A ministry of
AGAPE CHILD AND FAMILY SERVICES, INC.

Agape Child and Family Services, Inc. is a Christian based organization with a strong commitment to providing quality, professional services that are guided by Christian values.

BENEFITS AND RISKS OF THERAPY:
Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:
Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personnel in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

Client information and records are available to agency personnel for purposes of research, report, and quality assurance review. Clients who file insurance claims consent to review of records by an agent of the insurance company.

STAFF CREDENTIALS:
All counselors at the AGAPE Counseling Center possess Master's level or higher clinical degrees and competence in individual, group, marital, and family counseling. As a commitment to standards of excellence in the area of counseling, the AGAPE Counseling Center's counselors adhere to state statutes regulating their discipline and the standards of practice mandated by their professional and regulatory agencies.

CLIENTS WITH DISABILITIES:
It is the policy of the AGAPE Counseling Center and AGAPE Child & Family Services, Inc. to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodation should inform AGAPE Counseling Center staff prior to receiving services. Clients with disabilities are also encouraged to inform Louvadie King, the Clinical Director, (901) 323-3600, of their need for accommodation.

NONDISCRIMINATION POLICY:
In accordance with Title VI of the Civil Rights Act of 1964, the Agape Counseling Center and Agape Child & Family Services, Inc., do not discriminate against participants or clients on the basis of race, color or national origin. Services are offered to all eligible persons. If you believe that the Agape Counseling Center or Agape Child & Family Services, Inc., have discriminated against you, contact your Title VI Representative, Nichole Love, at (901) 323-3600.

FEE POLICY:
The fee for counseling services provided through Agape Child & Family Services, Inc. is $120.00 per 50-minute session. Reimbursement benefits for counseling services may be available to you through your medical insurance policy. You are expected to pay for the initial evaluation and for any deductible expenses, co-payments, and uncovered charges at the time services are rendered. If you do not have insurance benefits or the ability to pay the standard fee, payment for services can be arranged based on your family's annual gross income. Payment may be made by cash, check or credit/debit card. There is a $35.00 fee for returned checks.

PROFESSIONAL SERVICES:

Regular office hours are from 8:30 a.m. until 5:00 p.m. Monday through Friday. Appointments outside these hours may be arranged by mutual agreement with your therapist following your first appointment.

CONSENT FOR TREATMENT/RESPONSIBILITIES FOR CLIENTS
I do hereby authorize and give my consent to Agape Child & Family Services, Inc. to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional disciplines governing the professionals on staff. Agape Child & Family Services, Inc. does not over-book appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment. These charges are the client's responsibility and cannot be billed to insurance companies or other third party payers.

I have read, understand and agree to the conditions of treatment described in this document.

____________________________________ ____________

Client Signature / Parent or Guardian **Date**

I agree to allow a representative Agape Child & Family Services, Inc., to contact me regarding my experience with counseling services I have received at this agency. The phone number where I can be reached for this purpose is ______________________.

____________________________________ ____________

Client Signature **Date**

CLIENT INFORMATION FORM-PAGE 1

DEMOGRAPHIC INFORMATION:

NAME_______________________PARENT/GUARDIAN_______________________DAT
E________
ADDRESS_____________________________ CITY
________________STATE___ZIP__________
DATE OF BIRTH________________ AGE _______ SOCIAL SECURITY
#____________________
HIGHEST SCHOOL GRADE OR DEGREE COMPLETED: CLIENT____________
SPOUSE__________
EMPLOYER____________________________ POSITION_______________HOW
LONG?_________
HOME PHONE____________________ OKAY TO CALL? ( ) YES ( ) NO
WORK PHONE ____________________ OKAY TO CALL? ( ) YES ( ) NO
CELL PHONE____________________ OKAY TO CALL? ( ) YES ( ) NO
E-MAIL ADDRESS_______________________ OKAY TO CONTACT? ( ) YES ( ) NO
MARITAL STATUS: SINGLE___ MARRIED__ WIDOWED__ SEPARATED__
DIVORCED____ COHABITING____
SPOUSE'S NAME:______________ DOB___AGE__ SOCIAL SECURITY #__________
ADDRESS:____________________CITY______________STATE:___ZIP__________
EMPLOYER______________________POSITION____________HOW LONG?_______
DAYTIME PHONE________________EVENING PHONE________________ OKAY TO
CALL?___

OTHER HOUSEHOLD MEMBERS	RELATIONSHIP	DATE OF BIRTH	AGE
1_______________	1_______________	1_______________	( )
2_______________	2_______________	2_______________	( )
3_______________	3_______________	3_______________	( )
4_______________	4_______________	4_______________	( )

HOW DID YOU LEARN ABOUT AGAPE'S COUNSELING PROGRAM? __________
RELIGIOUS PREFERENCE (OPTIONAL) ___________CHURCH MEMBERSHIP
AT_______________
EMERGENCY CONTACT NAME_______________________ DAYTIME
PHONE______________
EVENING PHONE__________________
ADDRESS____

CLIENT INFORMATION FORM-PAGE 2

NAME ______________________________

PROBLEM INFORMATION:

FOR WHOM ARE YOU REQUESTING COUNSELING? ______________________________
BRIEFLY DESCRIBE THE NATURE OF THE PROBLEM: ______________________________

____

____

____

____

DESCRIBE YOUR CURRENT LIVING SITUATION: ______________________________

____

____

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PLEASE IDENTIFY WHAT YOU WOULD LIKE TO ACCOMPLISH IN THERAPY: __________

____

____

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____

HAVE YOU (OR THE PERSON WHO WIL BE RECEIVING COUNSELING) EVER RECEIVED OUTPATIENT TREATMENT FOR A MENTAL HEALTH ISSUE? ( ) YES ( ) NO

IF YES, FROM WHOM? ______________________________ WHEN? ______________
HAVE YOU (OR THE PERSON WHO WIL BE RECEIVING COUNSELING) EVER RECEIVED INPATIENT TREATMENT FOR A MENTAL HEALTH ISSUE? ( ) YES ( ) NO

IF YES, FROM WHOM? ______________________________ WHEN? ______________
ARE YOU CURRENTLY BEING TREATED BY A MENTAL HEALTH PROFESSIONAL? ( ) YES ( ) NO
NAME OF TREATING PROFESSIONAL______________________ PHONE # __________
MEDICATION PRESCRIBED IN PAST FOR MENTAL HEALTH ISSUE ________________

____

____

CURRENT PRESCRIBED MEDICATIONS AND DOSAGES ______________________________

____

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CLIENT INFORMATION FORM-PAGE 3

FINANCIAL INFORMATION:

THE STANDARD FEE IS $120 PER SESSION. PAYMENT IS DUE AT THE TIME OF THE VISIT.
IF YOU HAVE INSURANCE BENEFITS AND CHOOSE NOT TO USE THESE BENEFITS, YOU MUST PAY THE STANDARD RATE.

IF YOU DO NOT HAVE INSURANCE OR OTHER THIRD PARTY PAYMENT BENEFITS, YOU MAY BE ELIGIBLE FOR A FEE ADJUSTMENT BASED ON FINANCIAL NEED. YOUR FEE WILL BE ADJUSTED ON A SLIDING SCALE DETERMINED BY GROSS (NOT TAKE HOME) INCOME.

IF YOU WISH TO APPLY FOR A FEE ADJUSTMENT BASED ON OUR SLIDING SCALE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. YOUR ANNUAL GROSS INCOME ………………………………………………$____________
2. SPOUSE'S ANNUAL GROSS INCOME……………………………………...........$____________
3. ANNUAL INCOME FROM OTHER SOURCES (investments, stocks, bonds, etc.) $__________

TOTAL $____________

INSURANCE INFORMATION:

1. PRIMARY INSURANCE COMPANY________________ POLICY #:________________

TELEPHONE # ________________INSURANCE PLAN NAME ________________

NAME OF INSURED________________ INSURED'S DATE OF BIRTH ____________

INSURED'S I.D. NUMBER ______________INSURED'S EMPLOYER ______________

ANNUAL DEDUCTIBLE AMOUNT $__________DEDUCTIBLE PAID THIS YEAR $_______

2. NAME OF OTHER INSURANCE COVERAGE ______________ POLICY #:____________

TELEPHONE # ________________ INSURANCE PLAN NAME ________________

NAME OF INSURED________________ INSURED'S DATE OF BIRTH ____________

INSURED'S I.D. NUMBER ______________INSURED'S EMPLOYER ______________

ANNUAL DEDUCTIBLE AMOUNT $________ DEDUCTIBLE PAID THIS YEAR $________

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON THE CLIENT'S BEHALF. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO AGAPE CHILD & FAMILY SERVICES, INC. FOR SERVICES RENDERED.

SIGNED: ____________________________________ **DATE:** ________________

CLIENT INFORMATION FORM-PAGE 4

NAME ______________________________ **DATE** ____________

MEDICAL INFORMATION:

WHICH OF THE FOLLOWING ILLNESSES OR COMPLAINTS HAVE YOU (THE CLIENT) EXPERIENCED?

___Diabetes	___Head injury	___Ulcer	___Irregular menses
___High blood pressure	___Thyroid problems	___Glaucoma	___ Difficulty sleeping
___Epilepsy	___Seizures	___Dizzy Spells	___Loss of appetite
___Liver problems	___Hepatitis	___PMS	___Herpes
___Kidney problems	___Asthma	___Back pain	___Syphilis or other venereal disease(s)
___Headaches/Migraines	___Respiratory problems	___Frequent constipation	
___Heart Attack	___Stroke	___Loss of consciousness	___Other

____

WHAT PRESCRIPTION MEDICATIONS ARE YOU CURRENTLY TAKING AND WHY?

MEDICATION	**REASON FOR TAKING IT**
1. ______________________	______________________________
2. ______________________	______________________________
3. ______________________	______________________________
4. ______________________	______________________________

PLEASE IDENTIFY ANY ALLERGIES THAT YOU HAVE:

1. ________________ 2. ________________ 3. ________________

WHAT OVER THE COUNTER MEDICATIONS DO YOU TAKE ON A REGULAR BASIS?

_____Diet pills/aides	_____Sleeping pills	_____Vitamins
_____Laxatives	_____Sinus medicine	_____ Ibuprofen
_____Cough medicine	_____Aspirin	_____ Stomach medicine

Do you have a primary care physician (PCP)? ____Yes ____No
If yes, please provide your PCP's name, address and phone number.

Name: ________________________ **Phone Number** ________________________
Address:
________________________ **City:** ________________ **State:** _____ **Zip:** __________

When did you last see your doctor? Date: __________ **Reason:** ____________________

AGAPE CHILD AND FAMILY SERVICES, INC.

CLIENT RIGHTS & RESPONSIBILITIES

You have a right to:

- Be treated with consideration and respect for your personal dignity, autonomy, and privacy;
- Fair and equitable treatment. You have the right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap.
- Receive professionally competent and ethical services;
- Confidentiality except in those areas regulated by State and Federal laws;
- Consent to or refuse any service, treatment, or therapy upon explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy of behalf of a client under 16 years of age;
- Active and informed participation in the establishment, periodic review, and reassessment of the treatment plan;
- Request restrictions on certain uses and disclosures of your protected health information to which your therapist/case manager may or may not agree; but, if he or she does, such restrictions shall apply unless our agreement is changed in writing;
- Access your records as applicable state and federal guidelines and professional ethical codes allow;
- Know the cost of services;
- Exercise any and all rights without reprisal in any form including continued uncompromised access to services;
- Revoke your authorization of your protected health information except to the extent that action has already been taken;
- File a grievance if you feel that your rights have been violated.

You have a responsibility to:

- Provide relevant information as a basis for receiving services and participating in therapy decisions;
- Seek out medical care if so requested by your therapist;
- Communicate any changes in your circumstances or any other significant matters to your therapist;
- Work toward better understanding yourself and develop additional problem solving skills.

We reserve the right to change our privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of our policies when you come for a future appointment(s).

Client Signature:________________________ Date:_______________

AGAPE Child & Family Services

HIPAA NOTIFICATION FOR CLIENTS

AGAPE is complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by informing clients of how we use and disclose personal health information (PHI).

What is PHI?

- Name
- Address
- Telephone Number
- E-mail address
- Social Security Number
- Medical Information (including progress notes, discharge summaries, treatment plans, etc. Any documentation relating to your care)

CLIENT RECORDS OF DISCLOSURES

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

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

Home Telephone:________________

____Ok to leave message with detailed information

____Leave message with call back number only

Work Telephone:________________

____Ok to leave message with detailed information

____Leave message with call back number only

Written Communication

____Ok to mail to my home address

____Ok to mail to my work/office

Other:____________________

I,____________________________ hereby acknowledge that I have been notified that my personal health information is protected under the new HIPAA regulations. I have been shown the posted notification and understand my rights as a client.

____

Patient Signature

____

Date

YOUR RIGHTS UNDER HIPAA

Health Insurance Portability and Accountability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law includes important new protections for millions of working Americans and their families who have preexisting medical conditions or might suffer discrimination in health coverage based on a factor that relates to an individual's health. HIPAA's provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA) as well as the Internal Revenue Code and the Public Health Service Act and place requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations (HMOs).

Your Rights Under HIPAA

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected. You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.

Details of the HIPAA Privacy Rule

The new privacy regulations ensure a national floor of privacy protections for clients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use clients' personal medical information.

How to File a Health Information Privacy Complaint

If you believe that a person, agency or organization covered under the HIPAA Privacy Rule ("a covered entity") violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule, you may file a complaint with the Office for Civil Rights (OCR). OCR has authority to receive and investigate complaints against covered entities related to the Privacy Rule. A covered entity is a health plan, health care clearinghouse, and any health care provider who conducts certain health care transactions electronically.