Informed Consent

Alyce E. Wellons, LCSW
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Smithfield, North Carolina 27577
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My name is Alyce Wellons and I am a Licensed Clinical Social Worker with 25 years of experience in the field of clinical social work. I have a Master in Social Work from Clark Atlanta University, earned my license as a Master Social Worker in 1995, and my license as a Clinical Social Worker in Georgia in 1999. I currently have my own practice for the general practice of clinical practice and psychotherapy.

I am trained and experienced in providing psychotherapy individually, with couples, families, and in groups with adults and adolescents. I have additional training in Mindfully Based Stress Reduction (MBSR), a Certified Imago Therapist, and a certified Level II with Trauma specialization in LifeForce Yoga for mental health.

Earlier in my career, I worked in non-profit agencies serving different populations from HIV to homeless substance abuse as well as long term inpatient and outpatient treatment centers for addictive and psychiatric disorders. I have in depth, long term training in the assessment, diagnosis and treatment of addiction from over 15 years of working in inpatient and outpatient treatment settings, ongoing continuing education, and presenting on the various aspects of addiction. I provide consultation, continuing education and am a frequent presenter and member of panels at various institutions and settings throughout Georgia.

Mandatory Disclosure Statement

Client Rights and Important Information

You are entitled to receive information from Alyce E. Wellons, LCSW about the methods of therapy/assessment, the techniques used, the duration of your therapy and fee structure. Information regarding this will be provided upon your first meeting at Alyce E. Wellons, LCSW.

As a client, you have the right to choose a counselor/therapist who best suits your needs and purposes. Please be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end therapy at any time.

In Case of Emergency

If you have an urgent situation that you feel needs immediate support, please take the following steps first: (1) Call 911 (2) Go to the nearest hospital emergency room. After the emergency is over, please follow up with me for continuity of care.

Termination of Treatment

If you decide to terminate therapy, you understand that it can be helpful to discuss termination with your therapist. This can be an important part of the therapy process. Alyce E. Wellons, LCSW reserves the right to discontinue therapy due to continual cancellations, lack of payment, our clinical work in no longer beneficial, etc.

☐By checking, I agree to the terms of termination of treatment.

Complaint Procedures

If you are dissatisfied with any aspect of the counseling/assessment process, please inform Alyce E. Wellons, so we can determine if our work together can be more efficient and effective or if a referral is appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact: The North Carolina Social Work Board: NCSWCLB, PO Box 1043, Asheboro, NC 27204. The Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, http://verify.sos.ga.gov/verification/ to file a complaint.

☐By checking, I understand how to file a complaint if one were to arise.

PRIVILEGED COMMUNICATION

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential with some exceptions. As a mandated reporter by the state of North Carolina and Georgia, I must report any instances where you present a danger to yourself, others, or where the safety of minors or elderly are at risk.

☐I understand that all communication between myself and Alyce E. Wellons, LCSW is privileged communication except where prohibited by law.

45 CFR 164.520] 45 C.F.R § 164.520 - Notice of privacy practices for protected health information.

(a) Standard: notice of privacy practices— (1) Right to notice. Except as provided by paragraph (a)(2) or (3) of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information.(1) Required elements. The covered entity must provide a notice that is written in plain language and that contains the elements required by this paragraph. (i) Header. The notice must contain the following statement as a header or otherwise prominently displayed: “THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.” (ii) Uses and disclosures. The notice must contain:(A) A description, including at least one example, of the types of uses and disclosures that the covered entity is permitted by this subpart to make for each of the following purposes: treatment, payment, and health care operations.(B) A description of each of the other purposes for which the covered entity is permitted or required by this subpart to use or disclose protected health information without the individual's written authorization.(C) If a use or disclosure for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of this section is prohibited or materially limited by other applicable law, the description of such use or disclosure must reflect the more stringent law as defined in § 160.202 of this subchapter.(D) For each purpose described in paragraph (b)(1)(ii)(A) or (B) of this section, the description must include sufficient detail to place the individual on notice of the uses and disclosures that are permitted or required by this subpart and other applicable law.

☐By checking, I understand my rights to privacy of my protected health information.

Teletherapy

Telemental Health is the delivery of psychological testing or psychotherapeutic services using interactive audio and visual electronic systems and/or by the electronic transmission of information where the provider and the client are not in the same physical location.

My practice uses a HIPAA-compliant secure video platform, encrypted end-to-end, with a BAA to ensure your privacy.

As a client, it is your responsibility to choose a secure location to ensure that family, friends, employers, co-workers, strangers, or hackers cannot overhear my communications or have access to the technology or devices I am using.

☐By checking, I understand and agree to assessment and/or treatment via the use of HIPAA-compliant Secure video as deemed necessary by my clinician.

RELEASE OF INFORMATION

If you would like me to release your records to another provider/agency/school, you may request a Release of Records form. All requests disclosure of health information must be in writing and signed by the client. Legible facsimiles are acceptable. A release form will be provided upon request. The signed form can be mailed or faxed.

Mail to: Post Office Box 2524, Smithfield, NC. 27577 Email to: alycewellons@hushmail.com.

☐By checking, I understand I must complete a release of information form with the provider/agency/school name for Alyce E. Wellons, LCSW to communicate information to those entities.

I give my consent to complete an assessment and/or treatment. I understand that the information provided is strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. I am aware, however, that information may be released without consent in the case of a medical emergency or if the information is court ordered. I grant Alyce E. Wellons, LCSW, permission to seek emergency medical care from a hospital or physician if deemed necessary. I am aware I have the right to refuse or withdraw from evaluation or treatment any time.

In an emergency, I would like _____ called, their number is _____.
Name & Relationship Phone number

If they are not available or I need to be hospitalized, I would like to be admitted at _____.
Name of hospital

☐By checking, I am giving my consent for a complete assessment and/or treatment. I also agree that I may be admitted to the above hospital if Alyce E. Wellons, LCSW deems it necessary in an emergency or mental health crisis.

Clients Rights General Statutes 122C-51 Declaration of policy on clients' rights.

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment. It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

Assessment and Treatment or Service Plan. The plan shall include: written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Disability Rights North Carolina is a private nonprofit organization. Designated by the Governor in 2007 to ensure the rights of all state citizens with disabilities through individual advocacy and system change, DRNC is part of a national system of federally mandated independent disability agencies. DRNC is completely independent of government and the disability service system in order to be free of any conflicts of interests which would undermine our capacity to advocate vigorously on behalf of the human and legal rights of people with disabilities. If you feel your rights are being violated or that you require assistance, you may contact Disability Rights North Carolina.

Address: 2626 Glenwood Avenue Suite 550, Raleigh, NC. 27608 Telephone: Voice (919) 856-2195 Toll Free Voice (877) 235-4210, TTY 888-268-5535 Fax: (877) 235-4210 Email: info@disabilityrightsnc.org

☐By checking, I understand my rights as a client of Alyce E. Wellons, LCSW.

Payment Agreement

It is understood that the client is responsible for the full payment of services rendered at the time of each visit. If you would like a super bill or tax preparation statement, please let me know and one can be provided. I, Alyce E. Wellons, will prepare the document, we will review together, and you will then be responsible to submit.

Insurance companies state that any information provided is not a guarantee of payment. As such, if your insurance carrier does not remit payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. All insurance refunds will be remitted to you the client.

If a scheduled appointment is missed, you will be charged the full session fee unless the appointment is cancelled 24 hours in advance. If two or more appointments are missed without 24 hours' notice the client may be dismissed from the practice for a period of time or permanently.

A credit card must be kept on file through Square and will be charged at the time of each session.

FINANCIAL RESPONSIBILITY: The undersigned agrees, whether they sign as agent or as patient, that in consideration of the services rendered to the patient, he/she/they hereby individually is obligated to pay Alyce E. Wellons, LCSW the full charges as incurred over the course of treatment, including those fees not paid by the insurance carrier and/or other sources of financial support or benefit. In the event

that it might become necessary to refer the account to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Please discuss these matters with Alyce E. Wellons if you have any further questions.

☐By checking, I agree to having my credit card information securely stored through Square and payment to Alyce E. Wellons, LCSW at the time of services rendered.

☐By checking, I agree that I have received a copy of this document and been given the opportunity to ask questions.

Signed: _____
Date: _____