Dear Parent,

Thank you for enrolling your child in the Nurture and Grow/Sprout group. Throughout the course of the group, we will send home information with your child about anxiety and ways that you can support your child as they learn some helpful techniques. The goal of the group is not to eliminate anxiety or other emotions, but rather to assist your child in their ability to identify, understand and manage those feelings.

Although the majority of group is done with your child, your support and participation are very important. We encourage you to read over the materials provided, ask your child to share with you what they are learning and support your child by practicing the new techniques with them. A key component of success is practicing what is learned. When a child is stressed or worried, they often need a supportive adult to remind them of the new skills they have learned.

You and your child will learn more about how to recognize and manage feelings as they participate in the group. Some techniques will work better for your child than others. We know that children demonstrate faster benefits when they are able to apply what they have learned to real world situations. Those moments will be the time that your support will play a valuable role.

Please feel free to reach out to the group facilitators, ask questions along the way and share any concerns that you may have. If you have any concerns or questions about the material presented, please feel free to contact one of the group facilitators:

Angie Hilken, LCSW

angiehilkenlcsw@gmail.com

407-706-7074

Summer Darnell, LMHC

summer@thenurtureplace.org

202-321-2020

INTAKE INFORMATION

Child's Name _____ D.O.B. ____/____/____ Age _____
Parent's/Legal Guardian's Name _____
Resides With _____ Relationship _____
Current Address _____
_____
Home No. _____ Mother's Work. No. _____ Father's Work. No. _____ Mother's Cell _____Father's Cell _____

Parent's Marital Status (please circle): Married/Never Married/Divorced

Is there a divorce or a separation in progress? ☐Yes ☐No

Has the child ever received counseling or psychological testing before? ☐Yes ☐No When? _____ Where? _____

With whom? _____

Has the child ever been admitted into a mental health hospital? ☐Yes ☐No

If so, when and where? _____
Medications _____
_____

Any allergies/serious medical conditions? ☐Yes ☐No

If so, please specify: _____
_____

Has the child ever threatening or harmful to self or others? ☐Yes ☐No

Does the child attempt to run away? ☐Yes ☐No If so, when? _____

Presenting Behaviors: _____
_____

Signature _____ Date _____

GROUP COUNSELING CONSENT, POLICIES & AGREEMENT

If you do not understand any part of this agreement, please ask any questions prior to signing the agreement. You may also receive a copy of this agreement, please ask the therapist/facilitator if you would like to have one. All persons must also sign the Privacy Practices Notice (HIPAA) form as well.

I hereby grant my permission for The Nurture Place therapist/facilitator, to provide group psychotherapy services in the form of group.

Group Counseling & Therapeutic Process: Participating in group counseling can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek group counseling.

Many people report discomfort during group counseling as they begin to look at areas in their life that aren't working or not working as well as they would like them to. Sometimes undesirable feelings can emerge as one considers unpleasant, difficult or embarrassing subjects. The facilitator or group may suggest new and different ways of handling situations that may trigger upsets for you.

Change can happen quickly; but more often it can be slow. For some, problems may get worse before they get better. It is also possible that group counseling does not work. Even so, many people find that group counseling is worth the difficulty it may entail leading them to the intended results they are seeking.

Confidentiality:

● I agree to indemnify and hold The Nurture Place harmless for any loss or damages, including costs and attorney's fees, incurred by The Nurture Place as a result of my breach of another's confidentiality.

● Further information regarding these situations and my privacy rights has been provided in the Notice of Privacy Practices for Protected Health Information

I also understand that anything said in group is confidential, *except* for the following limitations: ● Anything said between any two or more group members at any time is part of the group and is confidential. I understand that everything said in this group is confidential and not to be shared with anyone outside of the group, except as may be

otherwise required by law.
I agree to keep confidential the names of other members of the group and what is said in the group.

As a member of this group, I agree to not disclose to anyone outside the group any information that may identify another group member. This includes, but is not limited to, names, physical descriptions, biological information, and specifics to the content of interactions with other group members.

● Child abuse and/or neglect (which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out, physical abuse, etc) (Florida statute 39.201),

● Vulnerable adult abuse or neglect (Florida statute 415.1034),
● Threats to harm oneself (Florida statute 413.341),
● Threats regarding harm to another person (Florida statute 413.341),
● A court subpoena, or
● My specific request, in writing, to disclose information regarding my psychotherapy to a third party.

* Please note that if you choose to send communications through text or email these communications are not protected and confidentiality cannot be assured.

Group Counseling Structure, Frequency & Guidelines:

See attached for Group days and times

Emergencies:

It is necessary that The Nurture Place therapist/facilitator has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name: _____

Relationship: _____

Phone Number(s): _____

_____

□ I agree to allow The Nurture Place therapist/facilitator to contact my emergency contact on my behalf should an emergency arise.

I understand that the therapist/facilitator is not available 24 hours a day and that in a crisis situation, I should call 911. All participants, 18 years of age or older, are required to sign this agreement prior to attending a therapy/group counseling session. Minor children are invited, but not required, to sign this agreement.

Your signature on this agreement signifies that you have read, understood and are consenting to services provided by The Nurture Place.

By my signature below, I indicate that I have read carefully and understand the Group Consent, Policy and Agreements, and I agree to its terms and conditions. I have asked and had answered any questions I have concerning the Group, Consent, Policy and Agreements. I am aware signing the Agreement is required for my admission to the group. I am also aware that my refusal to sign this Agreement will exclude me from participating in the group.

Signature:_____
Date:_____

Consent to Participate in Group

Consent for participation of Minor Child(ren) in group: I hereby certify that I have the legal right to seek services for minor(s) in my custody and give permission to The Nurture Place to provide service to my minor child(ren). If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **The Nurture Place** prior to or at the beginning of group. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Name of child_____

Name of Parent_____

Parent Signature_____

Date_____

Name of witness_____

Witness Signature_____

Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you.

I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.

- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or

   administrative order, although my preference is to obtain an Authorization from you

   before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties

   authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or

counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last

six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature: _____ Date: _____