Information and Consent to Counseling

Client Name: _____

Professional counseling services through Orchard Hill Church provide professional care for individuals, couples and families who may be facing challenging life circumstances. Counselors offer hope in a supportive atmosphere in times of need by combining biblical guidance with professional counseling. Orchard Hill Counseling provides non-profit counseling services through Orchard Hill Church and operates on a cost-recovery basis only.

Patient Rights and Responsibilities

Every client of Orchard Hill Counseling is entitled to:

- Participate in decisions during his or her counseling.
- Be treated at all times with dignity and respect by counselors and staff.
- Voice a complaint about care provided.

Every client being counseled by Orchard Hill Counseling has a responsibility to:

- Provide information the counselor needs to give appropriate care.
- Follow the counselor's recommended plans and instructions for care.
- Participate in the counseling process by focusing on problems and developing mutually agreed upon goals.
- Keep scheduled appointments or provide 24-hour notice of cancellation.

Fees and Payments

A 55-minute counseling session is $75.00. Orchard Hill Counseling does not accept any insurance for counseling services. Payment must be made with cash, check or credit card for each counseling session.

Appointment Scheduling, Cancellation, and No-Show Policies

All appointments are scheduled by Orchard Hill Counseling. Every attempt will be made to schedule times that are convenient for you. If you are unable to keep your scheduled appointment, Orchard Hill Counseling requires a 24-hour advance cancellation notice. ***Without this notice, a $25 cancellation fee will be assessed.***

Clinical Emergency and After-Hours Procedures

Normal business hours and appointment availability for sessions are Tuesday through Thursday, 9 am - 8 pm. If you are experiencing a clinical emergency, please call 911 or go to the nearest hospital emergency room. Pastoral support is available by calling the main office of Orchard Hill Church at 724-935-5555, Monday through Friday, 9 am - 5 pm.

Termination of Treatment

Both you and your counselor may terminate counseling for any reason. Upon request, Orchard Hill Counseling will be happy to connect you with another one of our counselors or provide you with a referral to another qualified provider.
If you sign a release of information at that time, Orchard Hill Counseling will gladly forward a copy of your records to your new provider.

Privacy and Confidentiality

Your client records are protected from disclosure under both state and federal laws relating to mental health services. Conversations are held in strict confidence unless otherwise provided for by state or federal regulations such as: you are a danger to yourself or to others, or a child is endangered. If your counselor needs to consult with someone regarding your treatment, you will be asked to sign a release form that will clearly identify the information to be exchanged, the parties involved in the exchange and the reason for the communication.

Federal law contained in the Health Information Portability and Accountability Act (HIPAA), effective April 14, 2003, mandates some exceptions to absolute confidentiality. These include:

1. The counselor's right to use or disclose any medical information that may be required for purposes of carrying out treatment and related healthcare operations, and for obtaining payment for services.
2. The requirement that the counselor shares with the proper authorities: reports or evidence of child or elder abuse; reports or actions of suicidal or homicidal intent; and situations of life-threatening medical emergency. In such instances, my consent is not required.

3. I understand that I may request additional restrictions, beyond those stipulated in HIPAA, on the use and disclosure of my medical information, and that, while not required to agree to such requests, the counselor will cooperate as far as possible. Where there is agreement, however, the restrictions will be binding on the counselor.
4. I understand that, although my file is the property of the counselor's, I have a right to review and discuss the information in it, or to obtain a copy or summary of it at a reasonable charge.
5. I am aware that my counseling relationship with my counselor will not deprive me of any civil rights, nor will I be discriminated against by any counselor from Orchard Hill Counseling.

Consent to Counseling

I agree that I have read and understand the policies stated above and have been informed of my counseling fees and payment policies. I am aware that communication with my counselor is noted and kept in a confidential file. I understand that, unless I authorize and sign a release of information form, it is the provider's policy to safeguard any information it gathers about me, as well as the medical and payment records it compiles, from anyone who is not directly involved in my treatment. I further understand that, in cases of couple or family counseling, all participants ages 14 and over must authorize this release.

Consent to Telehealth Counseling

I understand that telehealth is the practice of delivering professional counseling via technology assisted media or other electronic means between a counselor and a client who are in different locations. I understand there are risks, benefits and consequences associated with telehealth, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. I also understand there will be no recording of the online sessions by either party. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.

By signing below, I consent to in-person and/or virtual counseling and acknowledge that Orchard Hill Counseling and its counselors, employees, or agents may use or disclose my medical information as deemed appropriate (and according to state and federal law) to carry out counseling and related healthcare operations.

The undersigned hereby forever releases, acquits, discharges, and agrees to hold harmless Orchard Hill Church and its counselors, agents, employees, directors, officers, successors, assigns, and volunteers, from any and all claims, demands, actions and causes of action of any sort, for personal injury or damage to property arising out of or sustained during their presence while on Orchard Hill Church property. The undersigned hereby certifies that he/she has read the foregoing and agrees to its content.

_____

Signature of Client or Legal Representative Date

_____

Parent/Guardian Signature (If client is under the age of 14) Date

Additional Signatures (Family or Couples Counseling)

_____

Signature of Client or Legal Representative Date

_____

Signature of Client or Legal Representative Date

_____

Counselor Signature Date