CHRISTOPHER GALTON, LPC
106 Black River Road
Myrtle Beach, SC 29588-7413
PHONE: (843) 650-1030 Cell: (843) 450-0455
E-MAIL: CBGalton@gmail.com
Web Page: LakeViewCounseling.net

I welcome you to this practice and hope you will find you have benefited when we have completed therapy.

Therapy is a **mutual** relationship. Once you have identified what problems you are having, we will work together to identify what you want in place of these problems. What we do in therapy is based on what you identify as your strengths and weaknesses as well as how determined you are to work on making **changes**.

Ultimately, your efforts within and outside the sessions will determine how successful your therapy will be.

A therapist can help you see alternatives and ways to change things, but….

Only *you* are the one who will make it **happen**.

Your responsibilities:

To provide honest and correct information to the therapist.
To keep your appointments, or cancel in a timely manner.
To pay for your counseling.

Therapist's responsibilities:

To listen and respond to what you are saying and asking.
Provide you with timely and up to date information.
To refer you to someone else if you need additional help.

Your rights:

To consent to treatment as well as to stop therapy.

To privacy: Every effort will be maintained to safeguard your privacy, including you being a patient or your diagnosis (etc.) unless you have provided written authorization or where mandated by state and federal statutes, which specify three exceptions: threatening to harm yourself or others or ordered by a judge.

Limitations:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions. Usually, these are resolved over a few sessions.

Christopher Galton is not a physician and cannot prescribe medications but he is knowledgeable about many and supports the appropriate use of them.

Christopher Galton is not available 24 hours a day. If you cannot reach him at the above numbers, you may go to the local hospital's Emergency Department.

If you feel you need different or additional service, Christopher Galton will be glad to help you find that.

Professional Disclosure Statement -- Christopher Galton LPC

The majority of these documents are mandated by both S.C. State law and Public Law 104-191; they are provided for your protection. Christopher Galton LPC has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with him.

Contact Information:
Christopher Galton LPC is located at 106 Black River Road, Myrtle Beach, SC 29588.
Office hours are Mon.-Fri. 9AM-6PM. The telephone/Fax # is: 843 650-1030. Cell # is: 843 450-0455 (not monitored)
Clients are seen by appointment only and special appointments for evenings and weekends will be considered.
The email address is **cbgalton@gmail.com.** This should not be used for emergency situations.
The webpage is **LakeViewCounseling.net** and contains more information regarding Christopher Galton LPC.

Personal Qualifications:
South Carolina Licensed Professional Counselor ID # 3548. Masters from the University of Arizona in 1975.
Therapist for Individuals (Children, Adolescents, and Adult), Couples and Families.

Licensed/Ethics
Christopher Galton LPC is licensed and follows the Code of Ethics of:
S.C. Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists.
They may be contacted: Mailing address is P.O. Box 11329, Columbia, SC 29211-1329 Phone # 803-896-4652
You may file a complaint with the above licensing body.
Any type of sexual behavior between therapist and client is unethical. It is never appropriate and not condoned.

Fees:
It is customary and expected to pay for professional services at the time they are rendered.
The hourly fee for individual, couple, and family therapy is $90 for the first hour and $80 for each subsequent hour.
However, I usually give you an hour and a half of therapy but only charge for one hour.
You will be billed $50 if you do not cancel within 24 hours of appointment time.
If you are able to use your insurance:
You will only be required to pay the co-pay for your therapy. If you do not know whether your deductible has been met, you will be charged full fee. Your fee minus the co-pay will be refunded if your deductible has been met.
You are responsible for any fees due to Christopher Galton LPC that your insurance company does not pay.
If you have a hardship and do not have insurance, Christopher Galton LPC may adjust payment.

Confidentiality: The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations.
Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system.
Christopher Galton LPC is mandated by standards - through Duties to Warn - to breach confidentiality if he discovers:
1.) You are threatening self-harm or suicide, 2.) You are threatening to harm another or homicide,
3.) A child has been or is being abused or neglected, 4.) A vulnerable adult has been/is being abused or neglected.
Your protected health information will not be released to another party unless you sign a Release of Information.
I may listen to anyone who wishes to provide me with information about you.
If you are under eighteen years of age, be aware that your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record.
At times I may use a cellular phone to contact you or return your calls if the information you are discussing requires a more secure level of confidentiality, please let me know so other arrangements can be made.
I discourage sharing personal information on e-mails due to e-mail not being a confidential mode of communication.
I use a Fax machine in communications with other agencies that includes a confidentiality statement. However, I cannot ensure that the Fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand-carry documents to agencies if you wish. I will also mail documents on special request.
I can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that I have already relied upon it. To revoke your general written consent, please write to us above.

Health Insurance Portability and Accountability Act of 2002 (HIPAA):

Christopher Galton, LPC

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. This document may be updated without notice so please review it each time you visit. A copy of this statement is always available upon request.
All information revealed by you in a therapy session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA.
As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below.
Additional information regarding your rights as a client can be found in the Professional Disclosure Statement.

Use or disclosure of the following protected health information does not require your consent or authorization:
1. Uses and disclosures required by law - like files court-ordered by a Judge
2. Uses and disclosures about victims of abuse, neglect, or domestic violence – like the Duties to Warn explained in the Disclosure Statement
3. Uses and disclosures for health and oversight activities - like correcting records or correcting records already disclosed
4. Uses and disclosures for judicial and administrative proceedings - like a case where you are claiming malpractice or breach of ethics
5. Uses and disclosures for law enforcement purposes - like if you intend to harm someone else (see Duties to Warn in your therapist's/counselor's Disclosure Statement)
6. Uses and disclosures for research purposes - like using client information in research; always maintaining client confidentiality
7. Uses and disclosures to avert a serious threat to health or safety – such as calling Probate Court for a commitment hearing
8. Uses and disclosures for Workers' Compensation – such as the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim.

If you use third-party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. I may use your health information or share it with others so that you can get paid for your health care services.
In some cases, I may also disclose your health information for payment activities and certain business operations of another healthcare provider or payer.

As a client, you have the right to see your counseling/therapy file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right. As a client, you have the right to receive a copy of your counseling/therapy file. This file copy will consist of only documents generated by us.
As a client, you have the right to request amendments to your counseling/therapy file.
As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ $.20/page.
As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations.
If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Intake Form for Christopher Galton, LPC

Please fill that information which is pertinent to you

Name: Last: _____ First: _____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone #: Home: (___) _____ Cell: (___) _____ Work/Other: (_____): (___) _____
E-Mail Address: _____@_____ If using Insurance, Social Security: _____-____-_____

Please indicate if you do not wish to be contacted at the above address, phone, or e-mail.

Date of Birth: ____/_____/_____ Age: _____ Gender: M____F____ O____ Race/Ethnic: _____
Marital: Single: __ Engaged:__ Married:__ Separated:__ Divorced:__ Widow/er :__ Cohabiting:__ Spouse's name:_____
Ages of: children living at home: _____ # of children living away from home: _____
Who to call should you have an emergency? _____ Relation? _____ Phone #: (___) _____
Employment Info: Where: _____ Full__ Part-time__ Unemployed__ Disabled__ Retired___
What kind of work do you do, now or in past? _____
What is your highest level of education? _____ What would you like to be doing? _____

What are your goals for therapy? What do you want different when we are finished?

_____
_____
_____

Briefly: What problem brought you here today? (Problems, symptoms, issues, length of duration, stressors)

_____
_____
_____

What do you think are the causes? Why do you think you have the symptoms? Is there anything in your family history that might relate to the problem you have now? (Childhood issues, family mental health, current family problems, separations, alcohol/drug problems, Employment situations, feelings of worthlessness, hurt, anxiety, anger)

_____
_____
_____

What have you done to try to resolve these problems?
(Things you have done, people or organizations you have attempted to get help from?)

_____
_____
_____

Here are typical feelings that people have. Which ones have you felt? Indicate which 2 you feel most by a double check.
Sad___ Lack of energy___ Irritable___ Depressed___ Worthless___ Anxious___ Panicky___ Angry___

Here are typical behaviors that people do. Do you find yourself doing any of the following?
Retreating___ not speaking up___ yelling___ being violent_____
Not sleeping well____ sleeping more than I feel I should_____ eating more____ or eating less_____
Using alcohol _____ using other drugs _____ to help you deal with things.

Have you …..
Hurt someone you love: physically____ emotionally____
Hurt yourself (risky behaviors, self-mutilation or attempting to kill self) _____
Have legal problems? _____ Your lawyer's name_____

Have you been in counseling, or been in a treatment facility? If so, whom did you see, when and where?

_____

How is your current health? _____
How long ago did you see a doctor? _____ List what **major** medications you take:

Medication Name	Purpose	Dosage	Frequency	When started	Physician

Agreements:

By signing on next page you agree to the following:

Fees:

It is customary and expected to pay for professional services at the time they are rendered.
The hourly fee for individual, couple, and family therapy is $90 for the first hour and $80 for each subsequent hour.
If you have a hardship and do not have insurance, Christopher Galton LPC may adjust payment as noted here: $_____ / session.
I usually give you an hour and a half of therapy but only charge for one hour.
You will be billed up to $50 if you do not cancel 24 hours before appointment time. If repeated, you may be required to put down a deposit (half of the next appointment's fee).

Insurance:

I authorize **Christopher Galton, LPC** to provide a summary of care and assessment information regarding treatment for the purpose of processing claims for Insurance/EAP benefits.
I authorize payments of insurance claims to be paid directly to **Christopher Galton, LPC**. I understand that he is making an the attempt on my behalf. I understand I am responsible for all co-payments and deductibles associated with the insurance.
If he is unable to collect, **it is ultimately my responsibility to pay for the agreed cost of the sessions.**
You will only be required to pay the co-pay for your therapy. If you do not know whether your deductible has been met, you will be charged full fee. Your fee minus the co-pay will be refunded if your deductible has been met.
You are responsible for any fees due to Christopher Galton LPC that your insurance company does not pay.

If using Insurance: **Provide a card --** ***or*** **-- fill out the following:**

Name of the client/insured (as Insurance has it): _____
If the client is not the primary employee: Relationship of the client to the employee: _____
Name of the employee: ___Employee's ID or S.S. number: _____Birthdate: _____
Address of employee: _____ Phone: _____
Address of employer: _____
Insurance Company: _____ Address: _____
Telephone: _____Fax: _____ Insured employer (if group policy): _____Group #_____
Another insurance plan you might be covered under? _____

Confidentiality: What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your or your legal guardian's written consent. While I may listen to anyone who wishes to provide me with information about you, I may not divulge info about you.
The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. The following is a list of exceptions:

- Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system.
- Duty to Warn and Protect: If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.
- Abuse of Children and Vulnerable Adults: If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.
- Prenatal Exposure to Controlled Substances: Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.
- Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. If you are under 18 years old, both your parents have a right to receive general information on the progress of the treatment.
- Insurance Providers: Insurance companies and other third-party payers are given information that they request regarding services to the clients.

Electronic Devices: At times I may use a cellular phone to contact you or return your calls if the information you are discussing requires a more secure level of confidentiality, please let me know so other arrangements can be made.
I discourage sharing personal information on e-mails due to e-mail not being a confidential mode of communication.
I use a Fax machine in communications with other agencies that includes a confidentiality statement. However, I cannot ensure that the Fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand-carry documents to agencies if you wish. I will also mail documents on special request.
I can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that I have already relied upon it. To revoke your general written consent, please write to us above.

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you may be billed up to the entire cost of your scheduled appointment if it is not canceled in a timely manner, unless such cancellation is due to illness or an emergency. We appreciate your help in keeping the office schedule running timely and efficiently.

Fees

It is ultimately my responsibility to pay for the agreed cost of the sessions (should insurance not pay**).**

Consent for Treatment and Limits of Liability and Responsibility of Payment :

By signing below, my signature (and those who attend with me) confirms that I: have received, understand, and accept the information and agreements contained in, agreed to the above assumption of risk and limits of confidentiality and understand their meaning consent to the use and disclosure of my health information as agreed upon, and am ultimately responsible to pay for the agreed cost of the sessions.

I

_____ _____

Signature of Client **(Client's Parent/Guardian if under 18)** **Date**

……..

_____ _____

Signature of Client #2 Signature of Client #3

I am in possession of the following pages:

1. Welcoming page with information about therapy
2. Professional Disclosure Statement
3. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Client's Right
4. Client Intake Form
5. Agreement for: Fees, and Confidentiality
6. Signature page -- Consent for Treatment

(Release of Information when needed)

Authorization for Use or Disclosure of Protected Health Information