	current	past	Time of first onset _____
Headaches	current	past	Time of first onset _____
Shortness of Breath	current	past	Time of first onset _____
Chest Pain	current	past	Time of first onset _____
Lump in Throat	current	past	Time of first onset _____
Sweating	current	past	Time of first onset _____
Heart Palpitations	current	past	Time of first onset _____
Muscle Tension	current	past	Time of first onset _____
Pain in Joints	current	past	Time of first onset _____
Allergies	current	past	Time of first onset _____
Chills	current	past	Time of first onset _____
Hot Flashes	current	past	Time of first onset _____

Any additional information that you would like to include _____

_____

_____

_____

_____

Shirley Shani-Ben-Zvi, MFT Intern
1755 Woodstock Road Suite 200
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

INFORMED CONSENT

The following contains important information about the professional services provided by Shirley Shani Ben-Zvi. This document is designed to inform you about what you can expect from me regarding my understanding of therapy, confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is a part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Should we choose to enter into a therapeutic relationship, please know that it is a collaborative experience and I welcome any questions, comments, or suggestions at any time. By you signing this document we enter into an agreement that allows me, Shirley Shani Ben-Zvi, to provide therapeutic services to you.

Background Information

I received my undergraduate Bachelor Arts degree in Psychology from Tel Aviv University in 2000, became an NLP Master practitioner in 2007, and am a student in the Masters of Arts in Marriage and Family Therapy program at NorthCentral University of Arizona, with Medical Family Specialty. I have been providing therapeutic services to adolescents, families and social support groups as part of my studies since 2018. My professional experiences include a suicide prevention online hotline, emotional support in a veterinarian hospital, independent work as an NLP Master Practitioner, and grief work. I am currently contracted with Cornerstone Family Services (CFS) to provide outpatient mental health counseling services under the direction and supervision of Jennifer D. Vann MS, LMFT, owner of Cornerstone Family Services. I also receive supervision from Dr. Kara McDaniel, LPC, NCC, BC-TMH and take part in a supervision group in my school, led by a clinical faculty member.

Theoretical Views and Client Participation

I believe that a therapeutic relationship is based on a collaborative partnership between my clients and me. You are unique and so are your goals and your journey toward them. I am an incurable optimist and believe that we all have all the resources we need to be our best selves. In our sessions, I want to create a safe environment for you to set your own goals, express your best hopes and explore them with me. I work systemically from an integrative approach combined primarily from solution-focused, collaborative and narrative therapeutic techniques, focusing on your strengths. However, I will incorporate interventions from additional modalities as I see fit, adjusting them to your needs. I believe that it is my job as a therapist to see you as your exceptional best self, even when you don't. It is important to me that you to share your feedback around questions which you feel uncomfortable with. If you are unsatisfied with the direction of therapeutic services, I ask that you share your thoughts with me, so we can explore them together. I am honored to be allowed to walk part of your journey by your side.

Services Provided

During your first session, I will speak with you about the reasons that you scheduled your first appointment. If you are seeking therapy for your minor child, I require that I meet with the parent(s)/guardian(s) alone as well as the young child

during the first session. Finding the right fit for your treatment is an important part of the therapeutic alliance. It may take several sessions for you and I to determine if I am the therapist best suited to work with you. If at any point there is need for a referral to be made to a therapist who better fits your needs, I will provide contact information for at least 3 alternative treatment providers. I encourage you to interview several therapists to find the best fit for you/your family. Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. Please note that when working with children, the therapeutic process typically takes longer and is slower. Children need to feel comfortable with the therapist with whom they are working and processing significant issues require high levels of trust and safety.

If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

Working with Children

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in risky/dangerous behavior I will immediately inform you of the situation, or have your child do so as part of the therapeutic process. My definition of "risky/dangerous behavior" includes, but is not limited to: self harm or suicidal ideation, homicidal threats, threats of running away, any use of hard drugs, prolonged use of soft drugs, and unprotected sex. I will regularly update you on your child's progress and I encourage you to contact me as frequently as you feel is needed. I will not provide you updates after each session, however if you need to speak with me about your child's behavior please call prior to their weekly session or arrange a time to come in and speak with me. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. I am sensitive to a parent's needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process.

Risks

Given the work required for personal growth and change to occur, therapy may involve some risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns. There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

Confidentiality

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation. It may be imperative to my therapeutic relationship with a child or adolescent not to reveal the information disclosed to me in session to their parents/guardians. It is important that all parties involved in the therapeutic process are clear on our communication expectations. It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

1) When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
2) Therapists are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
3) When a judge orders that information be disclosed. I can not guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
4) When Homeland Security requests information, according to the Patriot Act.

Waive right to subpoena

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by "a licensed…marriage and family therapist… during the psychotherapeutic relationship." If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs. If, for any reason, I am required to participate in court proceedings my regular hourly fee will be applied from door to door. In addition, I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at $125 per hour.

Please note that in couple's therapy, I do not agree to keep secrets. Information disclosed in any context may be discussed with either partner.

Clinical Diagnosis for Insurance Purposes

Many clients decide to seek reimbursement for services through their insurance company. While I do not accept any forms of insurance directly, I am willing to provide you a "superbill" with information that will help you seek reimbursement from your insurance company. Please be advised that most insurance companies require a diagnosis in order for reimbursement to occur. Any diagnosis submitted to an insurance company will become a part of you/your child's permanent medical record. Please check with your insurance provider regarding the details of your insurance plan and network billing requirements.

Methods of Communication

The best way to contact me for any reason is by phone at 770-910-2753. I am unable to accept email at this time. Because I cannot guarantee the security of incoming and outgoing information, email is not considered a secured form of communication and therefore not protected by HIPAA.

Social Media

I am restricted by the Code of Ethics by which I abide from entering into dual relationships with clients except in very limited circumstances where these relationships would be beneficial to you. "Dual relationship" means any relationship outside of our therapeutic relationship. To abide by this code, I am not able to accept any requests to friend, like, or otherwise connect via the web or social media sites such as Facebook, LinkedIn, and Twitter.

Protecting Your Privacy

To protect your privacy, if we happen to see each other outside of session I will not initiate contact (e.g. say hello, indicate we know one another) unless you choose to do so first.

Supervision

Supervision helps to ensure that you and your family are receiving the best of care and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved supervisor to oversee cases that I feel the need to seek guidance on. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information. If you have any questions about this process you are encouraged to ask them at any point during your time in therapy. Director and Supervisor Jennifer D. Vann MS, LMFT and Supervisor Dr. Kara McDaniel, LPC, NCC, BC-TMH.

Internship

In addition to said supervision and as part of my internship, I attend weekly group supervision with Northcentral University. These groups are held by a faculty member. This group is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information.

Fees- Policy Applies to appointments scheduled outside of regular group sessions

Individual or family Clients seen by Shirley Shani Ben Zvi, MFT Intern, agree to pay $30.00 per 45-50-minute session. Services will be provided by Shirley Shani Ben Zvi, MFT Intern, at Cornerstone Family Services, LLC. Any services beyond the standard 45-50 minute session, such as phone consultation exceeding 20 minutes, excessive paperwork, attending school meetings or court appearances/preparation, will incur additional fees as listed above. Shirley Shani Ben Zvi reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. I will be happy to provide you with a receipt for payment. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

Group session clients seen by Shirley Shani Ben Zvi, MFT Intern, agree to pay $25.00 per 85-90-minute group session. Services will be provided by Shirley Shani Ben Zvi, MFT Intern, at Cornerstone Family Services, LLC. Any services beyond the standard 85-90 minute session, such as phone consultation exceeding 20 minutes, excessive paperwork, attending school meetings or court appearances/preparation, will incur additional fees as listed above. Shirley Shani Ben Zvi reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. I will be happy to provide you with a receipt for payment. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

Insurance companies have many rules and requirements specific to certain plans. If you choose to file with your insurance company for reimbursement, it is your responsibility to understand their policies and requirements for reimbursement. I will be glad to provide you with a statement for your insurance company provided you sign a written release of information giving me permission to do so.

Cancellations- Policy Applies to appointments scheduled outside of regular group sessions

You are expected to attend all scheduled sessions with your therapist. I understand that “life happens” and that unexpected interruptions occur particularly with children and adolescents, but I do expect you to make therapy a priority. If you need to cancel your appointment please call NO LATER THAN 24 HOURS PRIOR to your scheduled appointment. You will be charged $50.00 for appointments cancelled with less than 24 hours notice. Cornerstone Family Services requires

all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you "no show" or cancel your appointment without 24-hour notification the $50.00 cancellation charge will be charged to your card. Please note that insurance companies do not reimburse for missed appointments.

Any files that have no activity for a period of 3 months will be considered closed.

Upon my permanent incapacitation or death

In case of any personal emergency when I am unable to contact my clients, I have designated my director and supervisor Jennifer D. Vann MS, LMFT to have access to my client's first name(s) and contact information only. Your contact information is kept in a secure location on the premises of Cornerstone Family Services and only my designee has access to it. Again, this is only your contact information. No other information is available except as noted in the paragraph below.

In case of my death or permanent incapacitation Jennifer D. Vann MS, LMFT has agreed to abide by my confidentiality statement (listed in this informed consent) and will become the sole owner of all case files held in my possession at that time. Any dissemination of information from those files will then be at the discretion and clinical judgment of Mrs. Vann MS, LMFT. Upon my permanent incapacitation Mrs. Vann MS, LMFT may be contacted at 770-910-2753.

Emergencies

Shirley Shani Ben-Zvi, MFT Intern does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24-hour availability. Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one of more of the following:

1) Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589 2) Call 911
3) Go to the emergency room of your choice
4) Cobb County Mental Health Crisis Line 770.422.0202
5) Fulton County Mental Health Crisis Line 404.730.1600

Ethical Considerations

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. I make it a priority to be familiar with the AAMFT Code of Ethics and to structure my practice to follow those guidelines. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia Association for Marriage and Family Therapy and the American Association for Marriage and Family Therapy, both which govern my profession.

In order to maintain ethical standards, I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

Please keep the above information for your record. Return only this page.

Consent to Treatment

By signing below, you agree that you have read (or have had read to you) all of the above sections of the informed consent form and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

If Applicable:

_____ _____

Signature (Client/Parent/Guardian) Date Minor's Name

_____

Signature Date

_____

Signature Date

_____

Signature Date

Initial here:

_____ I have read & understand the "Working with Children" section.

_____ I have read & agree to the "Waive Right to Subpoena" section.

_____ I have read & agree to the "No Secrets" policy.

_____ I have read & understand the "Cancelation" section.

Shirley Shani Ben-Zvi, MFT Intern
1755 Woodstock Road Suite 200
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

CREDIT CARD POLICY

I am hereby entering into a contract for Shirley Shani Ben-Zvi, MFT Intern's professional time and services when I set an appointment. I understand that by entering this contract for Shirley Shani Ben-Zvi's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Mrs. Abney's cancellation policy requires 24 hours advance notice in order to be released from the contract for her time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24 hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of $50.00. I hereby authorize Cornerstone Family Services to charge the following card if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment.

Visa / Mastercard / Discover (please circle)
Credit card number_____
Expiration date_____ CVV code (last 3 digits on the back of the card)_____
Zip code to which billing statement is mailed_____
Name on credit card _____

I have read and understand the above credit card policy for services provided by Shirley Shani Ben-Zvi, MFT Intern through Cornerstone Family Services. Please have all consenting adults sign below.

_____ _____
Signature Date

_____ _____
Signature Date

Shirley Shani Ben-Zvi, MFT Intern
1755 Woodstock Road, Suite 200
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

PRIVACY PROTECTION NOTICE

Please keep these pages for your records

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect April 15, 2011 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on a client's behalf. (Please note that we do not file insurance for clients at Cornerstone Family Services, LLC.)

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The use of your protected health information refers to activities my office conducts for scheduling appointments, keeping records and other tasks within my office related to your care.

Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care. Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as "Business Associates." I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your correspondence sent to your home address so I will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;

 • The right to an accounting of non-authorized disclosures of your protected health information;

- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified.

VI. Complaints

Jennifer D. Vann, MS, LMFT is the appointed "Privacy Officer" for Cornerstone Family Services, LLC per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 1755 Woodstock Rd Roswell GA, 30075 or by phone at 770-910- 2753. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Shirley Shani Ben-Zvi, MFT Intern

Shirley Shani Ben-Zvi, MFT Intern
1755 Woodstock Road, Suite 200
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

RECEIPT OF PRIVACY NOTICES

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____

Client Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

Shirley Shani Ben-Zvi, MFT Intern
Cornerstone Family Services, LLC
1755 Woodstock Road Suite 200 Roswell GA 30075 770-91-2753

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Phone Number:_____

___OK to leave message with detailed information

___Leave message with name & call back number only

___ Do not leave messages at home number

___ Do not call me at home

Work Phone Number:_____

___OK to leave message with detailed information

___Leave message with name & call back number only

___ Do not leave messages at home number

___ Do not call me at work

Cell Phone Number: _____

___OK to leave message with detailed information

___Leave message with name & call back number only ___ Do not call me at this number.

Written Communication

___ OK to mail to my home address

___ OK to mail to my work/office address ___

_____ _____

Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

Informed Consent

General Information

This Informed Consent document supplements the regular informed consent you have already been given by this treatment facility.

You are receiving therapeutic services from a therapist who is currently enrolled in a marriage and family therapy training program at Northcentral University (NCU). NCU is an education and research institution and provides both standard and advanced education and training in marriage and family therapy (MFT). Our goal is to provide guidance and support through supervision of all trainees as they offer consistent and professionally competent services for their clients. To accomplish this goal, we routinely use video recording and direct supervision through secure online video conferencing, including review of video recordings of therapy sessions. Video recording, supervision, and consultation are standard practices in MFT training and education throughout the profession, and are used to assist the therapist in improving skills and in planning for future sessions. Just as importantly, these tools help us, the therapist's clinical supervisors, ensure that you are receiving the best possible care.

As a research institution, we are interested in finding out how therapy benefits families such as yours. Your therapist's case notes and video recordings may be used as one basis for possible future research to better understand the therapeutic process, which may benefit you and others in similar situations. You and/or members of your family may be asked to fill out questionnaires before you begin therapy and then again later in therapy. Please know that if any of this material should be used in a research project, you will not be personally identified in any way. You should also know that all research at Northcentral University is reviewed by the Institutional Research Board to ensure that the ethical rights of clients are properly respected and protected.

Video recordings are treated in a way to ensure that they remain confidential. They are not shared in any way not specifically addressed in this Informed Consent. We hope this information helps you understand our method of operation and the reasons behind it. Do not hesitate to ask questions or discuss any part of our procedures with your therapist. You may also contact the MFT Director of Clinical Training at Northcentral University at 888-628-6911 ext. 8154, or via email at mft@ncu.edu, if you have any additional questions.

Confidentiality

Your case records, including videotapes, will be kept confidential and private unless disclosure is authorized or required by law. Within the limits of this confidentiality agreement, your therapist may discuss and review your case information with a local supervisor, and with a supervising faculty member and a supervision group at Northcentral University. All NCU supervisors and participants in the supervision group have committed to uphold the MFT professional standard of confidentiality. Additionally, every possible effort is taken by your therapist to limit the disclosure of any identifying information. All supervisors and therapists who are granted access to this confidential material are bound by the same ethical standards of confidentiality as your primary therapist. Your treatment facility's primary informed consent will provide you with information about other limits to confidentiality as set forth in your state laws.

Consent

I voluntarily consent to receive therapy services or have my child accept services provided by Shirley Shani-Ben Zvi. I understand that my therapist is a marriage and family therapist in training under the supervision of clinical faculty. I further understand that Northcentral University is a teaching program.

I understand the purpose and potential benefit of questionnaires, videotaping, and supervision of my therapy services, and I voluntarily consent and agree to their use.

I understand that this consent to services will be valid and remain in effect as long as I attend therapy sessions unless revoked by me in writing, with written notice provided to my therapist. If I have any questions or concerns now or in the future, I understand that I should consult with my therapist or the MFT Director of Clinical Training at NCU (928-541-8186).

I certify that this form, including the statements on the limits of confidentiality, has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I certify that I have legal authority to give consent for the treatment of all minor children that are included in therapy.

Date

X

Signature of Client or Other Legally Authorized Person | Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person | Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person | Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person | Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person | Print Name and Relationship to Client

RELEASE AND PERMISSION TO TAPE

Video and audio recordings are routinely used at Northcentral University to help us ensure the quality of services our students provide you, their client(s). It is necessary for us to have your written permission to use these electronic helpers. Should you refuse permission, you should be aware that our student must still make written and/or verbal case reports on all clients to their clinical supervisor. If you refuse to allow our student to discuss your case with his/her clinical supervisor, our student will be unable to provide treatment for you.

I (We), the undersigned, do consent to the video and/or audio recording of my (our) therapy sessions. This consent is being given in consideration of the professional services being rendered by the intern to me at this facility. I (We) understand that I (we) may request the recording to be turned off or erased at any time during the session. I (We) understand that the recording may be reviewed by my therapist's clinical supervisor and by other advanced therapy interns. I (We) are aware that the clinical supervisor and others who may listen to these sessions are bound by the same rules of confidentiality as my therapist and that the purpose of these recordings is to ensure the quality of care that I (we) receive. These recordings will be stored in a manner to ensure their security and my confidentiality, and they will be destroyed at the earliest time that they are no longer needed.

I (We), the undersigned, acknowledge that the purpose and value of taping has been fully explained to me (us) and that my (our) consent to such taping is given freely and voluntarily.

_____	_____
Name	Date
_____	_____
Name	Date
_____	_____
Name	Date
_____	_____
Name	Date
_____	_____
Name	Date