RUACH RESTORATION, LLC

Jennie Armstrong, DMin, LPC
Licensed Professional Counselor
1711 Meriweather Drive, Suite 100
Watkinsville, GA 30677
706-431-3910

PROFESSIONAL DISCLOSURE STATEMENT

BELIEF STATEMENT

Professional Christian Counseling integrates the best theory and proven methods of the mental health profession with Biblical truths and spiritual practices to produce "Christ-like" character, behavior, and contentment in the lives of the people served.
Clients can expect to receive professional Christian counseling built from biblical wisdom and Christian spiritual formation, combined with current mental health practices. The counseling, available here, is holistic in that it is oriented toward a bio-psycho-social-spiritual assessment and intervention. I believe the goal of treatment is to address the mental and emotional issues with the goal of growing in Christian maturity.

BACKGROUND INFORMATION

The following disclosure of my educational background and therapy experience is an ethical requirement of my profession. If you have any questions, please feel free to contact me or discuss further at your scheduled appointment time.

BBA Finance from the University of the Georgia (1994)
Emmanuel College (2014-2015)
Hope Counseling Center- Mt. Paran, Atlanta, GA, (2014-2015)
MA Counseling from Richmont Graduate University (2015)
Certificate Christian Sex Therapy from Richmont Graduate University (2015) Certificate Spirituality and Counseling from Richmont Graduate University (2015) Certificate Spiritual Formation from Renovaré Institute in Spiritual Formation (2015)
Angel H. Davis, P.C. (2015-2018)
Ruach Restoration LLC (2018-present)
Doctor of Ministry Spiritual Formation and Leadership from George Fox Evangelical Seminary (2019)

RUACH RESTORATION, LLC

CONFIDENTIALITY

All information that you provide during a session is confidential, other than to insurance companies (if you choose to use insurance). Records or any information shared will not be divulged to anyone without discussing this with you first. You would indicate your consent by signing a "Release of Information" form. Exceptions to this include my responsibility to report any instance of suspected child abuse or neglect, any situation in which a client threatens to harm themselves or another person, (these are both Georgia State laws), and any situation that my records are subpoenaed by the court and I will be held in contempt of court if I fail to comply.

FEES and INSURANCE POLICIES

Services are provided at a rate of $150.00 for a 50-minute session. Acceptable forms of payment are cash, check, and credit card (3.5% transaction fee applicable).

Insurance policies are a contractual agreement between you, the subscriber, and the insurance company. I can in no way alter the policy nor guarantee what services are covered or ascertain what your reimbursement will be for my services.

CANCELLATION POLICY

Please give a 24-hour notice, per email, if you need to cancel or wish to change your appointment. In case of emergencies, call as soon as possible. There will be a full-session charge for appointments not kept or cancelled according to the 24-hour policy requirements.

IN CASE OF AN EMERGENCY

Ruach Restoration LLC is considered to be an outpatient facility, accommodating individuals, couples, and families who are reasonably safe and resourceful. We do not carry a beeper, nor are we available at all times. Generally, we will return phone calls within 24 - 48 hours.

If you have a mental health emergency, you are encouraged not to wait for a call back. Rather, please take immediate action with one of the following options:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other crisis hotline
- Call Ridgeview Institute at 770.434.4567 or local hospital
- Call Peachford Hospital at 770.454.5589 or local hospital
- Call SummitRidge Hospital at 678-442-5800
- Call 911.
- Go to your nearest emergency room.

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

USE OF EMAIL/TECHNOLOGY

Email and texting can be used to schedule or change appointments. I also offer email as a form of sharing, as you need to. Please not that counseling will NOT take place via email or texting. You are free to share what you need to share, but please note that only short responses or no response may be given back to you. There is much that can be misconstrued via technology, so I use it on a limited basis. All information over these methods is held confidential according the policy mentioned above.

_____ _____

Signature Date

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

Jennie Armstrong, DMin, LPC
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1711 Meriweather Drive, Suite 100
Watkinsville, GA 30677

CONSENT FOR SERVICES

I want to welcome you as a client and appreciate the opportunity to serve you. This form is an agreement that gives permission to Ruach Restoration LLC to provide services to you. It is also designed to provide you with information to answer some of the questions you may have regarding your visits to this office and to help you use our services more effectively. Please read this sheet carefully and direct any questions to **Jennie Armstrong, DMin, LPC.**

1. I am requesting services provided by Ruach Restoration LLC.
2. I hereby give my consent for evaluation, treatment and/or support from Ruach Restoration LLC.
3. I agree to provide accurate and complete information to the Ruach Restoration LLC and to update this information as changes occur.
4. I understand that all professional communication between client and counselor will be held in confidence and will not be revealed without my (or a parent, in the case of a minor) written authorization to release this information, excepting the following situations (in accordance with Federal Law): notification in the event my condition or behavior endangers myself or other persons, or in situations of child or elder abuse, neglect or endangerment. It is also possible that a court of law could require me to release information. It should be noted that client records are the jurisdiction of Ruach Restoration LLC and consultation with other professionals regarding your case may take place, without your name or identifying information being disclosed.

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

Client Rights

This facility strives to provide the best quality of services to its clients. When you receive services at Ruach Restoration LLC., your rights are protected. These rights are summarized below.

- *The right to receive care suited to your needs.*
- *The right to receive services that respect your dignity, and protect your health and safety.*
- *The right to be informed of the benefits and risks of your treatment.*
- *The right to participate in planning your own treatment.*
- *The right to prompt and confidential services.*
- *The right to review and obtain copies of your records, unless staff feels it is not in your best interest.*
- *The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen.*
- *The right to be free of physical and verbal abuse.*
- *The right to file a complaint if you think any of these rights have been restricted or denied*.

I, _____, have read the above information and request services provided by Ruach Restoration LLC. My signature below indicates my understanding of and agreement with all of the above statements.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Legal Guardian Date

(for student under 18 years of age)

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

Personal Information Form
Confidential

Today's Date: _____
Full Name: _____ Date of Birth: _____
Address: _____
City: _____ _ State: _____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Email address: _____
Referred by: _____
Name of Church:_____Denomination:_____
Occupation: _____
Degree(s): Grades Completed: _____ Bachelor's:_____Master's:_____Other:_____
Spouse's first name: _____
Number of children: _____ Name(s) and age(s):_____
Have you been in counseling? If yes, please provide details._____
_____
_____
Briefly describe what brings you here. _____
_____
_____

Check the issues that pertain to you: rate degree of stress/urgency for applicable areas, 1 (low) to 5 (high).

___Depression	___Chronic Illness	___Sexual Identity Issues
___Marital Problem	___Occult	___Anger
___Drug Addictions	___Insomnia	___Physical Abuse
___Eating Disorder	___Alcoholism	___Sexual Abuse
__ Grief/Loss	___Low Self-Esteem	___Emotional Abuse
___Occult Oppression	___Career Decision	___Relationships
___Workaholism	___Financial Crisis	___Loneliness
__ Unforgiveness/Bitterness	___Excessive Anxiety/Fear	___Spiritual Issues/Concern
___Sexual Concerns	___Thoughts of Suicide	___Thoughts of Harm/others
___Other		

Are you under a doctor's care? _____ If yes, Doctors Name_____
Please share what you are being treated for and any medications you are currently taking.
_____
_____
_____

In Case of Emergency, who would you like to be contacted?
Name/Relationship_____Phone:_____

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

Jennie Armstrong, DMin, LPC
Licensed Professional Counselor
1711 Meriweather Drive, Suite 100
Watkinsville, GA 30677

No Show Cancellation Charge

I understand and agree to pay a No Show fee equaling our agreed upon session fee of $150 with applied 3.5% transaction fee if I do not cancel my scheduled appointment at least 24 hours ahead of time or I do not attend a scheduled appointment with any therapist at the office of Ruach Restoration LLC.

I understand that Jennie Armstrong, DMIN, LPC will automatically charge the credit card listed below when I do not attend my scheduled appointment or do not cancel within the understood 24-hour cancellation period.

Credit Card #: _____3 or 4Digit #:_____

Expiration Date: _____Zip Code:_____

Credit Card Type: □AMEX □VISA □MASTER CARD (Check One) . *Note: It is the responsibility of the client to keep the card updated.

I AUTHORIZE RUACH RESTORATION LLC TO PROCESS THE ABOVE CREDIT CARD AS "SIGANTURE ON FILE" FOR THERAPEUTIC SERVICES

Participant Signature:_____ Date: _____

RUACH RESTORATION, LLC

Jennie Armstrong, DMin, LPC
Licensed Professional Counselor
1711 Meriweather Drive, Suite 100
Watkinsville, GA 30677

Communication Addendum

Secure and private communication cannot be fully assured utilizing cell/smart phones or regular email technologies. It is the Client's right to determine whether communication using non-secure technologies may be permitted and under what circumstance. Use of any non-secure technologies to contact your therapist will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification form the client. Please check below which modes of communication are permitted and are not permitted. This consent may be altered at any time should circumstances or preference change. In the event that client does not allow non-secure modes of communication, contact will only be made via wire to wire phone or mail.

1.Voice communication to client's ***and*** from therapist's cell/smart phone for: **Circle each Permitted**:1.scheduling appointments 2.reminders 3.between session contact

2.Email communication to client's ***and*** from therapist's email address for:

Circle each Permitted:1.scheduling appointments 2.reminders 3.between session contact
Permitted email address: _____

3. Teleconferencing based communication to client's portal ***and*** from therapist's portal:

Circle each permitted: 1. telehealth video session appointments 2. between session contact

If permitted, please list permitted portal site(s): **https://doxy.me/jenniearmstrong**

Permitted email address: _____

Statement of Validation

I have read this **Communication Addendum**, it has been adequately explained to me and I understand its contents:

	Print Name	**Signature**	**Date**
Client:	_____	_____	_____
Parent/ L. Guardian:	_____	_____	_____

Please initial that you have read this page ----------

RUACH RESTORATION, LLC

RUACH RESTORATION LLC
PATIENT NOTICE OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protection surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patients protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("the privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Ruach Restoration LLC is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

Client Name (Print) _____

I have received a copy of the Ruach Restoration LLC Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____ _____
Client Signature Date

_____ _____
Parent Signature if Client is a Minor Date

_____ _____
Guardian Signature if Client is Legal Charge Date

Please initial that you have read this page ----------

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Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: *Jennie Armstrong* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *Jennie Armstrong* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *Jennie Armstrong* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *Jennie Armstrong* would use and/or disclose your PHI. Use of PHI means when *Jennie Armstrong* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *Jennie Armstrong* releases, transfers, gives, or otherwise reveals it to a third party outside of the *Jennie Armstrong.* With some exceptions, *Jennie Armstrong* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *Jennie Armstrong* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *Jennie Armstrong* Please note that *Jennie Armstrong* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *Jennie Armstrong* has created or maintained in the past and for any of your records that *Jennie Armstrong* may create or maintain in the future. *Jennie Armstrong* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *Jennie Armstrong* Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: ***Jennie Armstrong*** will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *Jennie Armstrong* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *Jennie Armstrong* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *Jennie Armstrong* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *Jennie Armstrong* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
3. To Obtain Payment for Treatment: *Jennie Armstrong* may use and disclose your PHI to bill and collect payment for the treatment and services *Jennie Armstrong* provided to you. Example: *Jennie Armstrong* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *Jennie Armstrong* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *Jennie Armstrong's* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *Jennie Armstrong* will always do its best to reconcile this with you first prior to involving any outside agency.
4. Employees and Business Associates: There may be instances where services are provided to *Jennie Armstrong* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *Jennie Armstrong* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *Jennie Armstrong.*

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *Jennie Armstrong* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – YOUR NAME may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *Jennie Armstrong* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *Jennie Armstrong* may make a disclosure to the appropriate officials when a law requires *Jennie Armstrong* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *Jennie Armstrong* may disclose information about you to respond to a court or administrative order or a search warrant. *Jennie Armstrong* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *Jennie Armstrong* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *Jennie Armstrong* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *Jennie Armstrong* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *Jennie Armstrong* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *Jennie Armstrong* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *Jennie Armstrong* may provide PHI to law enforcement personnel

or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. **Minors:** If you are a minor (under 18 years of age), *Jennie Armstrong* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *Jennie Armstrong* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *Jennie Armstrong* has a reasonable suspicion of child abuse or neglect, *Jennie Armstrong* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *Jennie Armstrong* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *Jennie Armstrong* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *Jennie Armstrong* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *Jennie Armstrong* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, *Jennie Armstrong* may release PHI about you as required by military command authorities. *Jennie Armstrong* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *Jennie Armstrong* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *Jennie Armstrong* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *Jennie Armstrong* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**
    Jennie Armstrong may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *Jennie Armstrong* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *Jennie Armstrong* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *Jennie Armstrong*'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**

Please initial that you have read this page ----------

18. **In the Following Cases,** *Jennie Armstrong* **Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *Jennie Armstrong* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *Jennie Armstrong* in writing of your decision. You understand that *Jennie Armstrong* is unable to take back any disclosures it has already made with your permission, *Jennie Armstrong* will continue to comply with laws that require certain disclosures, and *Jennie Armstrong* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *Jennie Armstrong* possession, or to get copies of it; however, you must request it in writing. If *Jennie Armstrong* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *Jennie Armstrong* within 30 days of receiving your written request. Under certain circumstances, *Jennie Armstrong* may feel it must deny your request, but if it does, *Jennie Armstrong* will give you, in writing, the reasons for the denial. *Jennie Armstrong* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *Jennie Armstrong* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *Jennie Armstrong* limit how it uses and discloses your PHI. While *Jennie Armstrong* will consider your request, it is not legally bound to agree. If *Jennie Armstrong* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that *Jennie Armstrong* is legally required or permitted to make.

3. The Right to Choose How *Jennie Armstrong* **Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *Jennie Armstrong* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that Jennie Armstrong has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. Jennie Armstrong will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Jennie Armstrong will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. **The Right to Choose Someone to Act for You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has *Jennie Armstrong* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *Jennie Armstrong*'s receipt of your request. *Jennie Armstrong* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed,(c) not part of its records, or (d) written by someone other than *Jennie Armstrong*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *Jennie Armstrong*'s denial will be attached to any future disclosures of your PHI. If *Jennie Armstrong* approves your request, it will make the change(s) to your PHI. Additionally, *Jennie Armstrong* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *Jennie Armstrong*'s Director and Privacy Officer, **Ruach Restoration LLC.,** at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision ***Jennie Armstrong*** made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. ***Jennie Armstrong*** will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. *Jennie Armstrong*'s **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

RUACH RESTORATION, LLC

Good Faith Estimate

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care. Ruach Restoration LLC is not in your health plan's network. This means that Jennie Armstrong DMin, LPC and Ruach Restoration LLC do not have an agreement with your plan. Getting care from this provider could cost you more.

***IMPORTANT: You may choose to get care from a provider or facility in your health plan's network, which may cost you less. If you would like assistance with his document, ask your provider or patient advocate. Take a picture or keep a copy of the form for your records*.**

If your plan covers the item or service you are receiving, federal law protects you from higher bills:

- **When you get emergency care from out-of-network providers and facilities, or**
- **When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.**

Ask your healthcare provider or patient advocate if you need help knowing whether these protections apply to you.

If you sign this form, you may pay more because:

- **You are giving up protections under the law.**
- **You may owe the full costs billed for items and services received.**
- **Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.**

Before deciding to engage in treatment with this provider, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment.

- **Review your detailed estimate below. It includes a cost estimate for each item or service.**
- **Call your health plan. Your plan may have better information about how much of these services are reimbursable.**

● Questions about this notice and estimate? Discuss them with your therapist at Ruach Restoration LLC or email Jennie Armstrong at jennie@ruachrestoration.com.

● Questions about your rights? Contact the Georgia Secretary of State by emailing soscontact@sos.ga.gov or calling 404-656-2817.

PRIOR AUTHORIZATION

Except in an emergency, your health plan may require prior authorization or other limitations for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

MORE INFORMATION

For more information about your rights under federal law, visit: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

BY CONTINUING WITH SERVICES

By continuing with services, I agree that I might pay more for out-of-network care. I agree to receive services from Jennie Armstrong at Ruach Restoration LLC. I acknowledge that I am consenting of my own free will, and I'm not being coerced or pressured. I also understand that:

● I am giving up some consumer billing protections under federal law.

● I may get a bill for the full charges for these items and services or have to pay out-of-network cost sharing under my health plan.

● I was given a written notice explaining that my provider or facility is not in my health plan’s network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.

● I received the notice either on paper or electronically, consistent with my choice.

● I fully and completely understand that some or all amounts I pay may not count towards my health plan’s deductible or out-of-pocket limit.

● I can end this agreement by notifying the provider or facility in writing before receiving services.

GOOD FAITH ESTIMATE

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. The estimate is based on information at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You

could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

The estimate does not include any information about what your health plan may cover. If you choose to, you may contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay if you decide to use your health plan.

Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis and presenting clinical concerns.

Please note that the place of service (in office vs telehealth) is not delineated because the charges are identical.

OUT-OF-NETWORK PROVIDER: Jennie Armstrong DMin LPC

FACILITY: Ruach Restoration LLC, 1020 Barber Creek Drive, Suite 203, Watkinsville, GA 30677

FEDERAL TAX ID (EIN): 83-1296351 NPI#: 1720561145

SERVICES AND FEES

Service Code	Description	Fee
90791	Initial Diagnostic Evaluation	$150
90837	Psychotherapy 50 minutes	$150
Cancellation or Missed Session Fee	Your therapist requires 24 hour cancellation prior to appointment	$150
90853	Preengagement/Premarital Counseling 6 session hours included	$800

This Good Faith Estimate explains therapist's rate for each service. Total expected cost Is your fee times the number of sessions needed as determined by collaboration with your therapist.

GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider has given you a copy of your Good Faith Estimate, and any questions or concerns have been addressed. Thank you.

Name of Client:

Client Signature:

Date of Signature:

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Ruach Restoration LLC has put in place preventative measures to reduce the spread of COVID-19; however, Ruach Restoration LLC **cannot guarantee** that you will not become infected with COVID-19. Further, attending in-person appointments with Ruach Restoration LLC Ruach Restoration LLC **increase** your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending in-person appointments with Ruach Restoration LLC and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Ruach Restoration LLC, may result from the actions, omissions, or negligence of myself and others, including, but not limited to Ruach Restoration LLC, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to me, (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at in-person appointments with Ruach Restoration LLC. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless the Ruach Restoration LLC, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Ruach Restoration LLC, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Ruach Restoration LLC.

_____

Name of Client

_____ _____

Signature of Client Date