**Pastoral Institute, Inc.**
2022 15th Avenue, Columbus, GA 31901
A SAMARITAN CENTER

# Counseling Center Minor Client Information

For Office Use Only
Date of Visit: _____
Patient#: _____
Clinician: _____
Payment Type: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender:_____ Social Security #:_____ Race:_____ Ethnicity:_____

School: _____ Religion:_____ Church:_____

Parent/Guardian Name: _____ Date of Birth:_____

Social Security #: _____ Employer: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Preferred method of contact: _____Cell or _____Home; _____Voice _____Text _____Email

Marital Status: _____Single _____Live-in _____Married _____Divorced _____Widowed

Military status: _____Active _____Veteran _____Disabled _____Retired _____Dependent

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Emergency Contact Name: _____ Relation: _____

Home/Cell Phone: _____ Work Phone: _____

Address: _____

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## Financial and Insurance Information

Primary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #:_____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Secondary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #:_____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

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**In order to file your insurance, we must have a copy of your insurance card(s).**

**Mental Health Information:**

What has happened to cause you to seek counseling for your child? *(continue on back if needed)*

_____

_____

_____

_____

Has your child received previous mental health care? _____ Yes _____ No

If so, what dates did your child receive treatment?

_____

_____

**General Health Information:**

Is your child presently under the care of a physician? _____ Yes _____ No

Name of physician/psychiatrist: _____

Physician's telephone number: _____

Types and dates of surgeries:_____

_____

Does your child drink alcohol/do drugs? _____ Yes _____ No

If yes, how much/how often? _____

List medication(s) taken regularly

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

**SOCIAL MEDIA POLICY**

Pastoral Institute staff will not accept friend requests or contact requests from current or former clients on any social networking site; i.e., Facebook, LinkedIn, etc. Adding clients and/or family members as friends or contacts on these sites can compromise a client's confidentiality and our mutual privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions, please do not hesitate to discuss the issue with your clinician.

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize the Pastoral Institute or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment necessary for payment of insurance claim. The insurance company is hereby authorized to pay the Pastoral Institute, Inc., basic benefits and/or major medical benefits for medical and/or treatment expenses, or to include their name on the check payable to patient for medical and/or expenses.

*For Tricare Beneficiaries:* I consent to the Pastoral Institute, as a Military Treatment Facility (MTF) to send a copy of my Protected Health Information (PHI) to referring MTFs for continuity of care.

_____ _____

Client Name (Printed) Date

_____ _____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

**FINANCIAL POLICY AND AGREEMENT**

For those with health insurance, the Pastoral Institute will assist in filing claims and seeking reimbursement. The Pastoral Institute cannot guarantee insurance reimbursement. It is the responsibility of the patient to follow up with the insurance company to make sure they pay the claims correctly. If the insurance company does not pay within 90 days, the unpaid balance is due from the Guarantor. Some insurance coverage for mental health services requires pre-authorization. The patient must call for authorization. The insurance company will not pay for services that have not been authorized. All fees charged are the direct responsibility of the client. Payment of any and all services rendered will be expected from the guardian that escorts the patient to his or her appointments. It is the policy of the Pastoral Institute to bill for any appointment cancelled without a 24-hour notice.

Payment for co-pay or deductible is due at the time service is rendered. Accounts that become more than ninety (90) days past due may be forwarded to a collection agency. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

**Financial Agreement:**

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that the statements are correct unless questioned within thirty (30) days in writing or by telephone contact with the Pastoral Institute Business Office.

_____ _____

Client Name (Printed) Date

_____ _____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

**PASTORAL INSTITUTE BROKEN APPOINTMENT POLICY**

The scheduled appointment time has been reserved just for your child. If you find it impossible to keep your appointment time, please call us at least 24 hours in advance. Failure to call our office and cancel your appointment 24 hours in advance will result in a charge of $60.00. We offer appointment reminder phone calls and/or texts 48 hours prior to your appointment. However, this is a courtesy and you are still responsible for cancelling your appointment at least 24 hours in advance.

_____ _____

Parent/Guardian Signature Date

**COUNSELING, CONFIDENTIALITY, PRIVACY PRACTICE AND NON-RECORDING AGREEMENT**

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute's (PI) staff members. I agree to collaborate with my therapist and other appropriate professional staff members of the PI for the purpose of assessment and evaluation of my current situation to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand that the PI is committed to quality care. I may contact the Clinical Director regarding any questions about my therapist or concerns about quality of care. I understand that the PI may call my home or other designated location and leave a message on voice mail or in person to assist the practice in carrying out health care operations, such as appointment reminders, insurance concerns, and any call pertaining to my clinical care. I have read the above and give my consent to the counseling process of the PI. I have also read and understand the Pastoral Institute's statement regarding the limits of confidentiality. In addition I have had an opportunity to review the Pastoral Institute's Notice of Privacy Practices and have had an opportunity to obtain a copy and ask questions to seek clarification I needed about these important materials.

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

_____ _____

Client Name (Printed) Date

_____ _____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

**E-MAIL CONFIDENTIALITY RELEASE AGREEMENT**

_____

Parent/Guardian's E-mail Address

I understand that confidentiality of e-mail communications with my therapist cannot be guaranteed. I further agree that I will not attempt to extend therapy via e-mails, but only use it to conduct business of information sharing such as cancelling or confirming an appointment. Any therapeutic issues I will handle either during the therapeutic face-to-face meeting or as appropriate, by telephone in emergencies. E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail will be read and responded to within a particular period of time.

Possible e-mail-related concerns can include, but are not limited to the following:

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the e-mail and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to my e-mails according to his/her professional judgment.

_____ _____

Client Name (Printed) Date

_____ _____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

# Pastoral Institute's Child and Family History Chart #_____

Child's Name: _____ ☐ M ☐ F Age:_____ Birthdate:_____ Grade:_____

School_____ (Does child Sign?_____) Race/Ethnicity:_____ Handedness: Rt___ Left____

Referred by: _____ Form completed by_____ (relationship?_____)

## PLEASE CHECK CURRENT CONCERNS ABOUT YOUR CHILD

- ○ Academic/Learning Difficulties
- ○ Adoption Issues/Problems
- ○ Suspected Alcohol/Drug Abuse
- ○ Allegations of Abuse
- ○ Anger Issues
- ○ Attendance Difficulties
- ○ Attention/Hyperactivity Difficulties
- ○ Autism/Aspergers disorder
- ○ Behavior Difficulties
- ○ Emotional Difficulties—

____Anxiety ___Depression

- ○ Eating Problems
- ○ Language Difficulties
- ○ Health Concerns_____
- ○ Home Schooling Issues
- ○ Hearing Difficulties
- ○ Gifted Assessment
- ○ Suspected Intellectual Difficulties
- ○ Family difficulties
- ○ Grief issues
- ○ Gross Motor Delays/Clumsiness

- ○ Memory Difficulties
- ○ Self-Harm
- ○ Suicidal
- ○ Visual Motor Coordination Difficulties/Writing; Difficulties
- ○ Social Skills Difficulties
- ○ Traumatic Brain Injury
- ○ Violent behaviors

## PARENT/GUARDIAN INFORMATION

**Highest Educational Level:**

| | |
|---|---|
| Mother | |
| Father | |
| Stepparent | |
| Adoptive | |
| Guardian | |

**Living Arrangements:**

The Child currently lives with _____

How many other children live with child? _____

How long has the child lived in the present living arrangements? _____

How often have the custodial arrangements changed in the last three years? Y____ N____; how often?_____

## Events Producing Family Stress:

- ○ Death of a family member
- ○ Incarceration of a family member
- ○ Custody disagreement
- ○ Parent emotionally/mentally ill/substance abuse
- ○ Abandonment by parent
- ○ Parental deployments #_____
- ○ Serious illness of a family member
- ○ Loss of employment of a major wage earner
- ○ Unsafe home environment
- ○ Birth/Adoption of another child
- ○ Parental disagreement about child-rearing
- ○ Involved with Social Services/Child Protective Services/Juvenile Court
- ○ Other _____
- ○ Loss of home
- ○ Parental separation
- ○ Parental divorce
- ○ Sibling conflict
- ○ Child neglect/abuse
- ○ Financial problems
- ○ Single-parent family

**Prenatal/Birth History**

- ○ Child was born with no complications
- ○ Experienced anoxia at birth/assistance breathing
- ○ Experienced in utero exposure to drugs/alcohol
- ○ Experienced in utero trauma (e.g. cord wrapped)
- ○ Was born past due date
- ○ Gestational diabetes
- ○ Was born premature
- ○ Was born via C-section
- ○ Weighed less than 5 ½ pounds at birth
- ○ Weight over 9 lbs
- ○ Rh incompatibility
- ○ Toxemia
- ○ Other_____

**Which of the following applied to the infant? (Check all that apply)**

- ○ Required Oxygen/Breathing problems
- ○ Required incubator
- ○ Sleeping problems
- ○ Infections
- ○ Feeding problems
- ○ Bleeding into brain
- ○ Excessive crying
- ○ Seizures/convulsions
- ○ Placement in the NICU (if so how long?)_____
- ○ Did the infant require: ☐X-rays ☐CT scans ☐Blood Transfusion
- ○ Unusual appearance, describe:_____
- ○ Jaundice (were bilirubin lights used?) ☐ Yes ☐ No How long:_____
- ○ Length of stay in the hospital:_____ Mother:_____ Infant:_____

| **Developmental Milestones** | Early | Typical | Late | Not Yet |
|---|---|---|---|---|
| Sitting Alone | | | | |
| Crawling | | | | |
| Fed self | | | | |
| Fed self with spoon | | | | |
| Gave up bottle | | | | |
| Started solid foods | | | | |
| Standing Alone | | | | |
| Walking Alone | | | | |
| Speaking First Words; age____ | | | | |
| Speaking Short Sentences; age ____ | | | | |
| Using Toilet When Awake | | | | |
| Staying Dry at Night | | | | |
| Dressed Self | | | | |
| Rides tricycle | | | | |
| Rides Bike | | | | |

**When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?**

☐ Time out ☐Loss of allowance/privileges ☐Physical Punishment ☐elling

☐ Ignoring ☐Grounding ☐Other, describe:_____

Who is mainly in charge of discipline?_____

What do you find most difficult about raising your child?

_____

_____

_____

| **Sensory Motor Skills:** | **Date of Last Testing** | **Results Normal Y/N** |
|---|---|---|
| **Vision Testing** | | |
| **Hearing Testing** | | |

**Medical/Psychiatric/Neurological Concerns:**

- ○ No major medical/psychiatric concerns
- ○ Asthma
- ○ Attention deficit/hyperactivity disorder
- ○ Depressive disorders
- ○ Diabetes
- ○ Family History of Mental or Emotional problems _____
- ○ Fetal alcohol syndrome
- ○ Food allergies _____
- ○ Chronic ear infections
- ○ Lead poisoning
- ○ Seizure disorder
- ○ Severe allergies
- ○ Spina bifida
- ○ Stomach problems
- ○ Surgeries
- ○ Other_____

**Neurological Status:**

- ○ No signs of neurological concerns
- ○ Episodes of head banging
- ○ Seizures or convulsions
- ○ A serious head injury
- ○ A motor tic
- ○ Periods of unconsciousness
- ○ An unusual number of accidents
- ○ Other_____

**Medication:**

Is he/she currently on any medications? Y___ N___ If so, names of all medications:

_____ _____ _____ _____

_____ _____ _____ _____

**Education:**

Did he/she attend a formal pre-kindergarten? Y__ N__ Fulltime__ Halftime__

Did he/she attend a formal kindergarten? Y__ N__ Fulltime__ Halftime__

Has he/she been in the same school since initial enrollment? Y___ N___

| Has he/she ever been held back? |
|---|
| Y___ N___ |
| If yes what grade(s)_____ |

He/she is currently in:

- ○ full time classes
- ○ part time classes
- ○ gifted/talented courses
- ○ regular classes
- ○ special education classes
- ○ homeschooled

He/she has:

**Attendance:**

- o no significant attendance problem
- o an excellent attendance record
- o frequent un-excused absences
- o frequent excused absences

**Conduct:**

- o exemplary conduct record
- o only minor disciplinary problems
- o frequent disciplinary problems
- o severe disciplinary problems
- o suspension from school
- o enrolled in correction program

**Academic Performance:**

- o an outstanding academic record
- o no serious academic difficulties
- o some academic difficulties
- o many academic difficulties

**Academic Testing:**

| | **Above average** | **Average** | **Below Average** |
|---|---|---|---|
| Reading | | | |
| Math | | | |
| Language | | | |

**Describe School Issues:**

_____

_____

**Services Received:**

Speech_____ OT_____ PT_____ABA_____ Social Skills_____ Early Child Special Education_____

**Extracurricular Activities**

☐ SportsClubs/Hobbies:_____

☐ Church:_____

**Strengths:** What are the child's greatest assets?_____

_____

What are the family's strengths? _____

_____

**Level of family stress related to child's condition:**

Low Moderate High

| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|---|---|---|---|---|---|---|---|---|---|

**Pastoral Institute, Inc.**
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## Informed Consent for Therapy with Parents/Guardians

**Divorce, Custody or Legal Issues**

As a mental health treatment practice, our primary focus, responsibility and goal is the treatment and well being of our identified patients. In the case of a minor child as the primary patient, it is essential that parents and legal guardians are in agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. This Consent states that you, as the parent and/or any legal guardian with authority over the health care decisions of the child, agree to the terms contained herein and to communicate effectively with any other parent and/or legal guardian as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible for the patient.

Although our responsibility to your minor child, as the primary patient, may require our involvement in conflicts between parents and guardians, you hereby acknowledge that the Pastoral Institute's involvement will be strictly limited to those actions which will benefit and be in the best interest of the patient. Additionally, you agree to the following:

- Anything that is said in any individual or group therapy session is and shall remain at all times strictly confidential;
- The Pastoral Institute's role is limited to providing treatment to the patient, and you shall not attempt to utilize any information related to your minor child's treatment to your benefit or for your advantage in any legal proceeding relating to a divorce or to the custody of your child that is derived from the treatment of your child by the Pastoral Institute. You acknowledge and agree that the use of any such information shall be determined by a court appointed guardian ad litem or by an order from a court with competent jurisdiction;

You shall not request or require the Pastoral Institute, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; Any communications between the minor patient and the clinician, whether during an individual or group session, are treated by the Pastoral Institute as privileged communications under applicable law. **You acknowledge that, prior to any clinician being required to testify or disclose any confidential and/or privileged communications between a patient and the clinician, a written waiver of the privileged communications shall be delivered to the Pastoral Institute. If you decide to subpoena your therapist, you will be responsible for his/her expert witness fees in the amount of a deposit of $300.00 to be paid at the time we are notified of a subpoena to provide a deposition or appear in court. Any additional time the therapist spends would be billed at the rate of $200.00 per hour including travel time. If your therapist is a licensed psychologist the fees are $250.00 per hour including travel time. You understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.**

- In the event of a group session, a written waiver of all participants shall be received by the Pastoral Institute prior to any disclosure. In the event the patient involves a minor child and the request is in connection with a divorce or child custody proceeding, you agree that a guardian ad

litem shall be appointed by the court to make the determination as to whether the minor child should waive the privilege, and that you, as the parent and/or legal guardian, shall not retain the right to waive any privilege on behalf of a minor child under such circumstances;

- Any and all medical records retained by the Pastoral Institute are subject to the applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") laws and regulations. Any requests for medical records of a patient shall be HIPAA compliant, and the Pastoral Institute will not disclose any medical records in its possession that would be in conflict with the applicable HIPAA requirements.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor **but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.**

In order for the Pastoral Institute to disclose privileged communications pursuant to any court order, such court order shall explicitly require the disclosure of any privileged communications of the patient.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my minor child under these terms and conditions set forth above by signing below.

I accept the responsibility of communicating with my child's therapist after every appointment to be updated regarding any change in the treatment plan related to my child's therapy. However, I acknowledge that I am not entitled to all of the communications and disclosures made by my minor child during any treatment sessions, and that such communications may consist of privileged communications which are afforded protection under applicable law.

I understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, I acknowledge that the Pastoral Institute will look to me as the sole party responsible for the financial obligations of the account.

Name of Child/Client (Printed): _____

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Name (Printed): _____

PI Witness: _____ Date:_____

**Pastoral Institute, Inc.**
2022 15th Avenue, Columbus, GA 31901
A SAMARITAN CENTER

# NOTICE OF THE PASTORAL INSTITUTE'S PRIVACY PRACTICES

*For Your Records – Client Copy*

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others and how you can get access to the same information

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the State of Georgia to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This updated notice takes effect on September 1, 2017, and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at the Pastoral Institute, Inc. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

**Here are some examples of how we use and disclose information about your health information.**

We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you with your written authorization.
2. To Pastoral Institute staff involved in your treatment program.
3. To any person required by federal, state or local laws to have lawful access to your treatment program.
4. To receive payment from a third-party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards and in connection with licensing, credentialing or certification activities.
6. To anyone you give us written authorization to have your health information for any reason you want. You may revoke this authorization in writing any time you want. When you revoke an authorization it will only affect your health information from this point on.
7. To a family member, a person responsible for your care or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.

8. To appropriate authorities under Georgia Law in the following circumstances: Imminent Danger to you or others, Child Abuse, Elder Abuse, Disabled Adult Abuse or under Court Order.
9. To help us carry out health care operations such as appointment reminders, insurance items and calls pertaining to your clinical care.

We will not use or disclose your health information, including psychotherapy notes, without your written authorization except in instances such as 1-9 above.

We will notify you in the event your unsecured protected health information is breached, unless a four-part risk assessment shows there is a low probability that protected health information was compromised.

We will not use your health information in any of our Center's marketing, development, public relations or related activities, nor will we sell your health information, without your written authorization.

We cannot use your health information that may be considered genetic information for underwriting purposes.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

We will not release your Protected Health Information (PHI) to your health plan if you have paid the full fee for services rendered and have requested to restrict certain disclosures of your PHI.

**As a client of the Pastoral Institute, Inc., you have these important rights:**

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. We will charge you $0.25 per page for making these photocopies.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those that, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12-month period, we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: HIPAA Compliance Officer, Pastoral Institute, 2022 15th Avenue, Columbus, GA 31901. Phone (706) 649-6500; Fax (706) 649-6521.

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

N. You are entitled to receive a notice from us if your protected health information is released in any way that is not authorized.

## PASTORAL INSTITUTE
## CONFIDENTIALITY STATEMENT

We are glad you have chosen the Pastoral Institute. Below is some information written for you to clarify confidentiality in the counseling process.

### CONFIDENTIALITY

We commit to keep confidential what you say in the counseling process. The following are the only exceptions:

1. **Supervision/Case consultation –** A part of our commitment to providing quality care for you is to regularly consult with other professionals on staff. Your identity is kept confidential during these consultations. From time to time, we may also audio or video tape your sessions, but only after receiving your written permission. The taping would be used for our professional consultations and in counselor training.
2. **Requirements by law –** The records from your counseling are confidential and cannot be released to anyone without your written consent except under the following conditions provided by the law:
    a. **Imminent Danger –** The law states that if we judge you to be a danger to yourself or others, we are required to take action to prevent harm from occurring to you or others.
    b. **Child Abuse –** We are required by law to report all cases of actual or suspected physical, emotional or sexual abuse or neglect of children to the Department of Family and Children Services.
    c. **Disabled Adult Abuse –** We are required by law to report all cases of actual or suspected physical, emotional or sexual abuse or neglect of disabled adults to the Department of Family and Children Services.
    d. **Elder Abuse –** We are required by law to report all cases of suspected physical, emotional, financial, sexual abuse, neglect, self-neglect or financial exploitation of older persons (65+) who do not reside in long-term care facilities to the Department of Family and Children Services.

We hope this information is helpful to you. Please feel free to ask questions.

The Pastoral Institute
2022 15th Avenue
Columbus, GA 31901
(706)649-6500