Vicki Steine, LCSW
License 1196
4939 Lower Roswell Road, Suite 201, Buidling C, Marietta, Ga 30067
404-275-6200

Consent for Treatment and/or Consultation

I, _____, authorize and request that Vicki Steine, LCSW provide counseling, evaluation, treatment and or assessment procedures, which now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my therapist/nutrition educator and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy and or nutrition consultation but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may be conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Client Signature: _____

Parent Signature _____
For minor

Date _____

YOUR HEALTHY STRUCTURE
A Holistic Approach to a Better You

Communication Addendum to the Informed Consent Agreement

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact Vicki Steine, LCSW will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change.

In the event that the client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail.

Voice communication to client's cell/smart phone for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

Voice communication from Vicki Steine's cell/smart phone for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

Fax communication to client's non-secure fax or E-fax for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

If permitted, list permitted fax number(s):_____

Text communication to client's cell/smart phone for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

Text communication from Vicki Steine's cell/smart phone for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

Contact via the client's email for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

If permitted, list permitted email address(es): _____

Teleconferencing based on communication to client's portal for:

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

If permitted, list permitted portal site:_____

Teleconferencing based on communication from Vicki Steine's portal for: (Not applicable at this time)

Scheduling appointments ___Permitted __Not permitted

Appointment reminders ___Permitted __Not permitted

Between session contact ___Permitted __Not permitted

If permitted, list permitted portal site(s):_____

Statement of Validation Regarding Communication Addendum to the Informed Consent Agreement:

I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.

By Client (s)

_____	_____	_____
Print Name Here	Sign Here	Date
_____	_____	_____
Print Name Here	Sign Here	Date

By Vicki Steine, DSC, LCSW

YOUR HEALTHY STRUCTURE
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Rating Scale of Concerns

Using a scale of 1-10, with 1 be lowest, 10 being highest, please rate your areas of concern.

If you rate something over 7, please describe in more detail in the comment section below.

___Personal relationships	___Depression	___Headaches
___Physical health	___Mood Swings	___Pain
___Mental health	___Anger	___Fatigue, lethargy
___Spiritual	___Anxiety	___Hormonal issues
___Work	___Panic attacks	___Allergies
___Finance	___Trauma PTSD	___Sleeping issues
___Eating/nutrition	___Memory problems	___Safety
___Addiction	___Personal Direction	___Major life Change_____
		___Other

Comment here if you rated something 7 or higher. Please write the category as well as your comments. Please write legibly. Use the back of this sheet if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Vicki Steine, DSc; LCSW 404-275-6200 vicki@yourhealthystructure.com

Name _____

Nutrition Educator Service Agreement

I, _____ am consulting with Vicki Steine, Doctor of Science in Holistic Nutrition and Licensed Clinical Social Worker to gain information on health and wellness. I understand that Vicki Steine is NOT a physician and that she does not dispense medical advice nor prescribe treatment. Rather, she provides information to enhance my knowledge of how nutritious foods, herbs, supplements, and lifestyle affect health.

Vicki Steine's training includes a Doctorate in Holistic Nutrition from Hawthorn University, a distance learning school based out of California. She also has a Masters in Social Work from the University of Georgia and a Bachelor's of Science in Child and Family Development from the University of Georgia. The methods of evaluation employed on my behalf, which may include diet, supplementation, and lab assessments are not intended to diagnose disease. I specifically authorize the use of such assessments to help develop an appropriate dietary and health-supporting program and to monitor progress toward achieving my stated health goals.

These services are not a substitute for medical care, and do not claim to diagnose, treat, or alleviate disease. Nutrition education services are not licensed in the state of Georgia and they are alternative or complementary to the healing arts services licensed by the state. For medical diagnosis and treatment of disease, I would need to consult with a medical physician or other licensed healthcare practitioner.

I am acting solely on behalf of myself. I do not represent any other person, entity, and/or governmental agency.

I am currently ___or am not___currently under the care of a physician for a health problem or medical condition. By providing the following information, I give Vicki Steine permission to contact my physician_____(name), at the following phone number_____ on my behalf. The purpose of this contact would be to attain additional information from my doctor on his/her diagnosis or recommended treatment in order that Dr. Steine may best provide me with appropriate and complementary information. I know that Dr. Steine is not, and cannot be, a primary healthcare provider.

I agree to hold Dr. Vicki Steine and Your Healthy Structure harmless for any claims or damages in association with our work together. This is a contract between Dr. Vicki Steine/Your Healthy Structure and me and a general release of liability to Dr. Vicki Steine and Your Healthy Structure.

I understand that Dr. Vicki Steine has a 24 hour cancellation policy and I am aware that I will be charged for a missed session if proper notice is not given by calling and leaving a message at 404-275-6200.

Signature_____

Client

Name_____Date_____

Please keep a copy for your records.

YOUR HEALTHY STRUCTURE

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Date:_____Referred by:_____

If you are an EAP client, authorization number_____

Client Name: _____ DOB:_____ Age:____

Address:_____

State:_____ Zip:_____Home phone:_____Male__ Female___

Mom cell:_____ _____ Dad cell:_____Client cell:_____

Email address:_____

School: _____ Grade:_____

Client/parent/guardian employer:_____

List people who live in home:

Name	Relationship to Client	Age	Unusual Problems

Client's marital status: N/A Single Married Separated Divorced Widowed Other

Client's parents marital status: Single Married Separated Divorced Widowed Other

Diagnosis:_____

Please list medications:

Medication	Condition Requiring Meds	Prescribing Dr.	Optional: Dr. phone	Dates meds started

YOUR HEALTHY STRUCTURE
A Holistic Approach to a Better You

Vicki Steine, DSc; Holistic Nutrition; LCSW
4939 Lower Roswell Road Suite 201 Marietta, Ga. 30068
Office 404-275-6200
Vicki@yourhealthystructure.com

Dear Client,

In an effort to better serve you and keep the practice running smoothly, here are a few reminders about office policy:

Sessions are 50 minutes, unless otherwise discussed, and begin and end promptly.

Business, such as payment and appointment scheduling, is handled at the end of each session.

Payment is due at the time services are rendered. Attending psychotherapy statements will be given to you to submit for reimbursement from your insurance company if you so request. You may keep a credit card number on file with the front office for ease of payment.

Cancellations: Your time is reserved for you and cancellations must be made **24 hours prior to the appointment time** or the **full fee** will be charged.

If you are an EAP Consultant client, please note that if you do not show for a scheduled appointment, it counts toward your total number of sessions. Please let me know if you need to cancel a session so that you receive your full benefits.

Emergency situations: Of course it is understandable that emergency situations might arise that could prevent you from being able to cancel your appointment 24 hours in advance. Included in this category are: illness, illness of your child, accident and car trouble. A phone call informing me of your situation would be appreciated.

Scheduled Telephone or Skype Sessions: If you are ill, at home caring for someone ill, are hospitalized, or are out of town, and wish to schedule an appointment, that option is available to you. You will be responsible for all telephone charges and will call the office number at the scheduled time. Payments may be mailed to the office.

Additional Professional Services: Additional charges will be added to your account for professional services rendered by me, including:
Unscheduled telephone contacts over 15 minutes. These will be charged at $25 for each 15 minutes.
Scheduled telephone calls: first 15 minutes are free. $25.00 per 15 minutes will be charged after that.
Extensive communication with insurance companies or **special reports** will be billed at the same rate as above.

Confidentiality: As a reminder, client/therapist confidentiality is upheld unless there are disclosures of child abuse or of harm to the self or others.

Waiting Area: Please wait in the lobby for me to come get you. If my office door is open and I am not in there, please inform Max that you are waiting.

Because I am human and issues can arise for anyone, if I have communicated something to you, either verbally or in writing, that is confusing or upsetting in any way, I encourage you to **please discuss it with me.** I thank you for choosing me as your therapist and I look forward to assisting you on your path.

I have read and understand the policies mentioned above.

Signed by: _____

Date: _____

Additional: I would like to be added to the weekly blog/newsletter, Your Healthy Structure. Information is provided on mental health and nutrition.

Please circle: Yes No

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Vicki Steine, LCSW

NOTICE OF PRIVACY PRACTICES
Please review this carefully
The privacy of your health information is an important matter

This notice describes how medical information about you may be disclosed and how you can get access to this information. I am required by law to provide you with the information because of the privacy regulations of a federal law called the Health Insurance Portability and Accountability Act of 1998 (HIPAA). Because this law and the state laws are rather complicated, I have attempted to simplify the information.

If you have any questions about the information contained in this privacy policy, please do not hesitate to ask. Each practice must have a designated Privacy Officer and she will be glad to answer your questions. I handle all of my own administrative matters.

The HIPAA law requires me to keep your Protected Health Information private and to give you this notice of this privacy policy and legal duties which is called the Notice of Privacy Practices or NPP. When I read you information it is called "use", in the law. If your information is shared with others outside of myself it is called "disclosure", in the law. When I disclose your Protected Health Information with others I share only the minimum necessary information needed for the purpose. The law gives you the right to know abut your PHI, how it is used and to have the right say to say how it is disclosed.

Each time you visit me or any healthcare provider, information is collected about you and your physical/mental health. It may be if information about your past, present or future health or conditions, or the treatment you received from others or me or about payment for healthcare. The information I collect from you is called PHI, which stands for Protected Health Information. This information goes into your healthcare record or file.

Generally, I use your PHI for three purposes: treatment, obtaining payment and healthcare operations. I use your information to bill you or your insurance company to be paid for treatment I provide to you. I have to tell your insurance company about your diagnosis, what services you received, at times your progress, and treatment plans.

The PHI is likely to include these kinds of information:

Social and medical history, reasons you came for treatment/counseling; diagnosis; treatment plan; progress notes; records I receive from other professionals who have evaluated/treated you; psychological matters, if applicable; billing and insurance information.

I use this information for the following purposes:

To plan your treatment; o decide how well the plan is working; when I talk with other healthcare professionals who are treating you; when I talk to other healthcare professionals who referred you to me; to show that you actually received the services for which I bill you or your health insurance company.

If I want to disclose, (release) your information for any purpose, I will need your written permission on an authorization form to allow this.

The law requires me to disclose information without your consent in certain situations. The following situations are:

I have to report suspected child abuse
If you are involved in a lawsuit or legal proceeding and I receive a subpoena, I may have to disclose information.
If I receive a court order to disclose information, I will have to obey the order.

When there is a serious threat to your health and safety or the health and safety of another individual or public. (I will only share information with a person or organization that is able to help prevent or reduce the threat.)
I may have to disclose information to the government agencies that check on healthcare providers like me, to see that we are obeying the privacy laws.

Although your health record is the physical property of the healthcare provider who collected it, in this case I, the information belongs to you. You have a right to inspect, read or review it. If you want a copy I can provide this; however, there may be a charge for the costs of copying and mailing if you want it mailed to you. In some situations you cannot see all of what is in your records. If this is the case, I will be happy to explain this to you

You may request how I contact you, for example, if you wish to contacted at home only or work only or by cell phone only, etc.

If you find anything in your record that you this is incorrect or you think something important is missing you can ask me to change or amend you record, although in some rare situations I don't have to agree to do that
You have a right to a copy of this notice. You have a right to file a complaint if you feel your rights have been violated. You can also file a complaint with the Secretary of Health and Human Services, US Department of Health and Human Services, Washington, D.C.

I have read and understand the information outlined above.

_____ _____
Signature of Client Date