INTAKE FORM

Please provide the following information and answer the questions below. Please note: the information that you provide is protected as confidential information.

General Information

Name:_____
(Last) (First) (Middle initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone : _____ May I leave a message? _____

Cell phone: _____ May I leave a message? _____

E-mail: _____ May I e-mail you? _____

Referred by (if any): _____

Birth Date: _____/_____/_____ Age: _____ Gender: ___ M ___F

Marital Status:

_____ Never married _____ Married _____ Domestic Partnership

_____ Divorced _____ Separated _____ Widowed

Past Mental Health Treatment Information:

Have you previously received any type of outpatient mental health services (psychotherapy, psychiatric, counseling, marital therapy, group therapy, etc.)?

_____ No

_____Yes, previous therapist/practitioner:_____

Have you previously received any type of inpatient mental health services?

_____ No

_____Yes, facility/program name :_____

Are you currently taking any prescription medications:

_____ No

_____ Yes, please list _____

Have you ever been prescribed psychiatric medication(s)?:

_____ No

_____ Yes, please list and provide dates of use: _____

General Health and Mental Health Information:

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

_____ No
_____ Yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or any other phobias?

_____No
_____Yes, please describe_____

7. Are you currently experiencing any chronic pain?

_____ No
_____ Yes, please describe_____

8. Do you drink alcohol more than once a week? _____No _____Yes

9. How often do you engage in recreational drug use?

_____Never_____Infrequently _____Monthly _____Weekly _____Daily

10. Are you currently in a relationship
_____No
_____Yes, how long? _____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

12. Are you currently employed?
_____No
_____Yes, what is your current employment situation? _____

Is there anything stressful about your current work? _____

13. Do you consider yourself to be spiritual or religious?
_____No
_____ Yes, please describe your faith or belief_____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sibling, grandparent, uncle, etc.)

	Please circle	Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behaviors	yes/no	
Schizophrenia	yes/no	
Suicide attempts	yes/no	

Additional Information:

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____

What is your goal(s) for therapy?_____
_____

Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet

FINANCIAL INFORMATION FORM

Client's Name: _____

Client's Address: _____
(Street) (Apt. #)
_____
(City) (State) (Zip)

Telephone (H)_____ (C)_____

Client's birthday:_____

Client's relationship to insured: _____

Insurance Information

Insurance company name: _____

Insurance company address:_____
(Street) (City) (State) (Zip)

Insurance company phone number: _____

Insured person's name: _____

Insured person's birthday: _____

Member identification number/policy number:_____

Group or enrollment number:_____

Insured person's employer: _____

Insured person's employer address: _____

Authorization number (if needed): _____

Coverage information:

Co-pay amount:_____

Do you have a yearly deductible? _____ Have you met the deductible?_____

Consent to Treatment Form

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting 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.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. 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 know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. **If I do not cancel and do not show up, I will be charged for that appointment**.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I understand that communication via e-mail and/or cell phone texting is not a secure or confidential means of communicating.

***Important:**

Authorization of treatment from your insurance company does not necessarily mean that they will pay for the treatment that you receive. ***Insurance companies may deny a claim and if this were to occur it is your responsibility to pay "Connie Martin, Ph.D." for all claims that are denied***.

My signature below shows that I understand and agree with all of these statements and will comply with these terms during the course of treatment.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name Relationship to client (if necessary)

___ Copy accepted by client ___ Copy kept by therapist
This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet
Clinical Psychologist
7101 N. Cicero Avenue, Suite 203
Lincolnwood, IL 60712
312-458-9086
www.conniemartinphd.com
e-mail: cmartinphd@gmail.com

INFORMATION FOR CLIENTS

Welcome to my practice. I appreciate the opportunity to be helpful to you. I hope that this will be the start of a beneficial professional relationship.

This brochure is for you to keep and refer to as needed. The purpose of this brochure is to provide you as much information as possible in a convenient format. However, please feel free to ask any questions about the material or any other questions that might come up for you.

Professional Experience

I am a licensed clinical psychologist who provides individual and couples counseling for adults and adolescents. I received my Ph.D. in counseling psychology from Loyola University Chicago in 1995. I have been working in the mental health field in a variety of ways since 1987. I abide by the code of ethics set forth by the American Psychological Association. I have had training and experience working with a wide range of issues including depression, anxiety, relationship concerns, grief and loss issues, sexual identity concerns, eating disorders, low self-esteem and life transitions.

Appointments

We will usually meet for a 50 minute session. Your appointment time is reserved for you so it is necessary to charge the set fee for appointments which are not cancelled 24 hours in advance. Exceptions to this rule are made due to circumstances that we would both define as an emergency.

Messages

You can reach me through my voicemail at 312-458-9086. I will return your call within 24 hours and in most cases, by the end of the day. Please leave a number and range of times that I can reach you. You can also contact me via e-mail at cmartinphd@gmail.com or through my website at www.conniemartinphd.com Please note that e-mail and/or text messaging are not secure or confidential means of communicating.

Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet

Treatment

Evaluation: The first few meetings will be spent getting to know each other and gathering information about you. When the initial evaluation is over we will discuss the treatment recommendations. Throughout treatment we will assess your progress toward your goals and make adjustments as needed.

Treatment philosophy: I strongly believe that you should feel comfortable with the therapist you choose and the therapy itself. As a client you will be putting a good deal of time, money and energy into therapy. Thus, it is important to choose a therapist carefully. Therapy is more likely to helpful to you when you are comfortable with your therapist.

I think of my approach to helping people as a collaborative effort in which we work together to address the defined problem area. Psychotherapy requires your active involvement to change thoughts, feelings and behaviors. For example, I want you to tell me about important experiences, what they mean to you and what strong feelings were involved. It is my job to facilitate this process by providing an atmosphere in which all areas of a problem can be openly discussed. I will work with you to gain insights into the connections between your thoughts/feelings and life choices. Next, we can work together to explore different options or choices that you might try to solve problems or relate differently to people. The goal for therapy is for you to be empowered to make choices that are congruent with your wants and needs.

Aside from the many benefits of therapy there are some potential risks. You may experience uncomfortable levels of sadness, anxiety, anger or other feelings. These risks are expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out as anticipated for you. It is important that we discuss these issues as they come up. If it is determined that you might benefit from a different kind of treatment I will work with you to get it. For example, I may make a referral to your medical doctor, a psychiatrist, a nutritionist or other health care providers.

Ending treatment: The end of treatment usually occurs after you and I have discussed your progress and have determined that it is time to end treatment. However, you may opt to end treatment whenever you want. It would be constructive to have one or two sessions to summarize your progress and make plans for moving forward.

Client's rights/Confidentiality

Your confidentiality (privacy) is protected by state law and by the rules of my profession. The policies and practices to protect the privacy of your health information is outlined in the "HIPPA" form that you received in the first session. Areas in which confidentiality is <u>not</u> protected include:

1. If I believe that a child has been or will be abused I must report this belief.
2. If I believe that an adult has been abused or exploited I must report this belief.
3. If I believe that you are in imminent danger to hurt yourself or another person I must report this belief.

4. Judicial and administrative proceedings in which you are being evaluated for a third party or where the evaluation is court ordered.
5. Health Oversight Activities
6. Worker's compensation

There are two situations in which I might talk about your case with another therapist. I will ask for your agreement to let me do so in these two situations.

First, when I am away from the office for an extended time, I will have a fellow colleague cover for me. This therapist will be available to you in case of an emergency. Generally, I would tell this therapist only what he/she would need to know for an emergency.

Second, I sometimes consult other therapists or professionals about my clients. This helps me in giving high quality care to you. Your name will never be given to them and they will be told only as much information as they need to understand your situation.

Release of information/Record Keeping

If your records need to be seen by another professional I will discuss it with you. If you agree to share these records you will need to sign a release form. This form states the specific information to be shared, with whom, why and sets time limits. You will be given a copy of this form after you sign it.

Fees, Payment & Billing

For a session of 50 minutes the fee is $130. Fees for telephone sessions are billed at the rate of office sessions. I ask clients to pay for each session at its end. If we agree to a monthly billing system you will receive a bill in the last scheduled session of the month. I ask that the bill be paid the following session. If you think you will have trouble with payment please discuss this with me. If your bill remains unpaid, termination of services may be initiated and appropriate referrals will be made.

For clients with limited incomes, I am willing to adjust my fee. This will be agreed upon during the evaluation phase of treatment.

Insurance

Clients are personally responsible for the fees for service. If you will be using health insurance we can discuss what each of our responsibilities will be in obtaining payment.

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Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet
7101 N. Cicero, Suite 203
Lincolnwood, IL 60712
Email: cmartinphd@gmail.com
312-458-9086

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I am required by applicable federal and state law to maintain and safeguard the privacy of your Protected Health Information (PHI). PHI is information in any format (electronic, paper, or verbal), about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition or the payment or provision of related health care services to you. I am required to provide you with this Notice about my privacy procedures. This notice must explain when, why, and how your PHI may be used or disclosed, my legal duties, and your rights concerning your PHI. I must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2013 and will remain in effect until further notice. I reserve the right to change the privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this notice from me, or you can view a copy of it in my office.

I. Uses and Disclosure of Your Protected Health Information (PHI)

I may use and/or disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of uses and disclosures, with some examples. Except for the purposes described below, your PHI will be disclosed only with your written permission. You may revoke such permission at any time in writing.

A. **For treatment.** Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your physician, psychiatrist, another psychologist or other licensed healthcare provider who provides you with health care services or are otherwise involved in your care.

B. **For health care operations.** Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I may also provide your PHI to business associated (attorneys, accountants and consultants) with whom I have written agreements containing terms to protect the privacy of your PHI.

C. **To obtain payment for treatment.** Your PHI may be disclosed to bill and collect payment for the treatment and services provided to you. Example: I may send your PHI to your insurance company or health plan in order to determine eligibility, obtain authorization for continued services, and/or receive payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office. My policy is to provide the minimum amount of information that the insurance company needs to pay your benefits.

D. **Other disclosures.** Examples: Your consent is not required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

SPECIAL SITUATIONS

1. **Required by Law**. Your PHI may be disclosed when/if required to do so by international, federal, state or local law. This includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

2. **Abuse and Neglect Reporting**. If I have reasonable cause to believe a child or individual (who is protected by state law) may be abused, neglected or financially exploited, I must report this belief to the appropriate authorities.

3. **To Avert a Suicide or Violence/Homicide**. I may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. If such a situation does come up, I will do my best to discuss the situation with you before I intervening, unless there is a very strong reason not to.

4. **Health Oversight Activities**. I may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

5. **Health related benefits or services.** Examples: I may disclose your PHI in order to obatin information about alternative treatment options, or other health care services or benefits**.**

6. **Data Breach Notification Purposes.** I may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

7. **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, I may be required to disclose PHI in response to a court or administrative order. If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and can not be released without a court order. I can release the information directly to you upon your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

8. **Law Enforcement**. I may be required to release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I am unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

9. **National Security and Intelligence Activities**. If mandated to do so, I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States other authorized persons or foreign heads of state or to conduct special investigations or assisting with intelligence operations, counter-intelligence, and other national security activities authorized by law.

10. **Workers' Compensation.** We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

II. USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT.
In all instances--unless mandated by law, in a crisis situation or otherwise noted above—I will obtain your written permission before releasing your PHI. You have the right to opt out and object to uses and disclosures.

III. YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
Other uses and disclosures of PHI not covered by this Notice or the laws that apply will be made only with your written authorization. If you sign an authorization, you may revoke it at any time by submitting a written revocation and I will no longer disclose PHI under the authorization. Disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

IV. THESE ARE YOUR RIGHTS WITH RESPECT TO PHI
1. **Right to Inspect and Request Copies of PHI**. You have a right to inspect and request a copy of PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records and progress notes. To inspect and copy your PHI, you must make your request, in writing. Your request will be responded to within 30 days. A reasonable fee for the administrative costs (i.e., copying, mailing) or for other supplies associated with the request. Your request may be denied in certain limited circumstances. If your requested is denied, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request.
2. **Right to an Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. Every effort to provide you access to your PHI in the form or format you requested will be made if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form. A reasonable fee may apply. The cost-based fee would be for the labor/conversion associated with transmitting the electronic medical record.
3. **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a) use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.
4. **Right to Amend Your PHI.** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of receiving your request. Your request may be denied for reasons includingt: it was determined that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not

part of this offices records, or (d) written by someone other than Connie Martin, PhD. Such a 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 the denial be attached to any future disclosures of your PHI. If your request is approved, change(s) to your PHI will be made.

5. **Right to Choose How Your PHI Is Sent 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). Most requests can be fullfilled and your PHI can be provided to you in the format you requested. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
6. **Right to an Accounting of Disclosures**. If any disclosures of your PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization were made; you would have the legal right to request a list of these disclosures in writing. However, as a practical matter, all disclosures of your health information that would be made related to your treatment or payment would have been authorized by you in writing, unless these disclosures were legally required.
7. **Right to Request Limits and Restrictions on the Use and Disclosure of Your PHI**. You have the right to request a restriction or limitation on the PHI used or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the PHI that is disclosed to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that information not be shared about a particular diagnosis or treatment with your parents, spouse or partner. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that are legally required or that I am permitted to make. To request a restriction, please specify this restriction in writing on your release of information form. I am not required to agree to a restriction you request.
8. **Right To Restrict Disclosures When You Have Paid For Your Care: Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific service, you have the right to ask that your PHI with respect to that service not be disclosed to a health plan for purposes of payment or health care operations.
9. **Right to Request Confidential Communications**. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.
10. **Right to Request This Notice by Email and/or Request a Paper Copy.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. FOR YOUR INFORMATION

1. **One Set of Progress Notes.** I maintain one form progress note about your treatment**.** Should there be a reason for me to maintain two sets of progress notes I will inform you. Each set of notes requires a separate signed release of authorization.
2. **No Marketing, Sale or Fundraising**. Your PHI will not be used or sold for marketing purposes or fundraising purposes.
3. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with Connie Martin, PhD or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

Acknowledgment

By law, I am required to provide you with a copy of this notice and to obtain a signed acknowledgement from you that you have received it. By signing below, I indicate that I have received a copy of this "Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information."

Name: _____
Please Print

Signature: _____ **Date:** _____

Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet
7101 N. Cicero, Suite 203
Lincolnwood, IL 60712
Email: cmartinphd@gmail.com
312-458-9086

Consent For Non-Secure Electronic Communications

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Connie Martin, PhD., there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments that can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Connie Martin, PhD
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Connie Martin, PhD about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Connie Martin, PhD. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment.

Other information/communication:

_____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Signature Date

Connie Martin, Ph.D., Clinical Psychologist
Client Registration Packet
7101 N. Cicero, Suite 203
Lincolnwood, IL 60712
312-458-9086

Authorization for Release of Information for communication with Primary Care Physician

I HEREBY AUTHORIZE: CONNIE MARTIN, Ph.D.

To:__X____ Release Information To and/or ___X____ Receive Information From

Physician's Name:_____

Phone Number:_____Fax Number:_____

_____

The Following ___X__ Verbal Information and/or __X___Written Information

_____Summary of Psychological Treatment (including history of treatment)

_____Diagnosis (including supporting clinical info.)

_____Most Recent Contact Date

_____Nature of Treatment

_____Treatment Plan

_____Outcome of Treatment

_____Prognosis

_____Other (specify)

FOR THE PURPOSE OF EVALUATION AND TREATMENT OF CLIENT:

Client's Full Name (please print)_____ Birthdate:_____

In signing this form, I understand the following provisions:

a) I am under no obligation to sign
b) I have the right to inspect and copy any information disclosed
c) I have the right to revoke this authorization at any time by WRITTEN REQUEST (except for information already disclosed)
d) Failure to sign will mean that the information WILL NOT be requested or released

THIS RELEASE WILL REMAIN VALID UNTIL Date:_____

The purpose of for this release of information is for:

_____Continuity of care and treatment planning
_____Third Party Reimbursement
_____Other (specify)_____

Signed:_____Date:_____

Witness:_____ Date:_____