Coastal Haven Counseling, LLC

220 Ronnie Ct Suite 2 Myrtle Beach, SC 29579
3100 Dick Pond Rd Ste D Myrtle Beach, SC 29588
3723-C Forestbrook Rd Myrtle Beach, SC 29588

(843) 945-0346

Hours of Availability: 8am-9pm M-F, 8am-5pm Sat-Sun all by Appointment

PROFESSIONAL DISCLOSURE STATEMENT & CONSENT FOR TREATMENT

Welcome to Coastal Haven Counseling, LLC and thank-you for choosing to enter treatment with us. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, billing, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and healthcare operations. The Notice is attached to this agreement and explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information during this session. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it or if you have not satisfied any financial obligations that you have incurred. TYPES OF CLIENTS SERVED: Adults, children and families and couples in an outpatient setting.

THEORETICAL APPROACHES TO COUNSELING USED:

- Cognitive Behavioral Therapy is utilized to change unhealthy thinking patterns and behaviors and develop an awareness of the connection between a person's thoughts, feelings and actions.
- Solution-Focused Brief Therapy may be utilized to provide strength-based counseling focusing on the present and future to obtain goal achievement over a shorter term.
- Existential Therapy may also be utilized to focus on resolving inner conflict in relation to making sense of an individual's human existence.
- Body-oriented models such as Somatic Experiencing may be utilized to encourage harmony of spirit, body, and mind after a traumatic experience or chronic stress.

EDUCATION AND TRAINING OF COUNSELORS:

Sandra Quast MA, LPC

- M.A. Counseling, Webster University, 12/2014, LPC License #6522
- Certified Career Coach- Center for Executive & Career Coaching 2011
- B.A. Communications, William Paterson University, 5/2007

Jill Anderson MA, LPC

- M.A. Professional Counseling, Liberty University, 12/2008, LPC License #6063
- Certified Clinical Trauma Professional, IATP
- B.A. Communications, Catawba College, 6/1897

Jennifer McGonigal BA, LPC

- M.A. Mental Health Counseling, Webster University, 1996, LPC 2/2009, LPC Lic #5014
- B.A. Psychology, Indiana University of Pennsylvania, 1992

Michael Pickett MA, LPC

- M.A. Mental Health Counseling, Webster University, 1999, License #4576
- B.A. English, University of South Carolina, Columbia, SC 1996

Sheena Gaddis MA, LISW-CP

- M.A. Social Work, Fayetteville State University, 5/2008, LISW-CP License #12344
- B.S. Criminal Justice, Fayetteville State University, 5/2004

Wendy Talbert MEd, LPC

- Master of Education in Counselor Education, University of SC, 1991, License # 3981
- B.S. Elementary Education, Frances Marion, 1985

L. Chad Robinette, LISW-CP

- Certified Addictions Counselor, 2018, LISW-CP, License #10285
- Master of Social Work, University of SC, 2012

David Murray MA, LPC

- M.A. Mental Health Counseling, Liberty University, 2013, LPC License #6494
- Masters of Business, Winthrop University, Rock Hill, SC 1997

- BS of Business Admin, The Citadel, Charleston, SC

Debbie Jackson MSW, LISW-CP
- Master of Social Work, WV University Morgantown, 1993, LISW-CP License #12080
- B.A. Social Work, The University of Akron, 1990

Andrew Michaels MA, LPC
- M.S. Mental Health Counseling, Long Island University/CW Post, 2015, LPC License #7232
- B.A. Psychology, SUNY, 1984

Lindsey McFarland, MSW, LISW-CP
- M.S. Masters in Social Work, University of Louisville, LISW-CP License #11999
- B.A. Psychology & Sociology Western Kentucky University 5/2003 Bowling Green, KY

Veronica Seitzinger, MSW, LISW-CP
- M.S. Masters in Social Work, University of Louisville, LISW-CP License #11999
- B.A. Psychology & Sociology Western Kentucky University 5/2003 Bowling Green, KY

Gloria Burgess, MEd, LPC, LPCS
- M.Ed. Clinical Counseling The Citadel Charleston, SC 1990, LPC License #1722, LPCS License # 2522
- B.S. Psychology, Charleston Southern University 1988

SERVICES: Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to make changes in one's life. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. As your therapist, we have corresponding responsibilities to you. These respective rights and responsibilities are described in the following section. Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However psychotherapy has been shown to have benefits for individuals who undertake it such as reduction in experience of discomfort and increased satisfaction in interpersonal relationships, greater interpersonal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about outcomes. Psychotherapy requires active effort on your part. In order to be the most successful, you will have to work on things that we discuss outside of sessions. The first session and possible few subsequent sessions will involve a comprehensive assessment of your needs. We will then be able to offer some initial impressions of what our work might include. At that point we will discuss your treatment goals and create an individualized treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with us. Therapy involves a commitment of time, money and effort so you should be careful about the therapist that you select. We will discuss any questions you have about interventions or procedures as they arise.

APPOINTMENTS: We normally conduct an initial assessment that will last for one to two sessions. During this time we will decide if we are the best fit to provide the services you need in aiding you to meet your treatment goals. This initial assessment session lasts approximately 50-60 minutes. After assessments has been completed, we usually schedule individual and/or family sessions for 50-60 minutes. Clients are generally seen weekly or more or less frequently as needed or agreed upon as medically necessary. You may discontinue treatment at any time. The time scheduled for your appointment is assigned to you and you alone. We request that you provide 24 hours of notice if you must cancel or reschedule a session. You will be charged the full appointment fee for a missed appointment if not cancelled within 24 hours for BCBS and self pay clients. It is important to note that insurance companies do not provide reimbursement for missed sessions. You are responsible for attending appointments on time, and if you are late, your appointment will still likely need to end on time.

TERMINATION OR REFERRAL: A client has the right to terminate services at any time by notifying us by phone or by mail, anytime for any reason. This can be done verbally or in writing. When additional counseling is needed, a referral can be made, upon request. The therapist may terminate sessions with a client if: Client is not progressing, If clients missed 3 sessions, If the therapist feels they are at risk of harm, If the client's needs are outside of the scope and specialty of the therapist, For non-payment of services in a prompt manner.
GREIVANCE AND COMPLIANT CONTACT: South Carolina Dept of Labor, Licensing & Regulation 110 Centerview Dr. P.O. Box 11329 Columbia, SC 29211-1329 Telephone: (803) 896-4470 Fax: (803) 896-4656
PROFESSIONAL RECORDS: We are required to keep appropriate records of therapy services that we provide. Your clinical file consists of legal forms such as this form and your HIPAA notification form, a record of visits and payments, assessment results, individual plan of care, progress summaries, and copies of electronic communications and progress notes. These progress notes will contain enough information about you to justify treatment or support recommendations. Psychotherapy often includes discussion of sensitive and private information. Case notes include what was done in session and an accounting of treatments utilized and topics discussed. You have a right to look at your chart contents, and copies will be made available to other providers with your written consent for a fee. Your records will be maintained in a secure location in our offices. In the event of the death or incapacitation of Sandra Quast, owner of Coastal Haven Counseling, LLC, her Professional Executor as stated in her Professional will within Therapynotes.com EMR, may take control of records and contact clients to make referrals for your benefit.

FEES: Currently our standard fees are as follows: An initial clinical assessment is $160. Individual or family sessions lasting 50-60 minutes are charged $120 per session. All payments are due at the time services are rendered and can be by credit card (Visa, MasterCard, Discover or American Express) or HSA. There will be a $35.00 fee for checks that are returned for insufficient funds. If you need your therapist to attend court related to yourself or your child/foster child there will be a fee of $300 per hour which will be from the time the therapist leaves the office until they are able to return to the office that will be charged for this service. This is not a billable expense to insurance companies, therefore you must prepay for this service prior to your court date a retainer in the amount of $3000, plus hourly fees if the time is beyond 10 hours. If you prefer, your therapist can prepare a letter to express their expertise regarding your court issues in lieu of attending court in person if you sign a release. This letter will be provided free of charge. If payment is not received on the day of service, a late fee of 20% will be added for unpaid fees late over 30 days, and the 20% late fee will continue to be assessed monthly until payment is received in full including late fees.

INSURANCE: We are on several insurance panels, which means that we are considered an "in-network provider" for those specific panels. For other insurances, we are an "out-of-network provider. "If you expect to use insurance to provide coverage for counseling services, please check your current coverage carefully. Call the phone number on the back of your insurance card and ask about your mental health benefits. Some insurance companies will pay a reduced amount toward services provided by an out-of-network provider. To check on what is covered by your insurance company, it is recommended that you ask your insurance carrier the following questions: 1. Do I have mental health benefits? 2. What is my deductible? 3. Do I have a co-insurance and a co-pay, and what are these amounts? 4. How many sessions per calendar year does my plan cover? 5. Is Coastal Haven Counseling, LLC on your list of current providers? 6. If the question to no. 5 is no, you may want to ask how much is paid for an out-of-network provider. 7. Do I need a pre-authorization number for sessions to be covered? 8. Is family therapy covered on my plan? If you exceed the amount of sessions that are covered or deemed medically necessary then we must discuss options of paying out of pocket or sessions or discontinuing therapy. Remember that you are responsible for full payment of fees due by the date of services. We no longer accept dual insurances (a client having more than one insurance plan at a time).

CONFIDENTALITY: The confidentiality of all communications between a client and a therapist is generally protected by law and us as your therapists cannot and will not tell anyone else what you have discussed or even that you are in counseling services without your written permission. In most situations we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. With the exception of certain situations described below, you have the right to confidentiality of your therapy. You may request that information be shared with whomever you choose and you may revoke that permission at any time. There are some exceptions to confidentiality in which we are legally bound to take action even though that requires revealing some information about a client's treatment. If at all possible, we will make every effort to attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include but are not limited to the following: 1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If we believe a client is threatening serious bodily harm to another we may be required to take protective action which may include notifying the potential victim, notifying the police or seeking appropriate hospitalization. If a client threatens to harm him/herself or another we may be required to seek hospitalization for the client or contact family members or others who can provide protection. 2. If there is good reason to suspect or evidence of abuse or neglect toward children, the elderly or disabled persons. In such a situation, we are required by law to file a report with the appropriate state agency. 3. In response to a court order or where otherwise required by law. 4. To the extent necessary to make a claim on delinquent accounts via a collection agency. 5. To the extent necessary for emergency medical care to be rendered. 6. When your insurance company is involved, such as making a claim, insurance audits, case reviews or appeals. 7. In a natural disaster whereby protected records may be exposed. 8. For professional supervision consultation purposes. **Policy on restraints and seclusion:** We do not use restraints or seclusion interventions in this practice. If someone on the premises believes their physical safety to be threatened, the police will be called and a report made. **CONFIDENTIALITY OF E-MAIL, CELL PHONE, TEXT AND FAXES COMMUNICATION:** It is very important to be aware that email or cell phone communication or texting can be relatively easily accessed by unauthorized people and hence the privacy and confidentiality of such communication can be compromised. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that may go through them. Faxes can easily be sent erroneously to the wrong address. Please notify us at the beginning of treatment if you decide to avoid or limit in any way the use of all of the above mentioned communication devices. Please do not use e-mail or faxes in the case of an emergency.

CONSENT FOR TREATMENT: Client acknowledges that I have received, have read or have had read to me (if requested), and understand information provided to me about the therapy I am considering and have asked and had answered any questions regarding treatment. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made as to the results of the treatment or any of the procedures provided by this therapist. I understand sexual and/or romantic counselor interactions or relationships with current clients, their romantic partners, or their family members are prohibited. (American Counseling Association Code of Ethics, 2014; A.5.a) I am aware that I may stop my treatment with this therapist at any time. The only services that I will be responsible for paying are the services that I have already received. I understand that I may lose other services or may have to deal with other consequences if I stop treatment. I know that I must cancel a scheduled appointment within at least 24 hours before the time of the appointment. I understand that if I do not cancel or come to a scheduled appointment, I will be charged for that appointment. I am aware that a third party payer/insurance company may be given

information about the types, costs, dates and providers of any services I receive. This form authorizes Coastal Haven Counseling, LLC and contracted therapists to release information from my/the patient's records maintained while I was treated by this provider. This information may include but is not limited to intake summaries, clinical records, summaries, treatment plans, diagnoses, progress, recommendations, discharge summaries and other clinical documents. HIV- related information and drug and alcohol information contained in these records will be released in these records under this consent unless indicated here. ____ do not release. This information may be sent to a third party payer or its agents and is needed for the following purposes: -Receiving health insurance benefits, reimbursements, payments for services and other similar services. Re-disclosure or re- transfer of these records is expressly prohibited and such re-disclosure may subject you to civil and criminal liability. Federal and State laws restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

My signature below authorizes the payment directly to Coastal Haven Counseling, LLC of benefits payable under our policy. I understand that such payments will be credited to my account with this provider. I further understand that I am financially responsible to this provider for charges not covered or reimbursed by my policy, up to the fee the provider has agreed to accept. I affirm that everything in this form that was not clear has been explained to my satisfaction.

TeleHealth /TeleTherapy involves the use of electronic communications to enable health care providers to continue to treat clients with mental health counseling at a distance. **Expected Benefits:** Improved access to mental health care by enabling a patient to remain in his/her home or at a remote private setting while conducting counseling sessions with their therapist. **Possible Risks:** As with any mental health procedure, there are potential risks associated with the use of telehealth/teletherapy. These risks include, but may not be limited to: In rare instances, security protocols could fail, causing a breach of privacy of personal private information. We utilize a HIPAA compliant platform for telehealth https://doxy.me to address this concern as best as possible.

Informed Consent for Telehealth: By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of mental health information also apply to TeleHealth/TeleTherapy, and that no information obtained in the use of TeleHealth/TeleTherapy which identifies me will be disclosed to other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of TeleHealth/TeleTherapy in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to all information obtained in the course of a TeleHealth/TeleTherapy.
4. I understand that a variety of alternative methods of therapy care may be available to me, and that I may choose one or more of these at any time. My therapist has explained the alternatives to my satisfaction.
5. I understand that TeleHealth/TeleTherapy may involve electronic communication of my personal mental health information.
6. I understand that it is my option to inform my therapist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of TeleHealth/TeleTherapy in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of TeleHealth/TeleTherapy: I have read and understand the information provided above regarding TeleHealth/TeleTherapy, have discussed it with my therapist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleHealth/TeleTherapy in my mental health care. I hereby authorize my therapist at Coastal Haven Counseling, LLC to use TeleHealth/TeleTherapy in the course of my diagnosis and treatment. For questions or to reach us, our phone number is 843-945-0346 and our email address is coastalhavencounseling@gmail.com.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBITLIES: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **YOUR RIGHTS** When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights

by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. **YOUR CHOICES** For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information, **OUR USES AND DISCLOSURES** How do we typically use or share your health information? We typically use or share your health information in the following ways: We can use your health information and share it with other professionals who are treating you. For example: A doctor treating you for an injury asks another doctor about your overall health condition. To run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. To bill for our services. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: ww.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. To help with public health and safety issues. We can share health information about you for certain situations such as: •Preventing disease, •Reporting suspected abuse, neglect, or domestic violence, •Preventing or reducing a serious threat to anyone's health or safety. We can use or share your information for health research. To comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. To work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. To address workers' compensation, law enforcement, SSI, disability and other government requests. We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, For special government functions such as military or national security and presidential protective services, To respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website. Other Instructions for Notice: • Effective Date of this Notice – 3/1/2017 • Name or title of the privacy official Sandra Quast, MA, LPC (843) 945-0346. The Privacy Rule requires therapists to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission. If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Sandra Quast, LPC, Coastal Haven Counseling, LLC and other practitioners enrolled as private contract labor under group entity.

NOTICE OF PRIVACY PRACTICES of COASTAL HAVEN COUNSELING, LLC: Effective date: March 1, 2017 *THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.* This practice provides many types of services, such as individual, family and group counseling sessions, referrals to treatment services and communication with the courts. Information about you must be collected to provide these services. Information collected about you and your health is private. We are required to protect this information by Federal and State law. This information is called "protected health information" and referred to as PHI. This Notice of Privacy Practices tells you how protected information about your health may be used or disclosed in the normal course of business. Not all situations will be described. We will always disclose only the minimum amount of PHI necessary. I agree to follow these policies. However, if there is a need to change these policies you will be notified of any changes. Your Protected Health Information may be Used and Disclosed without Your Authorization. For Safety- If you are considered to be a threat to yourself or others or if a minor, disabled or elderly if you are being hurt. For payment: PHI may be disclosed to obtain payment, or as required by law and for law enforcement. PHI will be used or disclosed when required or permitted by federal or state law or by a court order. For abuse reports and investigations: I am required to report and disclose any PHI that indicates child abuse. To avoid harm: I may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public. In an emergency or for reasons of national security: For example, if you fell and were unconscious, I would tell an EMT what I knew about your medical condition even if I were not able to get your consent. **Other Uses and Disclosures Require Your**

Authorization: Mental Health and drug and alcohol treatment records: You must give your written authorization before your mental health treatment records can be disclosed to anyone. **Unusual use:** I will ask for your written authorization before using or disclosing PHI in unusual situations that are not covered by these guidelines. You may cancel this authorization at any time in writing. **Your PHI Privacy Rights:** Right to see and get copies of your records: In most cases, you have the right to look at or get copies of your records. You must make this request in writing. You may be charged a fee for the cost of copying your records. Right to request to correct or update your records: You may ask to change or add missing PHI to your record if you think there is a mistake. You must make the request in writing and provide a reason for the request. Right to request limits on uses or disclosures of PHI. You have the right to ask to limit how your PHI is used or disclosed. You must make the request in writing and tell what PHI you want to limit and to whom you want the limits to apply. Right to get a list of disclosures: You have the right to ask for a list of disclosures made after March 1, 2017. You must make the request in writing. This list will not include the times that PHI was disclosed for treatment, payment or health care operations or as required by law. The list will not include information provided directly to you or your family or information that was sent with your authorization. Right to choose how we communicate with you: You have the right to ask that PHI be shared with you in a certain way or in a certain place. For example, you may request for that information be sent to your work address instead of your home address. You must make this request in writing and do not need to provide a reason. Right to file a complaint: You have the right to file a complaint if you do not agree with how your PHI was used or disclosed. **My signature affirms I understand and will comply with all these policies.**

AUTHORIZATION FOR RELEASE OF MEDICAID AND/OR PRIVATE INSURANCE INFORMATION:

MEDICAID & BCBS/EAP: I authorize release of any medical information necessary to process MEDICAID, BCBS or other accepted insurance I have provided for claims and request payments of benefits to: Coastal Haven Counseling, LLC/Sandra Quast, LPC 220 Ronnie Ct Suite 2 Myrtle Beach, SC 29579 for services provided by them.

SELF PAY WITH or WITHOUT INSURANCE

I understand that while I am a beneficiary of health insurance coverage, I am choosing to pay out of pocket for counseling services at this time. I agree to the following self-pay rates OR I am choosing to pay for counseling services by HSA or credit card because I don't have insurance. I agree to the following self-pay rates: $160.00 for the Initial clinical assessment and $120.00 for individual or family sessions. Sessions run approximately 53-60 minutes.

CRISIS & EMERGENCY PROCEDURES

Mental Health Crisis: A mental health crisis is a non-life threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed. **Examples of a Mental Health Crisis include:** Talking about suicide threats, Talking about threatening behavior, Self-injury, but not needing, immediate medical attention, Alcohol or substance abuse, Highly erratic or unusual behavior, Eating disorders, Not taking their prescribed psychiatric medications, Emotionally distraught, very depressed, angry or anxious. **What to Do in Case of a Mental Health Crisis:** 1.Call Coastal Haven Counseling / Sandra Quast, LPC (843) 945-0346 or your therapist immediately to share the crisis with your/the client's therapist. 2. Call the Mental Health Crisis Response Line through Waccamaw Mental Health (24/7) 833-364-2274. **After Hours and Weekends:** 1.Take client to your local hospital emergency room for evaluation or call 911. 2. Please make your/ or the client's therapist aware of the situation as soon as possible after taking to the emergency room at their phone number above. **Mental Health Emergency:** A mental health emergency is a life threatening situation in which an individual is imminently threatening harm to self or others, severely disoriented or out of touch with reality, has a severe inability to function, or is otherwise distraught and out of control. **Examples of a Mental Health Emergency include:** Acting on a suicide threat, Homicidal or threatening behavior, Self-injury needing immediate medical attention, Severely impaired by drugs or alcohol, Highly erratic or unusual behavior that indicates very unpredictable behavior and/or an inability to care for themselves.

What to Do in Case of a Mental Health Emergency: 1. Call 9-1-1 and/or take yourself/ or the client immediately to your local hospital emergency room for evaluation. 2. Make your or the client's therapist aware of the situation as soon as possible.

***This document is 6 pages. My signature affirms that I understand and will comply with all of these policies and procedures.**

Client's Name Printed: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

Relationship to Client (please check one) : Self: _____ Parent: _____ Legal Guardian: _____