500 Holly Hills Road
Columbus, MS 39705
(662) 364-6058
vibrantcares@vibrantchurch.com

STATEMENT OF PROFESSIONAL DISCLOSURE
OFFICE PRACTICE AND POLICY

Thank you for selecting Vibrant Cares Center to provide you and your family with mentoring services. This statement is provided to assist you in making an informed decision about our services. Feel free to ask for clarification at any time.

Our facility is directed by a counselor who is supervised by a LPC-S (Licensed Professional Counselor Supervisor). In addition, we have certified mentors and graduate students who are completing their Master's and/or PhD degrees in counseling that have completed "Caring for People God's Way" by American Association of Christian Counselors through Light University. If a situation arises requiring additional expertise or medical advice, we will assist you with referrals for more appropriate services outside of Vibrant Cares Center.

The mentoring relationship differs from both social friendships and patient-physician contacts. Mentors are able to be objective and do not give specific advice. Instead, they serve as skilled listeners who help to clarify issues and deal effectively with problems.

The therapeutic process is also a cooperative effort between the client and the mentor where each assumes an active and responsible role in the process. Mentoring can help clients overcome destructive behaviors, heal relationships and develop more ways to effectively reach goals with support, encouragement, patience and optimism from a faith-based Christian perspective. We believe in the supremacy of Jesus Christ, and that all things are possible through Him.

OFFICE HOURS AND APPOINTMENTS
Individual sessions are 50 minutes in length. We ask that you arrive on time for all scheduled appointments so not to disrupt other scheduled client sessions. We see patients by appointment only, except for valid emergencies.

CANCELLATIONS AND MISSED APPOINTMENTS
If you are unable to keep your appointment, please provide 24 hour notice.
Note: You may stop your counseling sessions at any time with no penalty or repercussions.

IN CASE OF AN EMERGENCY
Who do you give us permission to contact?

Name: _____ Relationship: _____

Phone Cell: _____ Home: _____ Work: _____

CONFIDENTIALITY
Your communications and records are kept confidential and are protected both ethically and legally, with the following general exceptions:
1) If you intend to harm yourself or someone else, it may be necessary to involve other individuals to prevent such harm.
2) State law requires me to report known or suspected cases of child abuse, sexual abuse or abuse of the elderly or disabled to the Mississippi Department of Human Resources.
3) Your file may be subject to subpoena by the court.
4) If you are younger than 17 years old, your parents or legal guardians may have a right to know certain information. I will make every effort to maintain a relationship of trust with you, while acting in your best interest.

Complete information regarding financial requirements is provided in this introductory letter. Read it carefully, and if you have any questions please speak with me. With respect to your right to confidentiality, it is important to understand your right to remain anonymous in being a client.

With the above exceptions, confidentiality is limited. I will not discuss your case to people outside of the professional setting, nor will I tell people that you are a client. Professional setting is in the context of consultation and/or referral of cases between LPC, Graduate Student, Lay Counselor or Pastoral Counselor. Every effort will be made to avoid revealing your identity.

For you to waive the privilege of confidentiality, you must sign a release. If you wish information about yourself to be communicated to someone else, such as your physician, your attorney or in the case of a minor, a teacher or the school setting, please ask for a "Release of Information" form.

I do not present myself as an Expert Forensic Witness and choose not to participate in court-related testimony.

AGREEMENT AND SIGNATURES
I trust this information has been helpful to you and I look forward to a positive relationship with you in the days ahead. I welcome your questions and suggestions.

BY SIGNING BELOW, I STATE THAT I HAVE READ AND UNDERSTAND ALL STATED INFORMATION IN THIS DOCUMENT AND I AGREE TO COMPLY WITH ALL LISTED POLICIES AND PROCEDURES.

Client's Printed Name: _____

Client's Signature: _____ Date: _____

HIPAA
NOTICE OF INFORMATION PRACTICES and PRIVACY STATEMENT

How We Collect Information About You: Vibrant Cares Non-Profit (VC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications and clinical information that is either required by law, or necessary to process applications or other requests for assistance and services through our organization.

What We Do NOT Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between VC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need; or to obtain or purchase any type of medical supplies, devices, medications, insurance, assessment tools.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or results in either an actual crime of fraud for any reason, including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a counseling website, simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of VC. We reserve the right to use non-identifying information about our patients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Patients/Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Patient Signature **Date**

Printed Name **Date**