



Coastal Virginia Counseling  
Helping you reach your best

Coastal Virginia Counseling  
101 N. Lynnhaven Rd., Ste. 308  
Virginia Beach, VA 23452  
Office: 757-222-4944  
Fax: 757-544-9880

**Acknowledgement of Policies and Procedures and Consent to Treatment:** By signing below, client and/or guardian acknowledges that he/she has reviewed and fully understands the terms and conditions of the **Policies and Procedures** of Coastal Virginia Counseling and consents to treatment. 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 those Policies and Procedures and consents to participate in counseling/therapy with Therapist. 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.

**Acknowledgement of Notice of Privacy Practices**

By signing this form, you agree to the terms included in the **Policies and Procedures** of Coastal Virginia Counseling and acknowledge that the **Notice of Privacy Policies** has been explained and offered to you both today in the office and made available at [www.coastalvacounseling.com](http://www.coastalvacounseling.com). After reading and understanding the Policies and Procedures, you (and on behalf of any minor you are legal guardian) agree to participate in and receive treatment from Coastal Virginia Counseling.

\_\_\_\_\_  
**Printed name of Client**

\_\_\_\_\_  
**Signature of Client/Parent/Legal Guardian of Minor Child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Counselor/Therapist**

**Communication by 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. 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**

# COASTAL VIRGINIA COUNSELING, LLC

HELPING YOU REACH YOUR BEST  
SUITE 308  
101 N. LYNNHAVEN RD.  
VIRGINIA BEACH, VIRGINIA 23452

TELEPHONE (757) 463-0971

FACSIMILE (757) 544-9880

## AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to:

Release medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC, and/or AIDs information to:

Exchange information on an ongoing basis with:

**Coastal Virginia Counseling, LLC**  
101 N. Lynnhaven Rd., Ste. 308  
Virginia Beach, Virginia 23452  
(757) 222-4944  
(757) 544-9880 facsimile

for the purpose of individual, group and family therapy. The specific records/reports to be disclosed shall include:

<input checked="" type="checkbox"/> Complete Record	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab
<input type="checkbox"/> Abstract	<input type="checkbox"/> Consultations	<input type="checkbox"/> X-ray Reports/films
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Emergency	<input type="checkbox"/> Diagnostics
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Procedures/Operative	<input type="checkbox"/> Therapy Records
<input type="checkbox"/> Reports	<input type="checkbox"/> Patient Questionnaire	
<input type="checkbox"/> Other, Specify type: _____		
<input type="checkbox"/> Itemized Statement of account	For Date(s) of Stay/Treatment: <u>ALL</u>	

I understand that this consent is revocable upon written notice to the hospital/healthcare provider, except to the extent that action has already been taken on this authorization. Letters of revocations should be sent to the Medical Records Department. The authorization shall expire two years from the date stated below OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me: my written revocation. Any information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Alcohol, drug, HIV, ACR and/or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are accepted only if agreed upon by both parties. It is expressly understood and agreed that any and all copies of this Authorization shall be valid and of the same force and effect as the original. I understand that the information disclosed pursuant to this authorization is subject to re-disclosure by The Dickerson & Smith Law Group, and no longer protected by state or federal confidentiality rules, regulations or law.

\_\_\_\_\_  
Client/Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Parent/Legal Guardian

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