TRANSITIONS GRIEFCARE CONSENT

REQUEST FOR CARE AND CONSENT FOR PROVISION OF SERVICES

I, _____, request and authorize Transitions GriefCare to provide family illness education and support, pre-bereavement and/or bereavement services for the following (check all that apply):

☐ Myself | Date of Birth: _____

☐ My minor child (age 5-17) | Child's Name: _____ Child's Date of Birth: _____

I understand that grief counselors are bound by the laws, licensing, and regulations in North Carolina. As such, I agree that I will be residing in North Carolina while receiving grief services and agree to contact Transitions GriefCare if I am in another state or have a change in my address.

Address: _____ City, State, ZIP: _____

I authorize service delivery through the following (consider checking both for potential future needs):

☐ In-person ☐ Telehealth (audio/visual)

INFORMATION ABOUT SERVICES

I understand that Transitions GriefCare provides short-term grief support and counseling. Grief counselors refer to community mental health professionals when there are complicated grief concerns or other mental health needs that may benefit from closer monitoring or long-term counseling. Collaboration with other mental health professionals may be required to access services through Transitions GriefCare.

If I am unable to attend a scheduled appointment or group session, I agree to call Transitions GriefCare staff at least 24 hours in advance. Staff can be reached by calling 919.719.7199. In the event that I have more than one missed appointment, I understand that I may not be able to be rescheduled.

CONFIDENTIALITY AND PRIVACY PRACTICES

_____ (initial) I understand that the information disclosed by me to Transitions GriefCare will be kept confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are outlined in detail in our Privacy Practices (HIPAA) which have been made available to me. I am aware I can access this information at any time on the Transitions LifeCare website at transitionslifecare.org.

For reference, these exceptions are listed below:

1. I have given written authorization for the release of information.
2. In instances where the counselor believes I am at risk of harming myself or others.
3. When there has been an indication or report of physical or sexual abuse of a child or older adult.
4. When clinical records are subpoenaed by a legal entity.

I understand that while email may be used to communicate with my counselor, the confidentiality of emails cannot be guaranteed.

In the event counseling or support is taking place in a group setting, participants will be advised to treat what is being discussed as confidential and asked not to share information with others outside of the group. Confidentiality in a group setting cannot be guaranteed.

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INFORMATION ABOUT TELEHEALTH SERVICES

There may be instances where telehealth may not be advised or supported based on my unique needs.

I understand that there are risks and consequences of telethealth even when utilizing HIPAA-secure platforms, including but not limited to my information being disrupted or distorted by technical failures, information being interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons. Screenshots, photos and recording are strictly prohibited.

I understand that I am responsible for:

1. Providing the necessary computer telecommunications equipment and internet access and ensuring the security of my computer or device.
2. Securing a private location where the session cannot be overheard by others. I am required to inform Transitions GriefCare staff if there are others in the room, or who I believe may overhear the session.
3. Minimizing background noise, distractions, or intrusions for my telehealth session.
4. Accurately reporting my location at the time of service.

EMERGENCIES

My local emergency contact's name: _____ phone number: _____

I accept that Transitions GriefCare does not directly provide emergency services and that normal business hours are 8:30am–5:00pm Monday–Friday, except on holidays. If I am experiencing a mental health emergency, I can:

1. Call 911 or proceed to the nearest psychiatric hospital or emergency room for help.
2. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).
3. Contact Mental Health First Responders in my area:
   a. Therapeutic Alternative Services (Wake, Harnett, Johnston, & Chatham counties): 1-877-626-1772
   b. Freedom House Recovery Center (Orange & Durham counties): 919-967-8844
   c. Daymark Recovery Services (Granville & Franklin counties): 1-866-275-9552

CONSENT TO SERVICES

By signing this form, I certify that I have read or had this form read to me, and that I understand and agree to the information provided above. I have been given ample opportunity to ask questions and my questions have been answered to my satisfaction.

_____ _____

Signature of Client or Authorized Representative (if a minor) Date

_____ _____

Printed Name of Person Completing the Form Relationship to Client

Transitions GriefCare
919.719.7199
transitionslifecare.org/grief-care

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