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Counseling Education Center

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Adolescent Information

The purpose of this questionnaire is to assist your therapist in better understanding your adolescent. Please be assured that all information contained in this questionnaire will be held confidential within your adolescent's case record. Unless required by law, this information will not be released without your permission.

Please explain why you are seeking counseling services for your child at this time:

_____

_____

_____

_____

Please complete the following information regarding your adolescent:

Name: _____ Age: _____

Date of Birth: _____ Place of Birth: _____

School: _____ Grade: _____

Biological Father: _____ Age: _____

Biological Mother: _____ Age: _____

Is either parent deceased? Yes No Age(s) of parent(s) when he/she/they passed: _____

Parents Divorced? Yes No Date: _____

Step Parents: _____ Age: _____

_____ Age: _____

Siblings: _____ Age: _____

_____ Age: _____

_____ Age: _____

Individuals residing in the home: _____

_____

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Initial Child/Adolescent Questionnaire

DEVELOPMENTAL HISTORY (Please fill in any information you have on the areas listed below)

Name of child: _____ Age: _____ Date: _____

Pregnancy and Delivery: _____

Prenatal medical illnesses and health care: _____

_____

_____

Was the child premature? Yes No Weight and Height at birth: _____

Please list any birth complications or problems: _____

_____

_____

Please list any allergies:_____

_____

_____

Describe any changes in sleep patterns or sleeping problems:_____

_____

_____

_____

Personality:_____

_____

_____

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FAMILY HISTORY

Check any of the following that you know have applied to your adolescent's parents or siblings:

Specify family member below

___ Don't know
___ Hospitalization for mental illness _____
___ Attempted or committed suicide _____
___ Drinking Problem _____
___ Drug Abuse _____

Has either parent died?

___ No Yes, the mother, when the child was _____ years old

___ Unknown Yes, my father, when the child was _____years old

Who did the child live with most of the time while growing up? _____

How well do the parents get along with each other?

☐ Very well ☐ Not very well ☐ Fairly Well ☐ Very poorly ☐ Don't Know

MEDICAL HISTORY

Please list past or present medical problems your child has been treated for:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Present medications:

Medication	Doctor who prescribed it	Date when first prescribed	Dosage

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TREATMENT HISTORY

Previous psychiatric treatment (inpatient hospitalization, psychiatric medication):

Provider/facility	Reason for treatment	Outcome	Medication prescribed (if applicable)

ACADEMIC HISTORY

Schools	Grades Attended

Has your child been diagnosed with a learning disability? Yes No

If yes, what type(s)? _____

_____

Is your child currently having difficulty with:
___ Concentrating ___ Remembering homework ___ Study habits

Behavior in school (Specify): _____

_____

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ADDITIONAL HISTORY

Please check any of the following, yes or no, that are current or previous concerns you have for your child; if you checked yes to any of the following, please explain your answers

	Yes	No	Explain
Alcoholism/Drug Use or Experimentation			
Physical Abuse			
Sexual Abuse			
Sexual Perpetration (committing a sexual act against another individual without his/her consent)			
Emotional or Verbal Abuse			
Legal History (history of arrests, incarcerations). Please indicate charge(s) and date(s)			
Grief/Loss Issues (May include death of loved one, divorce in family, relocation, illness)			

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Are any of the following currently a problem? Please rate the severity of the problem using the following scale:

1	**2**	**3**	**4**	**5**
Not a Problem		**Somewhat**		**Very Problematic**

Temper Tantrums	_____	Nightmares	_____
Verbal Aggression	_____	Physical Aggression	_____
Insomnia	_____	Depression	_____
Anxiety	_____	Sibling Rivalry	_____
Fire Setting	_____	Bed Wetting	_____
Cruelty to Animals	_____	Thumb Sucking	_____
Bullying	_____	Lying	_____
Stealing	_____	Accident Prone	_____
Hurting Self (picking at wounds, scratching, cutting self)	_____	Running Away	_____

Other: _____

How comfortable is your child with the following:	Very comfortable	Moderately comfortable	Moderately uncomfortable	Very uncomfortable
Joining a group	☐	☐	☐	☐
Meeting people	☐	☐	☐	☐
With persons of same sex	☐	☐	☐	☐
With persons of opposite sex	☐	☐	☐	☐
Being a leader	☐	☐	☐	☐
Being a follower	☐	☐	☐	☐
Expressing an unpopular opinion	☐	☐	☐	☐
Being disliked	☐	☐	☐	☐
Asking for help	☐	☐	☐	☐
Taking advice	☐	☐	☐	☐
Accepting criticism	☐	☐	☐	☐
Competitive situations	☐	☐	☐	☐
Taking initiative	☐	☐	☐	☐

What is your child's occupation? _____

How long has your child been employed at the present job? _____

Does his/her present satisfy your child? Yes No Not Applicable

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TREATMENT EXPECTATIONS

Do you know anyone who has come to Breakthrough Counseling Education Center? Yes No

In your opinion, was this person helped:

☐ Greatly ☐ Moderately ☐ Minimally ☐ Not at All

How long do you think your child should be in treatment?

____ Less than one month

____ More than one month, less than six months

____ More than six months, less than one year

____ More than one year

____ Don't know/Not sure

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The client understands and agrees to allow this healthcare office to use his/her Client Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Client Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Client Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Guardian's Signature Authorizing Care:_____Date:_____

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GENERAL, FINANCIAL, AND LATE CANCELLATION/MISSED APPOINTMENT POLICY

Professional Fees

Your child's therapist is in independent practice and has established his/her own fee schedule. In addition to regular appointments and/or psychological assessment, other services may be provided to which the therapist may apply a fee. Such services include report writing, extended telephone conversations, consulting with other professionals, and preparation of records/treatment summaries. If you become involved in legal proceedings that require the therapist's participation, you will be responsible for the fees associated with the therapist's professional time, including preparation and transportation costs. Based on the difficulty of legal involvement, most therapists charge a fee greater than the usual hourly rate.

Please Initial: _____

Financial Policy

You will be expected to pay for each session prior to its start, unless you have arranged another agreement with your child's therapist. We accept cash, checks, and major credit cards. If your account is overdue and you have not made payments (or made a payment arrangement), you therapist has the option of charging the credit card on file with this balance. Please note that there may be a $25 fee applied to all returned checks.

FEES: Counseling sessions are 45 minutes long. The fee for a 45 minute session, either face-to-face or by phone, is due at check-in before each session.

Please Initial: _____

Insurance Policy

Our office manager will provide the courtesy of verifying your insurance. However, the initial information provided to us by the insurance company may not be accurate, and the actual coverage provided by insurance company cannot be determined until a detailed Explanation of Benefits is received with the insurance payment. As a courtesy, we also will file your insurance but cannot accept responsibility for collecting or negotiating for a settlement of a disputed claim. You will be fully responsible for any balances or unpaid claims by your insurance company. It is important for you, the patient, to find out exactly what mental health services your policy covers. If you have any questions about the coverage, please contact your plan administrator.

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Breakthrough Counseling Education Center accepts the following insurances:

United Behavioral Healthcare	**Aetna**
Blue Cross/Blue Shield	**MHNet**
UMR	**Value Options**
Ceridian Lifeworks	**Cigna**
Aetna EAP	**ComPsych**
Orlando Health/HealthChoice	**Beacon Health Strategies**

Some insurance carriers may not be listed but are accepted; therefore, please check with therapist. If your insurance is not covered, we will provide you with a receipt for services to submit to your insurance provider for reimbursement. It will be your responsibility to ensure that your insurance company accepts receipts for reimbursement.

PLEASE NOTE: YOU ARE RESPONSIBLE FOR ANY BALANCE THAT YOUR INSURANCE CARRIER DOES NOT PAY.

Please Initial: _____

Late Cancellation/Missed Appointment Policy

A 24 hour cancellation notice is requested so we have an opportunity to fill a canceled appointment. If you call the office with at least ***24 hours' notice***, you will not be expected to pay for the session time. **Please note that the office will not accept emails or text messages requesting cancellation. You must call the office. If you have to leave a voicemail message, please do so.** You will be charged a late cancellation fee of $50 (with the exception of EAP services) if the cancellation is made under 24 hours' notice (please see **Credit Card Guarantee for Personal Balances** on page 11).

EAP Clients: Please note that although you are not required to leave a deposit or your credit card information for late cancellation or no show fees, we request that you respectfully provide the office staff adequate notice (of at least 24 hours prior to appointment) of any cancellations.

Please be mindful that once your EAP services are completed and your services continue under your insurance, either your credit card information or a $50 deposit will be requested (please see **Credit Card Guarantee for Personal Balances** on page 11).

If there are more than two missed appointments or late cancellations, it will be left to the therapist's discretion to terminate services.

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If your child is scheduled to attend therapy on a Monday, we ask that you give notice of cancellation by 12 PM on the prior Friday. **Holidays are not considered business days.** Clients with appointments scheduled for the day following a holiday must cancel it on the business day prior to the holiday. For example, if an appointment is scheduled for January 17, 2017 at 11 AM (the day before Dr. Martin Luther King, Jr. Day), it must be cancelled by 11 AM on January 13, 2017 in order to avoid a Late Cancellation Fee. Cancelling that appointment after 11 AM on January 13, 2017 will result in a Late Cancellation Fee. You will not be charged for appointments rescheduled within the same calendar week, *if there are openings available*.

By initialing below, you understand that **weekends** and **holidays** are not counted as business days, and you are expected to cancel appointments with this in mind.

Please Initial: _____

Minors

For the safety of your child and for scheduling purposes, we ask that any minor 16 years old and younger be accompanied by a parent/guardian. **The office does not have child care services available. The parent/guardian must remain on site for the entire duration of the session with the child.** We encourage the parent/guardian to make the next appointment to ensure awareness of all of the child's appointments. If you allow your child to set their next appointment(s) with the therapist and a late cancellation or no show occurs, the Late Cancellation/No Show fees will be applied.

Please Initial: _____

Cancellation Code

When you need to cancel and/or re-schedule your child's appointment (by phone or in the office), the office manager will provide you with a cancellation code. This four digit code will serve as confirmation, for both the patient and the office, that your original appointment date and time has been cancelled. It will ultimately be your responsibility to obtain this code from the office manager. Please have this code written for your records. If you have any question about the cancellation, please call the office with this code.

Please Initial: _____

I have read and agree to the above conditions.

Parent/Guardian Signature _____ **Date** _____

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CREDIT CARD GUARANTEE FOR PERSONAL BALANCES

{ } SELF-PAY/UNINSURED CLIENTS

Clients who are uninsured or whose insurance does not cover the cost of mental health counseling are personally responsible for payment. Any missed or cancelled appointments without notice will be automatically charged to your designated card below.

□ I agree to pay: $ _____ for individual sessions and/or $_____ for family/couple sessions at the time of the appointment.

{ } INSURED CLIENTS

□ I agree that my insurance company will pay for additional costs for services. I understand and agree to pay my co-payment of $ _____ at the time of the appointment.

□ I understand that I have been authorized for _____ EAP Sessions. After that period, I understand and agree to pay my co-payment of $_____ for individual sessions; $_____ for family/couple sessions.

_____ _____

SIGNATURE **DATE**

CLIENTS WITH INSURANCE OR SELF-PAY CLIENTS ONLY

Complete This Section: Please note that your credit/debit card will be accessed ONLY if any missed appointments or late cancellations (as per the Late Cancellation/Missed Appointment Policy, *WITH THE EXCEPTION OF EAP SERVICES*), or if there is a balance due at the time of discharge. Only under such circumstances will services be automatically charged to your designated card below.

CREDIT CARD: ❒ AMEX ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

CARD # _____ EXP MONTH/YEAR ____/_____

By signing below, I agree to the above terms and authorize the office to charge any Late Cancellation Fee or Missed Appointment Fee.

_____ _____

SIGNATURE **DATE**

IF YOU ARE NOT COMFORTABLE PROVIDING THE ABOVE INFORMATION, WE UNDERSTAND THAT. THE ALTERNATIVE IS TO PROVIDE $50 AT YOUR CHILD'S INITIAL APPOINTMENT TO BE DEPOSITED INTO HIS/HER BCEC ACCOUNT AND HELD THERE UNTIL EITHER A MISSED APPOINTMENT OR A LATE CANCELLATION. IF THE $50 IS UNUSED WHEN YOUR CHILD IS DISCHARGED FROM BREAKTHROUGH COUNSELING, YOU WILL BE REFUNDED THE $50 VIA CHECK. IF YOU LEAVE A CHECK AND IT GOES UNUSED BY THE TIME OF DISCHARGE, IT WILL BE VOIDED.

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Consent to Treatment

Thank you for your trust that has been placed in the hands of Breakthrough Counseling Education Center. Know that we consider the psychotherapeutic relationship to be one of sacred trust. This letter serves to inform you about the therapeutic process, give you some information and answer questions about the professional relationship between therapist and clients.

Psychotherapy cannot insure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience as therapists that most people can gain some value from the therapeutic process. Know that as we embark on this journey together, new and often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work, and other areas of life. There are alternatives and many adjuncts to psychotherapy. These include, but are not limited to, medications, support groups and complimentary modalities. I will be happy at any time to discuss any alternatives you are willing to consider.

We have a number of client expectations about the professional relationship we embark on with each client. We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients, their obligations, relations and your therapist the courtesy of a 24 hour notice if you must cancel an appointment. Otherwise, you will be charged for this time. We always consider broken appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments.

If ever you need to cancel and/or re-schedule an appointment (in the office or over the phone), the office manager will provide you with a cancellation code, which will serve as confirmation of your appointment cancellation. It will ultimately be your responsibility to obtain this code from the office manager. Please have this code written for your records. If you have any question about the cancellation, please call the office with this code. If you need to re-schedule your appointment over the phone, please have the code ready to verify with the office manager. Once the code is verified, your appointment can then be re-scheduled.

Our current fee is $125 per individual session, $150 for the initial session and $135 for family/couples counseling sessions. Payment for your session is due at the time of service. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts, and we are responsible for filing claims for our services. You must pay your co-pay at the time services are rendered. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference. Payment arrangements are discussed during your initial session.

We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for the correspondence. We do not charge for customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular

rates to the nearest quarter hour. Sessions are 45 to 50 minutes in length. Our therapist take a few minutes of an hour between clients to relax, let go of the last session, and prepare for the next one.

Our appointment times are generally on the hour from 11 AM to 7 PM. The office assistant will schedule your next appointment at the end of each session. We are available in the Winter Park office Tuesdays, Wednesdays, Thursdays and Fridays. As our therapists are in session most of the day, they do often check voice mail and return messages several times a day. If your call is non-urgent, we will respond as soon as possible. Calls left for the therapist after 8 PM will be returned the following business day at the earliest.

If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in our office. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact. This allows you to maintain the privacy of your psychotherapeutic relationship. Please do not invite your therapist to social gatherings (including, but not limited to, parties, weddings, business meetings, etc.), offer gifts, or ask them to relate to you in any way other than the professional context of our therapy sessions. Although this may seem artificial and/or awkward, it is the best way to promote a good psychotherapeutic relationship.

Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; our therapists may occasionally share experiences and struggles with some regularity as models for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely. Our therapists will keep anything you say confidential, with the following exceptions: a) you direct the therapist to speak about you with someone, b) The therapist determines that you are a danger to yourself or others, or c) there is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DFCS and/or law enforcement authorities to attempt to prevent harm from coming to anyone.

Our therapists may attend peer consultation with colleagues. They may discuss the work occurring in your session in these sessions while maintaining your anonymity.

Our therapists utilize a variety of therapeutic models, which are individualized to each client and his/her needs. Our therapist works diligently to use what is most helpful for each individual rather than take any one approach exclusively. We hope this information is helpful to you. If at any time during your relationship for your therapist you have any questions, please feel free to ask.

I do hereby seek and consent to take part in the treatment provided by this agency. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

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I am aware that I (or my child) may stop treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party may be given information about the type (s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____

Signature of Person Acting for Client **Date**

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist **Date**

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PARENT INFORMED CONSENT

Youth's Name: _____ **Date of Birth:** _____

Parent Agreement: As the parent or legal guardian of _____, I do hereby give my consent for my child and family to participate in the Breakthrough Counseling Education Center program. I understand that we will:

- Receive referrals for psychiatric services, psychological services, social services, individual, group, and family therapy as determined to be appropriate by the therapist.
- Participate as a full member of the sessions or treatment planning as determined with therapist.
- Provide 24 hour advance notice if I or my child are unable to keep a scheduled appointment.
- Agree to attend all scheduled appointments consistently as this will contribute to my child's and family's success as determined with therapist.
- As a legal guardian, I agree to provide supervision for my child at all times.
- To speak with therapist if I have concerns about treatment that my child or I receive.
- Submit co-payment or agreed upon fees. Payment will be made to treatment provider upon each session in the form of cash, check, or credit card.
- I understand that I have the right to stop treatment at any time by notifying the therapist.
- If there is joint custody, I understand that both parents have equal access to our child's record unless the court order specifies differently.
- I will provide the therapist with a copy of the child custody order.

I have read the above statements, or have had them read to me, and have been given the opportunity to ask questions to ensure my understanding for which I am acknowledging. This document will automatically expire one year from the dated signature.

Parent: _____ _____ Date: _____
(Print) (Signature)

Parent: _____ _____ Date: _____
(Print) (Signature)

Therapist: _____ _____ Date: _____
(Print) (Signature)

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LIMITS OF CONFIDENTIALITY

This document contains important information about the limits of confidentiality. It also contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law providing privacy protections and patient rights in regards to the use and disclosure of your protected health information (PHI). HIPAA requires your therapist to provide you with a Notice of Privacy Practices, for use and disclosure of PHI for treatment, payment, and health care operations, as per your request. The Notice will explain HIPAA and its application to your PHI in greater detail. The law requires your signature, which serves as acknowledgement of your awareness of the availability of the Notice for your review.

Limits of Confidentiality

Confidentiality is an ethical concept prohibiting a therapist from releasing information about the client. Privileged communication is a legal term defined as the right belonging to the client that restricts a therapist from disclosing, in legal proceedings, information given with assumed confidentiality. Confidentiality and privileged communication remain the rights of all clients of psychotherapists according to state law. A therapist can only release information about a client's treatment with a client's signature on an Authorization to Release Information form that meets specific legal requirements imposed by HIPAA.

There are situations where a therapist can disclose some information about a client's treatment. These arise only when a therapist is legally obligated to take action.

- Clear and immediate probability of physical harm to client, other individuals, or society, a therapist may disclose information so that protective action can be taken. This disclosure may include communicating information to the potential victim, and/or appropriate family member, and/or the police.
- Knowledge or reasonable cause of suspicion that a child under 18 has been abused/abandoned/neglected by a parent, legal custodian, caregiver, or any other person responsible for said child's welfare. The law requires the therapist to file a report with the Department of Children and Families. Once such a report is filed, the therapist may be required provide additional information.
- Knowledge or reasonable cause of suspicion that a vulnerable adult has been or is being abused/neglected/exploited. The law requires the therapist to file a report with the Department of Children and Families. Once such a report is filed, the therapist may be required to provide additional information.

If at all possible, the psychologist or counselor will not inform such parties without first sharing that intention with the client. Every effort will be made to resolve the issue before such a confidentiality breach takes place. Please bear in mind we will not be able to provide legal advice to you. If you have special or unusual concerns, we strongly urge you to talk to a lawyer to protect your legal interests.

There are other situations when a therapist is permitted or required to disclose information without either your consent or signed Authorization:

- If a client is involved in a court proceeding and a request is made for information regarding diagnosis and treatment, that information is protected by therapist-patient privilege. The therapist cannot provide any information the client (your legal representative's) written authorization or a court order. Clients may want to consult with their attorneys to determine if the court will order the therapist to disclose information.

- If a government agency requests the information for health oversight services (within its appropriate legal authority), the therapist may be obligated to provide that information to them.
- If a client files a complaint/lawsuit against the therapist, the therapist may disclose relevant information about the client in order to defend oneself.
- If a client files a worker's compensation claim and treatment related to that claim is provided, the therapist must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, insurance carrier, or an authorized qualified rehabilitation provider.

There is one situation that requires only your written consent, provided in advance. Your signature on this agreement provides consent for this activity:

- Administrative staff is employed within this office, along with other mental health professionals. In most cases, the need to share protected information with these individuals is for both clinical and administrative purposes. Examples include scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside the practice.

Professional Records

At Breakthrough Counseling Education Center, your record will contain:

- Information about your reasons for seeking therapy
- Details of how your problem impacts your life
- Your diagnosis
- Treatment goals set during your first appointment
- Progress made towards those goals
- Your medical and social history
- Your treatment history
- Past treatment records received from other providers
- Reports of any professional consultations
- Your billing records
- Any reports sent to authorized individuals/organizations, including your insurance carrier

Except in unique circumstances that disclosure would physically endanger you and/or others, or makes references to another person (other than a health care provider) and your therapist believes that access can likely cause substantial harm to that other person, you may examine and/or receive a copy of your record, if requested by you in writing. Since these are professional records, there is a chance of misinterpretation and/or upset to untrained readers. For this reason, your therapist recommends for you to initially review them in his/her presences or have them forwarded to another mental health professional so that you may discuss their contents. In most circumstances, your therapist may charge a fee of $1.00 per page for the copies. The exceptions to this policy are contained in the attached Notice Form. If you therapist refuses your request for access to your Clinical Records, you have a right to review, which your therapist can discuss with you upon request.

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Patient Rights

HIPAA protects you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The Notice explains HIPAA and its application to your PHI in detail. The Notice will be available for your review.

Insurance

You should also be aware that your contract with your health insurance company requires that your therapist provides information relevant to the services provided to you. Your therapist is required to provide a clinical diagnosis. Sometimes, the therapist is required to provide additional clinical information such as treatment plans, summaries, or copies of your entire clinical record. In such situations, your therapist will make every effort to release only the minimum information about you that is necessary for the request purpose. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over as what they do with it once received. In some cases, they might share the information a national medical information databank. Your therapist will provide you with a copy of any report submitted per your request. By signing this Agreement, you agree that your therapist can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_____	_____	_____
Printed Name of Client/Guardian	Signature of Client/Guardian	Date