Coastal Virginia Counseling
Helping you reach your best

**Coastal Virginia Counseling**
**3500 Virginia Beach Blvd. Suite 440**
**Virginia Beach, VA 23452**
**Office: 757-463-0971**
**Fax: 757-544-9880**
**Crisis: 757-606-0015**

**Acknowledgement of Policies and Procedures, Privacy Practices and Consent to Treatment:** By signing below, client and/or guardian acknowledges that he/she has reviewed, fully understands and agrees to the terms and conditions contained in the **Policies and Procedures** of Coastal Virginia Counseling and consents to treatment. Client has discussed said terms and conditions with Therapist, and has had any questions with regard to those terms and conditions answered to client's satisfaction. Client agrees to abide by the terms and conditions of the Policies and Procedures and consents to participate in counseling/therapy with Therapist. Client acknowledges specifically reading the policy and procedures related to billing and communication with insurance companies and agrees to same. Client agrees to hold Coastal Virginia Counseling free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Finally, by signing this form you acknowledge that you have read and understand the **Notice of Privacy Practices,** and that it has been explained and offered to you both today in the office and made available at www.coastalvacounseling.com. After reading and understanding the Policies and Procedures and the Notice of Privacy Practices, you (and on behalf of any minor you are legal guardian) consent and agree to participate in and receive treatment from Coastal Virginia Counseling.

_____
**Printed name of Client**

_____ _____
**Signature of Client/Parent/Legal Guardian of Minor Child** **Date**

_____
**Signature of Counselor/Therapist**

**Communication by Email, Text Message, and Other Non-Secure Means**

During the course of treatment, it may become useful to communicate by contemporary means such as email and/or text. Please be informed that these methods are not confidential methods of communication.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS.

I consent to allow Coastal Virginia Counseling, LLC to use unsecured email and mobile phone text messaging to coordinate scheduling and other treatment related information. I have been informed of the risks of unsecured communications including, but not limited to a breach of confidentiality in treatment and unauthorized access of the data and information transmitted by e-mail and/or text messaging. I understand that I am not required to sign this consent in order to receive treatment. I also understand that I may terminate this consent at any time by notifying Coastal Virginia Counseling, LLC in writing.

_____
**Printed name of Client**

_____ _____
**Signature of Client/Parent/Legal Guardian of Minor Child** **Date**

*Revised 10/2016*

# COASTAL VIRGINIA COUNSELING, LLC

HELPING YOU REACH YOUR BEST
SUITE 440
3500 VIRGINIA BEACH BLVD.
VIRGINIA BEACH, VIRGINIA 23452
TELEPHONE (757) 463-0971 FACSIMILE (757) 544-9880

**AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION**

I, _____ hereby authorize _____ to:

___X___ Release medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC, and/or AIDs information to:

___X___ Exchange information on an ongoing basis with:

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Virginia Beach, Virginia 23452
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for the purpose of individual, group and family therapy. The specific records/reports to be disclosed shall include:

| | | |
|---|---|---|
| ___X___ Complete Record | _____ Progress Notes | _____ Lab |
| _____ Abstract | _____ Consultations | _____ X-ray Reports/films |
| _____ History & Physical | _____ Emergency | _____ Diagnostics |
| _____ Discharge Summary | _____ Procedures/Operative | _____ Therapy Records |
| _____ Reports | _____ Patient Questionnaire | |
| _____ Other, Specify type: | _____ | |
| _____ Itemized Statement of account | For Date(s) of Stay/Treatment: ALL___ | |

I understand that this consent is revocable upon written notice to the hospital/healthcare provider, except to the extent that action has already been taken on this authorization. Letters of revocations should be sent to the Medical Records Department. The authorization shall expire two years from the date stated below OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me: my written revocation. Any information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Alcohol, drug, HIV, ACR and/or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are accepted only if agreed upon by both parties. It is expressly understood and agreed that any and all copies of this Authorization shall be valid and of the same force and effect as the original. I understand that the information disclosed pursuant to this authorization is subject to re-disclosure by The Dickerson & Smith Law Group, and no longer protected by state or federal confidentiality rules, regulations or law.

_____ _____
Client Name Date

_____ _____
Date of Birth Social Security Number

_____
Client or Parent/Legal Guardian Signature