Footsteps Counseling
Life's Journey Carpe Diem

FOOTSTEPS COUNSELING, LLC
PO BOX 1221
ABERDEEN, SD 57402
PHONE: 605-377-7570

EMAIL: hhfootsteps@icloud.com

WEBSITE: www.footstepscounseling.com

NEW CLIENT INTAKE REGISTRATION INFORMATION FORM

How did you hear about us?

CLIENT INFORMATION

First Name	Middle	Last Name	Date of Birth	Gender □ Male □ Female □ Trans
Marital Status: □ Single □ Married □Partnered □Separated □Divorced □Widowed □Other	Employment Status □Full Time □ Part Time □Self-Employed □Retired □Military Active/Retired □ Other			Student Status □ Fulltime □Parttime

Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Indicate Best # to call/Leave Msg □ Home □Cell □Work Text Message □Yes □No

Email Address	Ok to discuss scheduling via email? □ Yes □No / Ok to discuss Receipts/Statements/Billing Via Email? □ Yes □No

EMERGENCY CONTACT

Emergency Contact Name	Emergency Contact Phone	Relationship to Client

RESPONSIBLE PARTY (if Different than Client)

Billing Full Name		Relationship to Client □Legal Guardian □Parent of 18+ dependant □Spouse □EAP Provider □Other

Billing Address	City	State	Zip

Billing Phone	Leave Message □Yes □No	Email Address	Ok to discuss Receipts/Statements/Billing Via

INSURANCE INFORMATION (Copy both Sides of the Insurance Card(s) needat at intake

Primary Insurance Company		Secondary Insurance Company			Do You Have an EAP □Yes □No	
Copay: $		Copay: $				
Deductible $		Deductible $				
Co-insurance		Co-insurance				

Verified by _____ On _____ Insurance Aproved _____ Y _____ N

ALL CO-PAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

*Policies with a DEDUCTIBLE or Out of Network Insurance Require a Credit Card on File	Do you have an HSA Credit Card? □Yes □No	

We Accept: Cash, Checks and Credit Cards  Same as Cash	Expiration Date: / CVV Code:	We Accept: Cash, Checks and Credit Cards  Same as Cash	Expiration Date: / CVV Code:

Card Number:	Card Number:
Card Holder Name:	Card Holder Name:
I hereby give consent to charge my credit card for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable to me.	I hereby give consent to charge my credit card for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable to me.
Cardholder Signature	Cardholder Signature

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PRIVATE PAY PAYMENT DUE IN FULL AT THE TIME OF SERVICE			
Service Decription:	Rate per unit $	Service Decription:	Rate per unit $

IMPORTANT SIGNATURES	
Client Full Name:	Date Of Birth:
If client is a minor, please print name of parent/guardian(s) signing on behalf of the client:	
Print Full Name	Relationship to Client:
Print Full Name	Relationship to Client:

MISSED APPOINTMENTS

I am financially responsible for my attendance at all scheduled appointments, unless cancelled with atleast 24 hours notice; I will be billed for a minimun NO SHOW charge of $30.00. This charge is not covered by insurance._____ ***Initials***

INSURANCE BILLING

I authorize Footsteps Counseling, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Footsteps Counseling, LLC , I understand that I am responsible for payment for services rendered by Footsteps Counseling, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Footsteps Counseling, LLC immediately whenever I have changes in my health plan coverage.

*Initials*_____

ACCOUNT RESPONSIBILITY

I am responsible for payment to Footsteps Counseling, LLC for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balances will be immediately due and payable. If I default on any payment obligations as called for in this agreement, Footsteps Counseling, LLC reserves the to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names Footsteps Counseling, LLC as a creditor in any bankruptcy filing.

*Initials*_____

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that there should be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other preceeding, nor will a disclosure for psychotherapy records be requested.

CLINICAL STAFF RELEASE

I understand that as part of prefessional clinical consultation, my situation may be reviewed using general clinical information, and that my therapist/counselor will obtain a signed release of Information (ROI) prior to discussing specific details of my situation.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

I am consenting to treatment and have received and understand the contents of Footstep counseling practices including: consent for communication of Protected Health Information, Consent Disclosure and Policies form, Policy on federal requirements regarding confidentiality and counseling/therapy agreement and client responsibilities, notice of privacy Practices (HIPAA)

My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Footsteps Counseling, LLC policies and practices. If I have questions, the Information has been explaind to me.

Signature (s)(Client or Legal Guardian) _____ Date: _____

Signature (s)(Client or Legal Guardian) _____ Date: _____

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FEES

SERVICE/INSURANCE CODE	DESCRIPTION	UNIT	RATE
90791	Intake/Evaluation	60 Min	$ 140.00
90837	Individual Therapy	53 Min	$ 140.00
90847	Family Therapy	60 Min	$ 140.00
90853	Group Therapy	60 Min	$ 30.00
90837	Individual therapy	38-52 Min	$ 105.00
90832	individual therapy	16-37 Min	$ 70.00
	Marriage/Couples	60 Min	$ 140.00
	Complexity add-on	N/A	$ 25.00
	Drug/Alcohol Intakes	60 Min	$ 180.00
	Drug/Alcohol Group	60 Min	$ 60.00
	Psychological Testing	TBD	Rate Dependant on testing
90839/90840	Crises Session	60 Min/30 Min	$140.00/$70.00
Not Billable to Insurance	Late Cancellation/No Show	N/A	$ 30.00
Not Billable to Insurance	Returned Check	N/A	$ 30.00
Not Billable to Insurance	Prefessional Consultations	60 Min	$ 250.00
Not Billable to Insurance	Seminars	60 Min	$ 400.00
Not Billable to Insurance	Court Appearances	60 Min	$ 200.00
Not Billable to Insurance	Phone calls, Letters & Reports	15 Min	$25 +
Not Billable to Insurance	Business EAP Trainings	60 Min	$ 250.00
Not Billable to Insurance	Custom Seminars		
Not Billable to Insurance	EAP's	60 Min	$ 140.00

MAKING PAYMENTS

Please understand that payment of your bill is considered a part of you treatment. If mailing , please remit to:

Footsteps Counseling
PO Box 1221
Aberdeen, SD 57401

PREPARATION OF FORMS AND REPORTS

These require chart review and often discussion with the client. A prorated charge is applicable to time spent and is not billable to your insurance.

PAYMENT FOR MINORS

Parents or guardians accompanying minors are responsible for payment of co-pays or balances at the time of service. If a minor is accompanied by an adult other than the parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges MUST be pre-authorized to an approved card, paid by cash or check, prior to or at the time of service.

RELEASE OF RECORDS

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved, Footsteps Counseling, LLC does not have control over and cannot assure its clients confidenitality. That means employees of the insurer and employees of the contracted organizations of the insurer have access to your chart. This is provided for in the insurance policy between you and your insurance company. The client record is legally the property of Footsteps Counseling, LLC. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's well-being. Information can be released to others only upon written consent of the client or their legal guardians. In a few cases, information is unavailable to a client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children and vulnerable adults. In event of request for transfer of records, the records will be forwarded upon completion of a Release Of Information Form and payment fee based on the Current SD Department of Health maximum allowed.

Copies of records are available for a $15.00 processing fee, plus $ 1.30 per page for copying and $ 5.00 for mailing.

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CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY NON-SECURE TRANSMISSIONS

This consent for is for the communication of Protected HEALTH INFORMATION that Footsteps Counseling may transmit without the written authorization of the client as described in the Uses and Disclosure section of Footsteps Counseling's Notice of Privacy Policies and Practices and Compliance with HIPAA regarding confidentiality of client record and dissemination of information.

I, _____, hereby consent and authorize Footsteps Counseling to communicate my protected health information through the following non-secure transmissions **(Please initial you choices)**

_____ Cellular/Mobile Phone (this includes SMS) as listed on Footsteps Counseling New Client information Form.

_____ Unsecured Email as Listed on Footsteps Counseling New Client information form **(this will allow Footsteps Counseling to send you appointment reminders and/or homework assignments).**

_____ I do not wish to have my protected health information transmitted electronically. ***Please be aware that checking this box will prohibit us from sending you appointment reminders, homework assignments, or communicating with you by phone.**

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Footsteps Counseling cannot guarantee that those communications will remain confidential. Even though Footsteps Counseling may utilize state of the art encryption methods, firewalls and backup systems to help secure communications, there is a risk that our electronic or telephone communications may be compromised, unsecure, and/or accessed by a unintended third party.

I, _____, understand that Footsteps Counseling may use and disclose the following protected health information without my written authorization. However, I consent to Footsteps Counseling transmitting the following protected health information by the above selected electronic communications. **(please Initial your choices)**

_____ Information related to scheduling (e.g. appointment reminders)
_____ Information related to billing and payments
_____ Information related to your mental health treatment **(may contain personal material forms, suggested articles, homework, etc.)**
_____ Information related to Footsteps Counseling Operations.
_____ Other information, Please Describe: _____.

_____ _____

Client Signature (or Parent/Guardian) Date

_____ _____

Client Signature (or Parent/Guardian) Date

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THERAPY AGREEMENT AND CLIENT'S RESPONSIBILITIES

Please be aware of these terms and conditions:

1. Sessions are scheduled on the hour and are usually 53 minutes in length. If more time is needed or requested, these additional service are subject to the usual fee and are your responsibility. Out–of-office, email and mail correspondence, and phone or Skype times is billed for five minutes or more in fractions of your therapy rate.
2. Payment is due at the time services are rendered. Major Credit Cards, Cash, or Valid Checks are accepted. Insurance will be pre authorized and Copay's must be rendered at the time of service. Make Checks Payable to: Footsteps Counseling Before the session begins. There is a $30.00 charge for returned checks and refused cards. Footsteps Counseling, LLC reserves the right to charge interests on any balances on accounts which will be access each month.
3. You are responsible for covering the cost of your counseling. Footsteps is a preferred provider with many health insurance plans. For some Footsteps Counseling is qualified as an "out-of-network". It is up to you to provide full payment for any services not covered under your plan.
4. When you confirm a specific time for counseling you guarantee payment for that time no matter how you use it. If you miss your scheduled appointment you will be charged for the time you have reserved regardless (unless of a true emergency). Cancellations must be made 24 hours in advance to avoid being charged. If you miss your appointment the $30.00 will billed and sent to you.
5. Footsteps Counseling, LLC provides counseling in cooperation with a number of organizations for third party billings (Court services, nonprofits, churches, employers). If such a sponsoring third party supports your case, you may be required to complete a release of information to allow sharing of the status of your treatment and payments to those responsible for the provision of your counseling. Footsteps Counseling may also consult with other qualified therapist's about various aspects of your treatment and client file on an anonymous basis.
6. As a supervisor and lead therapist, another therapist may be brought into the session to assist while serving your needs. It is possible that after a mutually agreed number of sessions, you may continue your course of therapy in the treatment of the partner therapist.
7. The notes taken by the counselor are the personal property rights of the counselor not the client. The results of any tests administered are confidential and remain in the therapists records. Some tests require additional fees, in which the client is responsible to pay.
8. You may be required to sign a release of information for sharing of information to and/or form other people deemed relevant to you treatment, situation (such as spouse, family, probation, court services, parole). All cases are treated with the utmost confidentiality and security.
9. Your signature below indicates that you so affirm that you are not presently involved or currently plan to be involved in litigation that would involve any matter related to you therapeutic treatment under Footsteps Counseling, LLC. Since your treatment aims towards you full honesty through total personal disclosure please understand it could be a conflict of interest if Footsteps Counseling were asked or subpoenaed by a court of law to divulge your personal information before potentially hostile witnesses and attorneys not in your favor. Footsteps Counseling, LLC serves you personally, not the courts or others.
10. If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____	_____
Client Signature	Responsible Party's Signature
_____	_____
Print Client Name	Print Responsible Party's Name
_____	_____
Date	Relationship to Client and Authority to Consent

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Welcome to Footsteps Counseling, LLC., we are required by the State of South Dakota and the Department of Regulatory Agencies to share the following information with you to help establish the understanding and trust essential to a therapeutic relationship. Please provide the requested information and read these documents carefully, as they contain important information about our practice, policies, and how your mental health information can be used and disclosed. Please note any questions or concerns that you have – you may discuss these with your therapist/counselor at any time. After you sign the enclosed documents, they will constitute a binding agreement between you, your primary therapist/counselor and Footsteps Counseling, LLC. (hereinafter also referred to as "Footsteps Counseling") **Only one copy of the forms is needed for couples or families, however all adults family members will need to sign the disclosure statement.**

Footsteps Counseling, LLC consists of Licensed Professional Mental Health Counselors. While you, the client, always have the choice in determining which therapist/counselors you want to see, Footsteps Counseling, LLC will do their best to set you up with a therapist/counselor best suited for you. If the requested therapist/counselor is not available, Footsteps Counseling, LLC will recommend another therapist/counselor at Footsteps Counseling, LLC or refer you to a therapist/counselor outside of Footsteps Counseling, LLC. **Your primary therapist/counselor, (hereinafter "therapist/counselor", "counselor", "primary therapist/counselor") identified in Part 2 below, will be solely responsible for this disclosure statement and all therapeutic treatment provided to you.** If you have any questions or concerns about your treatment please speak with your primary therapist/counselor.

PART 1: INFORMED CONSENT

Each client is required to sign the below form. Any child seventeen (17) years of age or younger must have a parent or legal guardian consent to the mental health services to be provided. Any adult eighteen (18) years of age or older may sign the below form and may consent to mental health services without consent of a parent or legal guardian. If the parent or legal guardian is consenting to the mental health services, the required disclosures shall be made to the parent or legal guardian. If the child is consenting to mental health services, the required disclosure shall be made to the minor child and their parent or legal guardian. If a parent or legal guardian is consenting to mental health services for his/her minor child, and the parent or legal guardian is divorced or separated, the parent is required to provide a copy of the Court Order and/or Custody Agreement that grants the parent or legal guardian authority to consent to mental health services. Failure to provide a copy of the Court Order or Custody Agreement will result in immediate termination.

Participation in therapy/counseling can result in a number of benefits, including improving relationships and resolving the concerns that led you to seek help. As a collaborative process, therapy/counseling requires your very active effort, honesty, and openness in order to achieve desired changes. You may also be contacted periodically by Footsteps Counseling, LLC to get feedback on the quality of services you are receiving. You may always request that Footsteps Counseling, LLC not contact you to receive feedback on the quality of services you receive.

The process of engaging in therapy/counseling can result in your experiencing considerable emotional discomfort. Your therapist/counselor may challenge your perceptions or propose ways of handling situation that can cause you to feel some distress. Attempting to resolve therapeutic issues may result in changes that were not originally intended. Therapy/counseling may also result in decisions about making changes that may be positive for one family member, but could be viewed negatively by another. Change will sometimes be easy and swift; other times it will be slow and even frustrating. There is no guarantee that therapy/counseling will yield the intended results. At all times, it is your decision whether to pursue the suggestions made by your therapist/counselor. It is always your responsibility, not your therapist/counselor's, to make decisions regarding relationships such cohabitation, marriage, divorce, separation, reconciliation, custody, etc.

You are entitled by law to receive information about the methods of therapy/counseling, the techniques used, the duration of therapy/counseling, if known, and the fee structure. During the course of therapy/counseling, your therapist/counselor at Footsteps Counseling, LLC is likely to draw on various therapeutic approaches according, in part, to the problem that is being treated and the therapist/counselor's assessment of what will best benefit you. Within a reasonable period of time after the initiation of treatment, your therapist/counselor will be able to offer you some impressions of what your therapy/counseling will include. You should also make your own assessment about whether you feel comfortable working with your therapist/counselor. If you have any questions about the process of therapy/counseling, please let your therapist/counselor know directly.

The most common reason for ending therapy/counseling is that a client's concerns have been addressed. You are entitled to end therapy/counseling or seek a second opinion from another therapist/counselor at any time. Most clients find it helpful to have one or two sessions to bring closure to therapy/counseling and discuss the therapeutic process. These sessions can help prevent future problems. Therapy/counseling can also end when your challenges lie beyond the limits of your therapist/counselor's ability to help. If this becomes apparent to your therapist/counselor at any point, your therapist/counselor is legally required to refer, terminate, or consult, and will discuss this with you, offer you appropriate referrals, and end treatment.

By signing this document, you affirm your understanding that should you discontinue therapy/counseling for more than 60 days without written notice to Footsteps Counseling, LLC, your treatment will be considered "terminated". You may resume therapy/counseling any time after the 60 day period by communicating your decision to resume therapy/counseling services to Footsteps Counseling, LLC. This document may remain in effect should you resume therapy/counseling if one (1) year has not elapsed since your last session. However, you may be asked to re-sign this document or provide additional information to update your client records and/or sign new forms. "Discontinuing therapy/counseling" means that you have not had a session with your therapist/counselor for at least sixty (60) days.

PART 2: DISCLOSURE STATEMENT (DEGREES, LICENSING, & OTHER CERTIFICATIONS)

Heidie J. Holmstrom: *Degrees*: Regis University, Bachelor of Science Business Finance with Minor in Psychology, Conferred 2010. Argosy University, Master of Arts Clinical Mental Health Counseling, Conferred 2014. License: LPC7175 State of South Dakota Board of Counselors.

- YOUR PRIMARY THERAPIST/COUNSELOR/COUNSELOR IS: _____.

The information provided by clients during therapy/counseling sessions is legally confidential, except as provided in South Dakota Codified Law Mental Health Statue SL 1990, ch 313, § 27; SL 1998, ch 240 § 9., and except for certain exceptions that are identified in our Confidentiality Form (See Part 4). In a professional relationship (such as counseling/ psychotherapy), sexual intimacy between a therapist/counselor and a client is never appropriate. **As stated previously, your primary therapist/counselor is solely responsible for both this disclosure and all therapeutic treatment provided to you.**

The South Dakota Board of Counselors and Marriage and Family Therapist is the regulating agency and Licensing Board that protects consumer of counseling, marriage and family services by mandatory licensing of qualified applicants. Licensed Professional Counselors and Licensed Professional Counselors – Mental Health must follows by the American Counseling Association (ACA) Code of Ethics. The South Dakota Board of Counselors and Marriage and Family therapist examiners has the general responsibility of regulating the practice of Licensed Professional Counselors and Licensed Professional Counselors – Mental Health can be reached at PO Box 2164, Sioux Falls SD 57101, 605.331.2927, Email: sdbce.msp@midconetwork.com. Clients are encouraged, although not required, to resolve any grievances through our internal process.

***Levels of Regulation Include: Licensing (requires minimum education, experience, and examination qualifications), Certification requires minimum training, experience, and for certain levels, examination qualifications.**

PART 3: OFFICE POLICIES

PAYMENT AND FEES:

- Individual Counseling $140.00 per 53 minute session
- Group Counseling $30.00 per session
- Family/Couples/Marriage Counseling $140.00 per 53 - 60 minutes session
- Drug/Alcohol Intakes $180.00
- Drug/Alcohol Group Counseling $ 60.00 per group session
- Psychological Testing – Determined by testing type
- You are expected to pay the full fee (as listed above) at each session, unless other arrangements have been made. If longer sessions occur, the fee will be prorated for each additional 10 minutes, as indicated above. All payments should be made directly to Footsteps Counseling. Additional services will also be prorated at this fee. Such additional services may include, but are not limited to, preparations of reports, correspondences, travel time, and phone calls lasting over 10 minutes. Acceptable forms of payments are cash, check, money order, Debit, Credit Cards (Visa, MasterCard, Discover, and American Express). If you miss your scheduled appointment you will be charged for no show appointment at the rate of $30.00, a bill will be sent directly to you. If your check is returned for non-payment, you will be charged and additional $30.00 to cover bank fees. Please notify your counselor if any problem arises regarding your ability to make payments. **Any court/legal appearances will be billed at $200.00 per hour, which includes but not limited to:** testimony related matter like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time.

Please check the box below if alternative payment arrangements have been made outside of the standard fee:

☐

Description of alternative fee agreement: _____

_____ _____ _____

Initial **Initial** **Counselor's Initials**

Third Party Payments (by clergy, EAP, other family members or insurance): When third party payers are paying for services, in full or in part, for the services you receive at Footsteps Counseling, LLC; you will be asked to make a copayment at the time of service. Footsteps Counseling will still collect your credit/debit card information before or at the first session to enable timely payment for any cancellations/no shows fees. If a third party is making a payment on your behalf, Footsteps Counseling will not disclose confidential information to the third party without your written consent.

Overdue Payments: if your account is more than 30 days overdue and suitable arrangements have not been agreed to, Footsteps Counseling may become obligated to turn past due accounts over to collection agencies or small claims court (if such legal action is necessary, the costs of bringing that proceeding will be included in the claim). Footsteps Counseling, LLC will provide the collection agency or court with any information requested by the collection agency or court deemed necessary to collect the past due amount.

Cancellations and No-Shows: Since your appointments involve the reservation of time specifically for you, and out of respect for your therapist/counselor, a minimum of 24 hours' notice is required for rescheduling or canceling an appointment, excluding emergency situations. Anytime you fail to attend a scheduled appointment without giving any notice of cancellation, you will be charged $30.00. Repeated cancellations (more than two) without the required 24 hours' notice may result in the termination of therapy/counseling. Multiple no shows will result in the termination of therapy/counseling. Although Footsteps Counseling may send clients email reminders about upcoming appointments, this is done as a courtesy and only if you consent to receive such communications via email. It remains your sole responsibility to keep track of and attend all scheduled counseling appointments, whether or not you receive the reminder from Footsteps Counseling.

Insurance: We will bill your insurance directly. It is your responsibility to pay copayments, uncovered services and remaining balances insurance did not cover. Please be aware of what your insurance will cover and be prepared to pay for uncovered services at the time of service. Not all therapeutic issues are reimbursable; it is your responsibility to verify the specifics of your coverage. Insurance companies normally do not reimburse for missed appointments or late cancellation fees, in which a bill will be sent directly to you.

Phone Contact: It is Footsteps Counseling policy to try to return all telephone messages by the following business day, although that may not always be possible. Our counselors check their messages a few times daily, though rarely during non-business hours. They may not be available to converse or check messages on weekends, holiday, when out of office and when they are out of town. Messages left during these times will be returned in a prompt manner when the therapist/counselor returns to work. Footsteps Counseling, LLC only provides non-emergency services by scheduled appointments. ***Please note that therapeutic calls lasting 10 minutes or longer are billed pro-rated at the regular fee.**

Teletherapy/counseling: In general, Footsteps Counseling, LLC does not provide Teletherapy/counseling, such as therapy/counseling over Skype or other video chat means. Should you want teletherapy/counseling, you must discuss your request with your therapist/counselor; however, it is in your therapist/counselor sole discretion whether to accommodate your request.

Texting/Messaging Policy: Please do not use SMS (mobile phone text messaging) or messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact your therapist/counselor and/or Footsteps Counseling, LLC as an avenue for therapy/counseling. These sites are not secure and your therapist/counselor may not read these messages in a timely fashion. Because it is not possible to guarantee the confidentiality of text messages (e.g. we cannot be sure that it is you sending the text), it is Footsteps Counseling, LLC policy that we do not text with clients. *If you have information that you need to communicate to your therapist/counselor, please call your therapist/counselor directly.*

Email Policy: Please use discretion in deciding whether to communicate with your therapist/counselor via email. Footsteps Counseling, LLC cannot be held responsible for any information lost in transit or viewed by a third party. Email should only be used for brief, general questions (e.g. question regarding billing or advance scheduling of appointments). Hence, therapeutic issues, emergencies, sensitive personal information, and cancellations should all be communicated to your therapist/counselor only over the telephone or in person. If you choose to initiate communication via email, or other electronic means that you have not previously specifically consented to, you will need to amend Footsteps Counseling, LLC Consent for Communication of Protected Health Information by Non-Secure Transmissions before your therapist/counselor may communicate with you via electronic means. Although, confidentiality will extend to information through email communications.

Social Media Policy: Please do not request Footsteps Counseling, LLC to "like", "follow", "friend" you etc. via any social media site. Any such request will be denied in order to maintain professional boundaries. Do not use wall posting, @replies, or other means of engaging with your therapist/counselor at Footsteps Counseling, LLC in public online if you have already established client/counselor relationship with a therapist/counselor at Footsteps Counseling, LLC. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of you legal medical record and will need to be documented and archived in your chart. Footsteps Counseling, LLC may have a business Facebook page, Blog, or other Business social media accounts. There is no requirement for you "like", "follow", or post comments on Footsteps Counseling, LLC social media accounts/blog, there is the chance that others will see you name associated with "liking", "following", "sharing" "tweeting" Footsteps Counseling, LLC. Any comments you post regarding therapeutic work between you and your therapist/counselor will be deleted as soon as possible after Footsteps Counseling, LLC becomes aware of such posts. By signing this form you agree that you will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that if you have a therapeutic comment and/or question that you will contact your therapist/counselor through the mode you consented to and not though social media.

Emergencies: Footsteps Counseling, LLC does not provide emergency care. Our therapist/counselors are often not immediately available by telephone. They do, however, check periodically for telephone messages. **If you need to talk to someone immediately and are having an emergency, CALL 911 or the 24-Hour National Crisis Hotline at 1-844-493-TALK (8255), or go to your nearest hospital emergency room.** If you require after hours emergency care, you are solely responsible for all cost arising from such care.

Litigation Limitations: If you are involved in divorce/custody litigation, your therapist/counselor's role is not to make recommendation to the court concerning custody or parenting issues. The court can appoint professionals who have no prior relationship with family members to conduct an investigations or evaluations and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of your children. Any request to testify or participate in any litigation will be charged directly to the client at the rate listed above.

Electronic Records: Footsteps Counseling, LLC may keep and store records for each client electronically on Footsteps Counseling, LLC computers and some mobile devices. In order to maintain security, Footsteps Counseling, LLC employs the use of firewalls, antivirus software, passwords, and encryption methods to protect computers from unauthorized access.

In addition, Footsteps Counseling, LLC may also use electronic backup or storing systems either by using external hard drives, thumb drives or similar methods, or on a cloud based service. The cloud based records system Footsteps Counseling, LLC may change from time to time to enhance better records and customer service. This is to help prevent the loss or damage of records. Footsteps Counseling, LLC maintains the security of these backup devices through HIPAA compliant encryption and passwords. The cloud based backup and storing systems means that the backups are stored on computers that are connected to the internet. In order to maintain security of these backups Footsteps Counseling, LLC has employed the following procedures:

- Entered into a HIPAA Business Associates Agreement with the cloud based company. Because of this agreement, the company is obligated by federal law to protect these backups form unauthorized use or disclosure.
- The computers on which these backups are stored are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The company employs various security measures to maintain the protection of these backup from unauthorized use or disclosure.

Generally speaking, the information provided by and to a client during therapy/counseling sessions is legally confidential if the therapist/counselor is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist/counselor, a licensed professional counselor, a licensed professional counselor – mental health, a licensed/certified addictions counselor or a licensed psychologist. If the information is legally confidential, the therapist/counselor cannot be forced to disclose information without the consent of the client. Information disclosed to a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist/counselor, a licensed professional counselor, a licensed professional counselor – mental health, a licensed/certified addictions counselor or a licensed psychologist is privileged communications and cannot be disclosed in any court of competent jurisdiction in the State of South Dakota without the consent of the person/client whom the testimony sought relates to or a court ordered subpoena.

Exceptions to the general rule of confidentiality are in South Dakota Codified Law SL 1990 CH 313, § 27, SL 1998 ch 240, § 9 such situations in which the law requires disclosures include, but are not limited to the following:

1. Your therapist/counselor is required to report any suspected incident of child abuse or neglect to law enforcement and/or the appropriate agency (South Dakota Department of Social Services, Child Protection Agency).
2. Your therapist/counselor is required to report any suspected abuse or exploitation of an at-risk elder or the imminent risk of abuse of exploitation.
3. Your therapist/counselor is required to report any threat of imminent physical harm by a client, including the harm to a child, to law enforcement and to the person(s) threatened.
4. Your therapist/counselor is required to initiate a mental health evaluation of a client who is imminently dangerous to self or others, including the harm of a child, or who is gravely disabled as a result of a mental disorder.
5. Your therapist/counselor is required to report if he/she determines you are a danger to yourself or others, including those identifiable by their association with a specific location or entity.
6. Your therapist/counselor is required to report any suspected threat to national security to federal officials.
7. Disclosure may be required pursuant to Court Orders and subpoenas. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy/counseling records and/or testimony by your therapist/counselor.
8. Disclosure may require during the course of supervision or consultation, the investigation of a complaint or civil suit filed against your therapist/counselor or Footsteps Counseling, LLC, or if otherwise ordered by the court of competent jurisdiction.
9. Your therapist/counselor will advise you of other situations where the law requires disclosure, should the situation arise. Provisions concerning disclosure of confidential communications do not apply to any delinquency or criminal proceeding, excepts as provided in South Dakota Codified Law 36-32-27, SL 1990 ch 313 §27; SL 1998 ch 240 § 9.

You should also be aware of the following additional Confidentiality Policies of Footsteps Counseling, LLC:

Consultation: In order to provide the best possible therapy/counseling treatment, your therapist/counselor consults with other professionals, such as supervisor, attorney, concerning his/her clients. In addition, the therapists/counselors at Footsteps

Counseling, LLC may consult with each other. The same confidentiality laws listed above bind all professionals with whom your therapist/counselor consults. The minimum amount of information necessary to consult will be disclosed. Signing this form gives your therapist/counselor permission to consult as needed to provide professional services to you.

Consultation with Psychiatrist/Medical Professionals: If a psychiatrist or other medical professionals is also seeing you for issues regarding or relating to your mental health, it is Footsteps Counseling, LLC policy to require a written authorization for your therapist/counselor to exchange information regarding your mental health treatment. If this is not a suitable arrangement for you, your therapist/counselor will assist you by offering referrals for you to been seen elsewhere.

In Couples & Family therapy/counseling, when different people are seen individually, your therapist/counselor will use his/her clinical judgment when revealing information disclosed in individual sessions. Should you reveal a "secret" to your therapist/counselor that you refuse to disclose to the others, and harms the therapeutic process, your therapist/counselor will terminate therapy/counseling. When possible you will be assigned a different individual and family therapist/counselor to minimalize the conflict of interest.

In Accordance with South Dakota Law

If you see someone you know in the waiting room, please respect their confidentiality by not discussing their attendance of therapy with others.

Considering all of the above exclusions, upon your written request Footsteps Counseling will release information to any agency/person you specify unless you therapist and/or Footsteps Counseling concludes that releasing such information might be harmful. Records will only be release to outside parties when Footsteps Counseling is authorized to do so, in writing, by every member of the couple/family in treatment legally able to execute a waiver.

This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to you your privacy, will be released without permission unless mandated by South Dakota Law as described in this form and the "Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of client records and dissemination of information". Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. You acknowledge that you have received Footsteps Counseling's Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information.

My signature below affirms my informed and voluntary consent to enter therapy/counseling/counseling (and/or have my child/children enter therapy/counseling/counseling), and that I have read and understand the nature of confidentiality in therapy/counseling as set forth above. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I affirm that prior to becoming a client of Footsteps Counseling, I was given sufficient information to understand the nature of therapy/counseling/counseling, including the possible risks and benefits. I understand and agree to abide by the office policies and procedure listed above. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I acknowledge that I have read the preceding information (pages 1 through 7). I understand that I have full access to this form online at Footsteps Counseling's website. I acknowledge that if I wish to have a copy of the signed document, I may request one at any time. Such requests shall be submitted in writing. I understand that I can ask questions and raise concerns about the treatment at any time. I also understand that I may terminate therapy/counseling at any time by providing written notice to Footsteps Counseling, LLC. Therapy/counseling shall be terminated upon receipt of my written notice.

_____ _____ _____ _____

Client Signature (or Parent/guardian) Date **Client Signature (or Parent/Guardian) Date**

Please indicate your relationship to the client if you are signing forms for a minor child/minor children in your care:

My relationship to the child/children is:_____.

_____ _____

Therapist/counselor's Signature **Date**

_____ _____

Supervisor's Signature - If applicable **Date**

_____ _____

Administrative Signature- (Person Receiving Form)(if Applicable) **Date**

Footsteps Counseling, LLC
PO Box 1221
Aberdeen, SD 57402

Life's Journey Carpe Diem

POLICY ON FEDERAL REQUIREMENTS REGARDING CONFIDENTIALITY OF CLIENT RECORDS AND DISSEMINATION OF INFORMATION- NOTICE OF PRIVACY POLICY

Given the nature of our work, it is imperative that we maintain the confidence of client information that we receive in the course of our work. Footsteps Counseling, LLC is a private mental health counseling practice that treats couples, families and individuals by providing marriage, family, couples, individual and group counseling. Along with psychoeducational groups, psychological testing and seminars. The practice works solely to provide the best counseling treatment options to its clients. Footsteps Counseling, LLC prohibits the release of any client information to anyone outside of immediate staff, employees, interns or volunteers except in limited circumstances. Discussions or disclosures of protected health information (PHI) within the organization is limited to the minimum necessary that is needed for the recipient of the information to perform their job. It is the policy of Footsteps Counseling, LLC to:

1. Fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. Provide every client who receives services with a copy of Footsteps Counseling, LLC Notice of Privacy Practices;
3. Ask the client to acknowledge receipt when given a copy of Footsteps Counseling, LLC Notice of Privacy Practices;
4. Ensure the confidentiality of all client records transmitted by facsimile;
5. Provide each client with the individual therapists' informed authorization for use or disclosure of Protected Health Information Forms.

Footsteps Counseling, LLC is required to follow all state statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14, and Title 25, Article 1, Part 1, CRS and Health Insurance Portability and Accountability Act (HIPAA), 45 C,F R Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, maintaining the confidentiality of protected health information.

Protected Health Information (PHI) refers to any information that is created or received by Footsteps Counseling, LLC and relates to an individual's past, present or future physical or mental health or conditions and related care services of the past, present, or future payment for the provision of health are to an individual; and

1. That identifies the individual;
2. With respect to which there is a reasonable basis to believe the information can be used to identify the individual; or

PHI includes any such information described above that Footsteps Counseling, LLC transmits or maintains in any form, this includes psychotherapy notes. HIPAA and federal law regulates that use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent for Communication of Protected Health Information by Non-Secure Transmissions.
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting year for free but will charge a reasonable, cost-based fee if you ask for another on within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, Calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.
- Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above.

Uses and Disclosures of Protected Health Information

A use of PHI occurs within a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when Footsteps Counseling, LLC reveals PHI to an outside part (i.e., Footsteps Counseling, LLC provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

1. Treatment (including the provision and coordination of care with other professionals, etc.)
2. Payment (to bill and receive payment from health plans or other entities, claims management, etc.)
3. Health Care Operations (general administrative activities of Footsteps Counseling, LLC, resolution of internal grievances, customer's service, etc.).

Uses and disclosures for payment and health care operations purposes are subject to minimum necessary requirement. This means Footsteps Counseling, LLC may only use or disclose the minimum amount of PHI necessary for the purpose of the use of disclosure (i.e. for billing

purposes, a therapist would not need to disclose a client's entire medical record in order to receive reimbursement. A therapist would likely only need to include a service code, etc.) Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

Footsteps Counseling, LLC is required to promptly notify you of any breach that may occur that may have compromised the privacy or security of your information.

Footsteps Counseling, LLC confidentiality of client records and substance abuse client records maintained is protected by federal law and regulations. It is Footsteps Counseling, LLC policy that a client must complete an Authorization for Use and Disclosure of Protected Health Information Release of Information, provided by Footsteps Counseling, LLC, prior to disclosing health information for any purpose, except treatment, payment or health care operations.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, Footsteps Counseling, LLC staff is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment, unless one of the following exceptions arises:

Footsteps Counseling, LLC is permitted and/or required to report or disclose PHI if and when any of the following occur with any Footsteps Counseling, LLC client:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against a counselor of Footsteps Counseling, LLC, etc.).
2. Disclosure is made to a medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluations.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at the program or against any person who works for the program; A minor child or elderly client reports having been abused; Client is planning to harm another person, including but not limited to the harm of a child; Client reports suicidal ideations or self-harm).
4. Address worker's compensation (with release of information), Law enforcement or other government request (by subpoena only).
5. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement (Footsteps Counseling, LLC may only use and disclose the minimum amount of PHI necessary for the intended purpose of the use and/or disclosure). See 45 C.F.R 164.512. Before using or disclosing PHI for one of the above exceptions, Footsteps Counseling, LLC staff must consult Footsteps Counseling, LLC Privacy officer or Attorney to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities in accordance with federal and state regulations. Know that Footsteps Counseling, LLC will never market or sell your personal information.

Special Authorizations

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: Your primary therapist will obtain a special authorization before releasing your Psychotherapy Notes and test results. "Psychotherapy Notes" are notes your primary therapist has made about conversations during a private, group, joint, or family counseling session, which your primary therapist has kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

HIV Information: Special legal protections apply to HIV/AIDS related information. Your primary therapist will obtain a special written authorization from before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use treatment. Your primary therapist will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations(of PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use information) at any time, provided each revocation is in writing, signed by you and signed by a witness. You may not revoke an authorization to the extent that (1) I have relied on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provided the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, Footsteps Counseling, LLC is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as a Footsteps Counseling, LLC employee, intern, or volunteer about a client or potential Footsteps Counseling, LLC client, may not be used or disclosed for non-work purposes or with unauthorized individuals. Footsteps Counseling, LLC may only use and disclose such PHI as describe area.
3. Seeking legal counsel in uncertain situations and/or incidences.

Your Choices:

For certain health information, you can tell us your choice about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. We may request you sign a separate document if you authorize us to share certain PHI. You may revoke that authorization at any time for future disclosure.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.

- Share information in a disaster relief situation
- Share information with probation/parole officers, CPS.
- Include your information in review, publications, websites and etc.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice is effective March 12, 2016.

Heidie Holmstrom

Heidie Holmstrom, MA, LPC, NCC, CEO

Footsteps Counseling, LLC

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

My signature below affirms I have received and read Footsteps Counseling Policy on Federal Requirements Regarding Confidentiality of Client Records and Dissemination of Information – Notice of Privacy Policy which is HIPAA Compliant. My informed and voluntary consent to enter therapy/counseling (and/or have my child/children enter therapy/counseling), and that I have read and understand the nature of confidentiality in therapy/counseling as set forth above. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I affirm that prior to becoming a client of Footsteps Counseling, I was given sufficient information to understand the nature of therapy/counseling, including the possible risks and benefits. I understand the HiPAA policies as stated above. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I acknowledge that I have read the preceding information (pages 1 through 6). I understand that I have full access to this form online at Footsteps Counseling's website. I acknowledge that if I wish to have a copy of the signed document, I may request one at any time. Such requests shall be submitted in writing. I understand that I can ask questions and raise concerns about the treatment at any time. I also understand that I may terminate therapy/counseling at any time by providing written notice to Footsteps Counseling, LLC. Therapy/counseling shall be terminated upon receipt of my written notice.

_____ _____ _____ _____

Client Signature (or Parent/guardian) **Date** **Client Signature (or Parent/Guardian)** **Date**

Please indicate your relationship to the client if you are signing forms for a minor child/minor children in your care. My relationship to the child/children is: _____.

_____ _____

Therapist/counselor's Signature **Date**

_____ _____

Supervisor's Signature - If applicable **Date**

_____ _____

Administrative Signature- (Person Receiving Form if Applicable) **Date**

FOOTSTEPS COUNSELING, LLC
PO BOX 1221
ABERDEEN, SD 57401
605-377-7570
www.footstepscounseling.weebly.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____ Date of Birth _____ Client Number _____

Footsteps Counseling LLC
PO Box 1221
Aberdeen, SD 57402
Phone 605.377.7570
Email: hhfootsteps@icloud.com

_____ Phone ( ) -
Agency/Program/Person

_____ Fax ( ) -
Address

_____
City State Zip

I,_____Authorize Footsteps Counseling, LLC to: ☐ To Disclose to: ☐ To Receive From

I understand that the specific type of information of my protected health information from my records to be disclosed (specify extent or nature of information to be disclosed):

☐ *Family and Social History* ☐*Medical History/Records* ☐*Treatment Plan/Progress* ☐*Diagnosis*
☐ *Discharge Summary/Plan* ☐*Substance Abuse Records* ☐*Educational Records* ☐ *Other: Specify* _____
☐ *Psychological Reports/Testing/Information* ☐*Group Progress: Specify Group* _____

I understand the information disclosed may include reference to treatment of alcohol/drug abuse or mental/behavioral and Protected Health Information. The purpose or need for this disclosure is: (check all that apply)

☐For Continuity of Services ☐Research ☐ Further Assessment, Treatment, or Care Coordination ☐For Supervision
☐To Fulfill Requirement of Purchaser/EAP ☐For the Purpose of Quality Assurance ☐Other: Specify _____

This authorization includes consent to release information verbally from these records ☐ ***Yes*** ☐ ***No*** ☐ ***Other*** _____I have been informed that I have the right to withhold my consent concerning release of Protected Health Information of confidential material relevant to me or the person named above. Expiration Date of this Authorization: If not previously revoked, this consent will terminate in one year ☐ ***After the Above information has been released*** ***OR*** ☐ ***On Specific Date or Event:*** _____

_____ _____
Signature of Client *Date*

_____ _____
Signature of Parent/Guardian/Legal Representative authorizing Disclosure *Date*

_____ _____ _____
Relationship to Client *Client Date of Birth* *Client Social Security Number*