Coastal Virginia Counseling
101 N. Lynnhaven Rd. Suite 308
Virginia Beach, VA 23452
Office: 757-222-4944 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 _____***(initial).*** 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.

I understand that if a credit card is on file, such credit card will be charged for payments. Additionally the credit card on file will be charged for missed appointments if not given notice 24 hours or more in advance of the scheduled appointment time _____***(initial).***

Finally, by signing this form you acknowledge that you have read and understand the **Notice of Privacy Practices (HIPPA form),** 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, and consent to the exchange of information with your health insurance provider as necessary for charging your insurance for services rendered.

_____ _____

Printed name of Client **Signature of Client/Parent/Legal Guardian of Minor Child**

_____ _____

Date **Signature of Witness**

Communication by Phone, 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 _____ ***(initial).*** I consent to allowing voice messages to be left on phone number provided in the intake _____ ***(Initial).*** 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 **Signature of Witness**

Revised 012/2017