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Psychological Assessment

Date: Name: DOB: Gender:

Guardian:
Communication Barriers: Marital Status:
Cultural/Ethnic/Sexuality Issues that impact therapy

Current Living Situation

		.

Presenting Problem

History of Presenting Problem

Behavioral Concerns

None	Destruction of Property	Inappropriate Sexual Behavior	Physical Confrontation
Running Away	Noncompliant Behavior	Negative Peer Group	
Bullied	Being Bullied	Fire Setting	
Family Stress	Cruelty to Animals	Bed Wetting	

Record #: 100938

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Activities of Daily Living

Sleep:	None	Difficulty falling asleep	Frequent awakenings	Nightmares	
Sleeping during the day	Hours a night	Increased sleep	Decreased Sleep	How long	
Appetite:	None	Weight loss	Weight gain	Number of pounds	Time period
Loss of appetite	Increase appetite	Skipping meals	Vomiting	Compulsive exercise	Binging
Self Care:	None	Bathing	Brushing teeth	Enuresis	Encopresis
Spectrum Signs:	Avoids eye contact	Rigidity	Repetitive behaviors	Ignores social norms	

Education History

Name of School	Current Grade	Grades Repeated	IEP or 504
Accommodations	On grade level		

Developmental History

Developmental Delays	Pregnancy complications	Illness/Injuries
Medical Conditions	Surgeries	

Allergies	Reaction Click here to enter text.

Medication

Medication/mg	Prescribing Doctor	Reason

Past Psychiatric Care

Agency	Inpt/Outpt	Reason	Dates of Services

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Substance Use History

Drug Used	Age of first use	How often/much	Length of use	Date of last use

Legal problems	Major role obligations	Physically hazardous	Recurrent social problems
Need for increased amounts	Tried to cut down in the past	Loss of relationships	Tobacco use

Risk Assessment

Suicidal Ideation	Plan	History	Self-Mutilation
Homicidal Ideation	Plan	History	

Abuse/Violence

Type	Age	Length	Perpetrator
Trauma history:			

Screen Time

How many hours a day	How long	Device
	Click here to enter text.	

Arrest History	Arrested	Convictions	Sentence

Family History

Member	Alcohol/Drugs	Mental Health

Mental Status

General Appearance:	Neat/Clean	Poor Hygiene	Disheveled	Groomed	Overweight
Dressed appropriately	Underweight	Average weight			
Affect:	Mood congruent	Calm	Anxious	Irritable	Depressed
Labile	Tearful	Hostile	Blunted	Flat	Suspicious
Mood:	Euthymic	Pessimistic	Depressed	Anxious	Angry
Speech Normal:					

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Thought Content:	Appropriate	Delusional	Guilty	Racing	Obsessions
Thought Process:	Coherent	Tangential	Loose Associations	Blocking	Disorganized
	Incoherent	Circumstantial			
Hallucinations	Visual	Auditory	Command	Tactile	
Insight:	Good	Poor	Limited	Fair	
Judgment:	Good	Poor	Limited	Fair	Impulsive
Concentration:	Normal	Decreased	Easily distracted	Poor	
Strengths:	Intelligent	Judgment	Insightful	Healthy	Treatment compliance
	Financial	Employed	Support system	Motivated	Social support
Weakness:	Intelligence	Finances	Education level	Judgment	Motivation
Treatment noncompliance	Unemployed	Insight	Health	Communication	Support

Strengths

.

Diagnostic Formulation

Diagnosis

Axis I:	Axis II:	
Axis III:	Axis IV:	Axis V:

Treatment Recommendations

X _____

Trent Morrow LCSW
Therapist

Treatment Plan

Record #: 100938

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Axis I:	Axis II:	
Axis III:	Axis IV:	Axis V:

Strengths:
Weaknesses:

Goal 1	Service/Intervention Coordination of care with medical/mental health providers. Individual therapy Family therapy.	Strategies CBT Solution Focused	Person Responsible Client Family Therapist	Outcome Target Date	Review Date Each Session
Goal 2	Service/Intervention Coordination of care with medical/mental health providers. Individual therapy Family therapy.	Strategies CBT Solution Focused	Person Responsible Client Family Therapist	Outcome Target Date	Review Date Each Session

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Date/Time	Signature/Credentials	Date/Time	I have had input into this plan and I agree with this plan. (Client/Legally Responsible Person Signature)

You have a right to a copy of this treatment plan. If you would like a copy of this plan please ask or submit a written request to L & B Counseling 1914 Brunswick Ave Charlotte NC 28207.

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Professional Disclosure Statement

Thank you for choosing L & B Counseling at 1914 Brunswick Ave Charlotte NC 28207, (704) 955 7312. Today's appointment will take approximately 50-55 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all of the information that you need.

Professional Credentials

I earned a Master's of Social Work (MSW) from the University of North Carolina at Charlotte in 2002. I am a Licensed Clinical Social Worker (#C005054) through the North Carolina Social Work Certification and Licensure Board. My education and experience has prepared me to counsel individuals, groups, parents, families, children, adolescents, couples, and adults.

Services Offered and Theoretical Approach

I believe counseling is a collaborative effort in which you and I work together to help you change the thoughts, feelings, and behaviors that are interfering with your being able to live a fulfilling life. I take an eclectic approach to counseling. I will use the approaches that I believe will best facilitate your arriving at answers to your questions and finding solutions to your problems. I will not attempt to impose my values on you. I may use counseling methods based on theories grounded in humanism, solution focused and cognitive behaviorism. I am qualified to provide therapy for a variety of problems.

Counseling Relationship

During the time we work together, we usually will meet weekly or bi-weekly (depending upon your need) for approximately 30-60 minute sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency. The number of times we will meet will depend on the presenting issues but generally counseling issues can be resolved within ten sessions.

Informed Consent

Consent for Treatment and Authorization to Disclose Health Information

I consent to Mental Health Treatment. I understand that L & B Counseling may release any and all records pertaining to treatment to the insurance company (if applicable), the primary care physician, psychiatrist or to the referring professional electronically, or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment or utilization review purposes. I have the right to refuse treatment.

Client Rights

The right to be treated with respect and recognition of their dignity and right to privacy. The right to refuse services. The right to request and receive a copy of their medical records subject to therapeutic privilege set forth in NC G.S. 122C-53(c) and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164 and the provisions of NC G.S. 122C-53(c). If the doctor or therapist determines that this would be detrimental to their physical or mental wellbeing, the consumer can request that the medical records be sent to a physician or professional of their choice. If they disagree with what is written in their medical records, consumers have the right to write a statement to be placed in their file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SAS retention schedule. The right to participate in the development of a written person-centered treatment plan and individualized crisis plan that builds on individual needs, strengths, and preferences. Their treatment plan must be implemented within fifteen (15) days of their starting service. The right to take part in the development and periodic review of their treatment plan and to consent to treatment goals in it. The right to treatment in the most normal, age-appropriate and least restrictive environment possible. The right to ask questions when they do not understand their care or what they are expected to do. Right to treatment of medical care and habilitation regardless of age or degree of disability. The protection and promotion of recipient rights is a crucial component of the service delivery system. All consumers are assured rights by law and it is expected that

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Providers will respect these rights at all times and provide consumers continual education regarding their rights as well as support them in exercising their rights to the fullest extent. North Carolina General Statutes (GS 122C 51-67) and the North Carolina Administrative Code (APSM 95-2) outline specific requirements for notification of individuals regarding their rights as well as operational policies and procedures that ensures the protection of rights.

Fee Schedule

I will provide therapy sessions for individual adults, children, families, and groups. My fee will be $140.00 for an intake assessment, $140.00 for individual and family sessions. Fees are due at the beginning of each session. Such services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings you have authorized with other professionals, preparation of records or treatment summaries and the time spent performing any other service you may request of me. **If you do not provide 24-hour notice prior to canceling an appointment, you will be billed half of the contracted rate for a missed appointment fee.** You are not responsible for this fee if you have Medicaid. Additionally, if you miss 3 appointments, your case may be terminated at the discretion of this therapist.

Cash, credit card or personal checks are acceptable methods of payment. All copayments will be accepted before service begins. I will provide a receipt for payment for personal tax purposes. I also will file insurance claims for you. If your insurance plan has an unmet deductible or the claim is denied for service, you are responsible for payment. I encourage you to contact your insurance company to answer questions you may have about the extent to which my fees are reimbursable. I ask that you authorize payment of medical benefits directly to L & B Counseling.

L & B Counseling may use and disclose medical information about you so that the services received may be billed and payment may be collected. Also understand that L & B Counseling may tell your health plan about the treatment you will receive in order to obtain prior approval and determine whether your plan will cover the proposed treatment.

Court

Although my responsibility to your child may require my involvement in conflicts between the parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with our children. In particular, I need your agreement that in any such proceedings, neither or you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at a rate of $150.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Confidentiality

The confidentiality of the information you share with me is protected by law and by my professional ethics. Information may be disclosed only by if the following criteria are met or are necessary:

- Diagnosis and date of service shared with your insurance company (if insurance is billed for treatment purposes)
- Mandated reporting of physical or sexual abuse of children
- Threats of suicide or homicide
- Cases where you have signed a release of information for information to be disclosed
- Information released as outlined in the HIPPA Notice of Privacy Practice

- Coordination of care with Medicaid/NC Healthchoice clients

Emergency Situations

If a mental health emergency should arise, you are instructed to call me your therapist 24/7, 911, contact your local mental health emergency room at 704 358 2700 or go to the nearest emergency department. In the event that I am ever unable to continue providing therapy, either temporarily or permanently; I have requested for my colleagues at L & B Counseling, or Laurie Howell LMFT, Shawntal Isaiah, LCSW, and Valerie Glascock, LPA to contact my clients in order to offer continued services or referrals. A crisis plan will be developed as needed for a client that is a history of risk or is currently at risk for decompensation.

Dual Relationships

The counseling relationship is a psychologically intimate but professional one. Our association will be limited to our sessions together and necessary phone contacts. Please do not offer me gifts or ask me to engage in social activities with you.

Grievances

If you are dissatisfied with any aspect of our work, please talk with me about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you can contact the North Carolina Social Work Certification and Licensure Board, PO Box 1043, Asheboro, North Carolina 27204, for clarification of clients' rights as I've explained them to you or to lodge a complaint or contact or NC Disability Rights 877 235 4210, Cardinal Innovations Anonymous Concern Line 1-888-213-9687, North Carolina Bar Association Lawyer Referral Service 1-800-662-7660, and Pro Bono Project of the North Carolina Bar Association 1-800-662-7407.

If you have a question, please feel free to ask. Please sign and date. A copy will be returned to you and L & B Counseling will retain a copy for their confidential files.

Appointment Reminders

We may use and share health information to contact you as a reminder that you have an appointment for treatment.

Business Associate

We sometimes hire other people to help us perform our services or operate our entities. We may share your health information with them so that they can perform the job we have asked them to do. We require them to protect your health information and keep it confidential.

Ways to be contacted

By checking below I consent to be contacted through the specific electronic medium.

- ❑ Phone
- ❑ Email (Email is used to communicate with the client and client's collaterals)
- ❑ Text (Text is used for appointment reminders and communicating with the client)

Social Media Policy This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy. Friending I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. All of the information shared on this page is available on my website. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I

believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Psychological Association's Ethics Code prohibits my soliciting testimonials from clients. I feel that the term "Fan" comes too close to an implied request for a public endorsement of my practice. Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to my Page. You are more than welcome to do this. Following I publish a blog on my website and I post psychology news on Twitter. I have no expectation that you as a client will want to follow my blog or Twitter stream. However, if you use an easily recognizable name on Twitter and I happen to notice that you've followed me there, we may briefly discuss it and its potential impact on our working relationship.

My primary concern is your privacy. If you share this concern, there are more private ways to follow me on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to my content. You are welcome to use your own discretion in choosing whether to follow me. Note that I will not follow you back. I only follow other health professionals on Twitter and I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour. Interacting Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at landbcounseling@landbcounseling.net is second best for quick, administrative issues such as changing appointment times or by secure text at 704 995 7312. See the email section below for more information regarding email interactions.

Use of Search Engines It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of Social Media Policy If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you

feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board.

Location-Based Services: If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis.

Email: I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

By sign this document you understand your rights and are **consenting** to treatment. You have the right to refuse treatment if you wish.

Client Name: _____
Signature: _____ Date: _____

Legal Guardian: _____
Signature: _____ Date: _____

Therapist: _____
Signature: _____ Date:_____

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

WE ARE COMMITTED TO PROTECTING YOUR HEALTH INFORMATION

We understand that information about you and your health is personal and private. We are committed to protecting your privacy and your health information. We are required by law to:

- Make sure that your protected health information (PHI) is kept private. We will protect PHI we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- Give you this Notice explaining our legal duties and privacy practices with respect to your PHI.
- Follow the terms of the Notice currently in effect and only use and/or disclose PHI as we have described in this Notice.

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI that we maintain. If we do so, we will provide you with the new Notice by:

- Posting the revised Notice in our offices;
- Making copies of the revised Notice available upon request

This Notice tells you about the ways we may use and disclose your PHI, as well as gives you some examples. We also describe your rights and our obligations for the use and disclosure of your PHI.

WHO WILL FOLLOW THIS NOTICE

This Notice applies to all records containing your PHI which are generated by L & B Counseling PLLC.

WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

1. To obtain payment for services. Generally we may use and give your medical information to others to bill and collect payment for the treatment of services we provide to you. Before you receive scheduled services, we may share information about these services with your health plan for pre-approval of services. We may also share portions of your medical information with our billing department and collection department, insurance companies, health plans and their agents which provide you coverage; consumer reporting agencies (e.g. credit bureaus).

2. To remind you about your appointment. We may use and disclose your PHI to remind you about an appointment you have for treatment or medical care.

3. To give you information about treatment alternatives, services, products or other health care benefits.

We may use and disclose your PHI to manage or coordinate your health care. This may include telling you about treatment alternatives, services, products or other health care benefits that may be of interest to you.

4. Disclosures to others involved in your care or payment for that care. We may share with a family member, personal representatives or other person identified by you, your PHI which is directly related to that person's involvement in your care or payment for your care.

5. When the use and/or disclosure is required by law.

6. When the use and/or disclosure is necessary for public health activities. We may disclose your PHI to the health department if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading ad disease or condition.

7. When the disclosure relates to victims of abuse or neglect. We are required to report suspected child/elder abuse and/or neglect.

8. When the disclosure is for judicial and administrative proceedings. We may disclose your PHI in response to an order of a court or administrative tribunal, including a subpoena, court order or a warrant.

9. When the use and/or disclosure is to avert or lessen a serious and imminent threat to health or safety. For example,

if you threaten to kill someone while you are in our care, we can notify the proper parties to protect the potential victim.

10. When the use and/or disclosure relates to worker's compensation. For example, we may disclose your PHI as required by law to provide benefits for work-related injuries.

ANY OTHER USE OR DISCLOSURE OF YOUR PHI REQUIRES YOUR AUTHORIZATION

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose your PHI. If you sign a written authorization allowing us to disclose your PHI in a specific situation, you can later cancel your authorization in writing by contacting the person listed at the beginning of this Notice. If you cancel the person listed at the beginning of this Notice. If you cancel your authorization in writing, we will not disclose your PHI after we receive your cancellation, except for disclosures being processed before we received your cancellation.

YOU HAVE CERTAIN RIGHTS

1. Receive a copy of this Notice.
2. Request confidential communications.
3. Inspect and copy.
4. Request amendment.
5. An accounting of disclosures.
6. Request restrictions on uses and disclosures of your protected health information.
7. File a Complaint.
8. Receive information about the handling of your information.

You have the right to a copy of this notice.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights have been violated by us, or you want to complain to us about our privacy practices, you may send a written statement of your complaint to the person listed on the front of this Notice or call (704) 965-2364. You may also send a written complaint to the US Secretary of the Department of Health and Human Services at Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909 or call them at 1-877-696-6775.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

North Carolina Law

Some North Carolina laws give you additional protection and rights over federal laws and we will follow them whenever they apply. A few examples of North Carolina law are:
North Carolina protects your discussions with a mental health provider about your mental health treatment.
Any request by you for treatment and rehabilitation for drug dependence will be treated as confidential, even if we refer you to someone else.
In general, you must consent before we disclose information about your mental health, developmental disabilities, or substance abuse services. However, we can disclose this information without your consent to help us care for you, for our health care operations, for your emergency care, and to others when necessary to coordinate your care. We are also allowed, and sometimes required, to disclose your information in the same situations which do not require your authorization. If we believe it is in your best interest, we may disclose your information to start a guardianship or involuntary commitment proceeding. We can disclose to your next of kin when you are admitted or discharged from a mental health, developmental disabilities, or substance abuse facility, if we believe it is in your best interest, but only if you do not object. If you are a minor, you have the right to consent to certain treatments without consent of your parent or guardian: (1) for pregnancy, (2) for abuse of controlled substances or alcohol; and (3) emotional disturbance. North Carolina has certain requirements for parental or guardian consent for abortions.

Initial_____

Privacy Notice Acknowledgement Form

Record #: 100938

L & B Counseling
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Client Name: _____

The notice of Privacy Practices provides information about how I may use and disclose protected health information about you. You have the right to review the notice before signing this consent. As provided in the notice, the terms of the notice may change. If I change my notice, you may obtain a revised copy in my office.

- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for L & B Counseling.
- I understand how and where I may file privacy related complaint.
- I understand that I have the right to request how protected health information about me is used or disclosed for treatment, payment or health care operations. I understand that L & B Counseling is not required to agree to this request but if they agree, they are bound by our agreement.
- By signing this form, you consent to L & B Counseling to use and disclose protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on my prior consent.

Signature of Client_____
Date Signed _____

Signature of legally responsible person, if required_____
Date Signed_____

Office Use Only:
Explanation if signature of client or legally responsible person is not obtained:
_____

Client Referral Form

Record #: 100938

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Last Name:_____ First:_____ Middle:_____ Sex:___

Date of Birth: ____/____/_____ Age:_____ Email address:_____

Home Address:_____ City:_____ State:____

Zip code:_____ Home phone number:_____ Cell phone:_____

Referral source:_____ Referral Contact Info:_____

Primary Care Physican:_____ Phone:_____

Responsible Party:

Last Name:_____ First:_____

Email address for receipts of payment:_____

Telephone #:_____

Race: ❑ White ❑ African American ❑ Hispanic ❑ Asian ❑ Indian ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employment Status: ❑ Unemployed ❑ Employed ❑ Student ❑ Retired ❑ Homemaker

Primary Language: ❑ English ❑ Spanish ❑ Other

Living Arrangement: ❑ Private Residence ❑ Homeless ❑ Foster Home ❑ Other

Insurance:

Insurance carrier:_____ ID:_____

Payment Information: Credit Card#:_____

Expiration date:_____ PIN_____ Billing Zip Code_____

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the release information may no longer be protected by federal privacy regulations once it is disclosed.

Record #: 100938

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Purpose of Release: ☒Ongoing Communication ❑Copy of Record ❑Legal or Insurance Review ❑Authorized Representative's Request ❑ Other _____

Release From: L & B Counseling is authorized to release the requested health information for the following date:
From: (MM/DD/YY)_____ To: (MM/DD/YY)_____
The authorization will expire when the requested health information, for the requested date(s) of service, range of time or events(s), is released to the recipient named in this document and the purpose of the release is satisfied.

Check the specific information to be released:
☒ All Records & Details ❑ Other (Please Specify)_____

Name of client whose information is to be released:
Last name:_____ First:_____ Date of Birth_____

Address:_____

Release To: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

_____
Name

Patient's rights and signature:

- I understand that I have a right to revoke this authorization at any time by notifying the provider of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third part can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.
- This is a full release including information related to behavioral/mental health, drug or alcohol treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

If the client is a minor or is clinically unable to sign, an authorized representative may sign this authorization.
Print Name:_____
Signature:_____ Date _____
Refusal to sign: □ Yes □ No

Therapist Name:
Signature:_____ Date_____

Record #: 100938