Tri-City Family Counseling

100 NW 16th Street
Newcastle, OK 73065
(405) 387-3838 Phone
(405) 387-3822 Fax
www.tricityfamilycounseling.com

The information requested in this form will be kept confidential.

IDENTIFYING INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Gender: ❑ Male ❑ Female Social Security#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May I leave a message? ❑ Yes ❑ No

Mobile Phone: _____ May I leave a message? ❑ Yes ❑ No

E-mail: _____ May I email you? ❑ Yes ❑ No

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Separated ❑ Divorced ❑ Widowed

Please list any children/people living in the household/ages: _____

EMERGENCY CONTACT: (For minors, please use **parent/guardian** as the emergency contact)

Emergency Contact: _____ Telephone: _____

Relationship to you: _____

Referred by: _____ Referral Date: _____

Referral Source: ❑ Website ❑Friend ❑ Family ❑ Physician ❑ Insurance Co. ❑ EAP ❑ Other _____

Reason for Referral: _____

_____

_____

_____

HEALTHCARE INFORMATION:

Primary Care Physician: _____ Phone: _____

Address: _____

Insurance: ❑ Private Pay ❑ Insurance ❑ Medicaid ❑ Medicare ❑ EAP ❑ Other: _____

Primary Insurance: _____

Policy Holder: _____ Birth Date: _____ Relationship: _____

Insurance#: _____ Group#: _____ Phone: _____

Secondary Insurance: _____

Policy Holder: _____ Birth Date: _____ Relationship: _____

Insurance#: _____ Group#: _____ Phone: _____

Tri-City Family Counseling

Financial Information

Patient Name: _____ SSN: _____

Date of Birth: _____ Sex M ❑ F ❑ Marital Status: S ❑ M ❑ D ❑ W ❑ O ❑ Student: FT ❑ PT ❑ NA ❑

Telephone# Home: _____ Work: _____ Fax: _____

Address: _____

Employment Name: _____ Phone#: _____

Emergency Contact: _____ Phone#: _____

Responsible Party Information

Name: _____ Relationship: _____

Address: _____ Phone#: _____

Insurance Information

Insured Name: _____ SSN: _____

Date of Birth: _____ Sex: M ❑ F ❑ Relationship to Patient: _____

Employment Name: _____ Telephone#: _____

Insurance Company Name: _____

Customer Service Telephone#: _____

Policy ID#: _____ Group#: _____

Claim Address: _____

Payments are due at the time of service rendered unless other arrangements have been made.

24 HOURS CANCELLATION NOTICE IS REQUIRED TO AVOID A FEE

I authorize payment of benefits to my Provider and/or Aimee Walker, MS, LPC, PLLC dba Tri-City Family Counseling. I understand I am financially responsible for any charges not covered by my insurance company or third party. I also understand that late or non-payment may result in additional fees related to additional billing and collection efforts. I understand that I must cancel appointments within 24 hours before the scheduled appointment time. If I fail to notify the office with an answered phone call before that time, I will be charged a $50 as a no-show/no-cancel fee.

Accordingly, I also hereby authorize Tri-City Family Counseling to charge my credit card of file for:
1) Co-pays/Service fees due at the time of the visit;
2) $50 NS/NC fees and/or
3) Any outstanding balance on your account 30 days or older.

(For your security, All Credit Card information provided to Tri-City Family Counseling is retained through our Credit Card Processing system. Other than the last 4 digits on the card provided, at no time will any employee, or your provider, have access to your specific card information,.)

I have read and signed all required authorizations authorizing the release of any medical information necessary to process my claims and resolve payment for services.

_____ _____

Responsible Party Signature Date

HEALTH HISTORY

Medical/Physical History: _____

Medication Allergies/Reactions Yes ❑ No ❑ If yes, please explain: _____

How would you rate your current sleeping habits? (Please Circle)

Poor.....Unsatisfactory.....Satisfactory.....Good.....Very Good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

CURRENT MEDICATIONS

Physician's Name	Name of Prescription	Type of Medication	Dosage of Medication	Frequency of Medication	Length of Time on Medication

Do you drink alcohol more than once a week? ❑ No ❑ Yes If yes, how often? _____

Do you currently use tobacco products? ❑ No ❑ Yes If yes, how often? _____

How often do you engage in recreational drug use? ❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

If yes, list drugs used and amount per use? _____

Are you currently in a romantic relationship? ❑ No ❑ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
(Bad) (Good)

DEVELOPMENTAL HISTORY

Were developmental age factors, motor development, and functioning accomplished within appropriate time frames?

No ❑ Yes ❑ Unknown ❑

If no, please explain: _____

_____

PERSONS LIVING IN THE HOME

Last Name First Name M. I. Age* Relationship

_____

_____

_____

_____

_____

CONCERNS ABOUT MEETING BASIC NEEDS (Food, Shelter, Health, Transportation, etc.)

_____

_____

_____

CURRENT SUPPORT SYSTEM

Is your family supportive? .....No ❑ Yes ❑ Is your employer supportive?...No ❑ Yes ❑

Are you involved in any self-help measures?..No ❑ Yes ❑ Is your church supportive?.....No ❑ Yes ❑

Comments: _____

_____

MENTAL HEALTH HISTORY

Have you ever been hospitalized for mental health reasons?....No ❑ Yes ❑

If yes, where:	Type: (Circle)	When:	How Long:
_____	Hospital DayTX Outpatient Sch.Based	_____	_____
_____	Hospital DayTX Outpatient Sch.Based	_____	_____

Have you ever attempted suicide? No ❑ Yes ❑

If yes, when? _____

Have you received any treatment for domestic violence?.....No ❑ Yes ❑

If yes, where:	Type: (Circle)	When:	How Long:
_____	Hospital DayTX Outpatient Sch.Based	_____	_____
_____	Hospital DayTX Outpatient Sch.Based	_____	_____

COUNSELING CONCERNS:

Please describe the concerns that bring you to counseling currently: _____

_____

_____

_____

_____

Please share what you hope to accomplish or gain through counseling: _____

_____

_____

_____

_____

Providers Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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405-387-3838

PROVIDER-PATIENT SERVICES AGREEMENT

This Agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA) and a copy of the HIPAA Notice of Privacy Practices. We can discuss any questions you have about the Agreement and/or Notice.

MENTAL HEATH SERVICES

Psychotherapy varies depending on the personalities of the "Provider" (Counselor) and the patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand, psychotherapy has also been shown to have many benefits, such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The length of therapy is determined by the type of symptoms or issues you are addressing, your goals and the type of therapy necessary for treatment. We hope to provide the most effective treatment in the shortest amount of time. Discontinuing Mental Health services may occur at any time and may be initiated by the patient or by the *Provider.* If you decide to discontinue, we ask that you tell us so we can discuss your reasons. We will make an appropriate referral if further services are needed. If at any time we determine that you require a higher level of care then we can provide, we will refer you to a professional or agency that we believe can meet your needs.

MEETINGS

We normally conduct an initial assessment at the first session, which are typically 60 to 90 minutes in length. For patients who are minors, parents/guardians are required to attend the first session. Sessions are 45 to 60 minutes in length. One session per week is typical, but more or less frequent sessions are available if we decide that is better for you. We typically recommend a decrease in the frequency of sessions as progress warrants it.

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer-generated voice message) the day before your scheduled appointments. If you request to receive appointment reminders, you should be aware that appointment information is considered to be "Protected Health Information" under HIPAA. By requesting reminders and signing this Agreement, you are waiving the right to keep this information completely private and requesting that it be handled as you indicated on your Patient Information Sheet.

If you are unable to keep an appointment, please notify the Provider or staff at least 24 hours in advance. **Appointments missed or cancelled less than 24-hrs in advance are subject to a $50.00 charge.** Insurance companies do not reimburse such appointments. After three consecutive failed appointments, we will not schedule additional appointments with you, until we have had an opportunity to talk and agree on future appointment expectations. If services are discontinued due to missed appointments, we will provide you with names of referrals for continued treatment if requested.

CONTACTING US

Due to our work schedule, *providers* are rarely immediately available by telephone. Office staff can assist you with billing and scheduling questions/issues. For other matters, you may leave a message for us, and we will make every effort to return your call on the same day. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

COURT TESTIMONY AND LEGAL INVOLVEMENT

We do not provide court testimony, forensic assessment, or custody evaluations. Our services are limited only to enhancing the health and functioning of our patients. If you are seeking a counselor who can testify on your behalf, such as in a custody or criminal matter, we will be happy to refer you to other mental health professionals who do provide that service. If a subpoena or court order is issued requiring our appearance or for our records and/or oral testimony, you will then be billed for any attorney fees, costs, and/or expenses incurred for the time

required to comply with or quash it, and for our time related to dealing with the subpoena or court order. Because of the complexities of legal involvement, we charge $300.00 per clock hour for preparation, travel, consultation, appearance, etc.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and their *provider*. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Consultation with other health and mental health professionals as needed. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential.
- Sharing of your protected health information (PHI) with office staff for both clinical and administrative purposes. Staff has been trained about protecting your privacy and has agreed not to release any information outside of the practice without permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- Court orders issued by judicial authority must be honored.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment.

- If we have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that we report to the appropriate government agency.
- If we have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that we report to the appropriate government agency.
- If a patient communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a patient has a history of violence and we have reason to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/his, or to contact family members or others who can help provide protection.
- If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in your clinical record (patient file). Your clinical record may include information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, treatment goals, your progress toward those goals, your medical/social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, we recommend that you initially review them in our presence so we can discuss any questions you might have.

Please note that we office with several other independently practicing mental health professionals. We share certain expenses and administrative functions; however, we are completely independent in providing you with clinical services and we alone are fully responsible for those services. Our professional records are separately maintained, and no other provider will access them without your written permission. All the mental health professionals are bound by the same rules of confidentiality. Staff members received education and training about protecting your privacy and agree not to release clinical information outside of the practice without our permission.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. For specific information about these rights, please refer to the HIPAA Privacy Notice included with this Agreement. We are happy to discuss any of these rights with you.

MINORS & PARENTS/GUARDIANS

Patients under 18 years of age who are not emancipated, and their parents/guardians should be aware that the law allows parents or guardians to examine their child's records. *Because privacy in psychotherapy is often crucial to successful progress, it is my policy to request agreement from parents/ guardians that we will provide them only with general information about the progress of the child's treatment and attendance at scheduled sessions. Other communication will require the child's agreement, unless we believe that the child is in danger or is a danger to someone else, in which case, we will notify the parents or guardians of my concern.* Parents may be asked to participate as collaterals to assist with their child's therapy. This does not constitute a therapeutic alliance with the parent.

PROFESSIONAL FEES	**per/hour**
• Initial interview (first appointment)	$175.00
• Individual and/or family therapy	
• 30 Minutes	$75.00
• 45 Minutes	$125.00
• 60 Minutes	$150.00
• Beyond 60 Minutes, per additional 15 min (may not be covered by insurance)	$125.00
• Psychological Evaluation (Includes time for written reports)	$125.00
• Psychotherapy for crisis (first 60 minutes)	$175.00
• Psychotherapy for crisis (each add 25-30 minutes)	$ 75.00
• Consultation performed on behalf of the patient, per hour	$150.00
• No-show or late cancellations appointments	$ 50.00
• Preparation of treatment summaries, letters, or other paperwork requested by patient	$100.00
• Employee Assistance Program	Covered by employer
• Copies of clinical records	$0.25/pg

BILLING AND PAYMENTS

Payment for each session is due the day service is rendered (unless other arrangements are made). This includes paying any deductible and/or co-pays required by your insurance company. If you have not met your deductible, you are responsible for 100% of the fee until it is met. If you are unable to pay the fee due at the time of service, it is your responsibility to make an arrangement with your provider.

- In the case of a minor, the parent who brings the child for the appointment will be responsible for payment of services. If payment is not made at the appointment, another appointment will not be scheduled until payment is made.
- If I fail to notify the office with an answered phone call before that time, I agree that you will charge my credit card listed below $50 as a no-show/no-cancel fee.
- If a credit card in on file, I hereby authorize you to charge my credit card on any outstanding balance of 30 days or older.
- Monthly statements will be mailed to you for any outstanding balance that you owe. If your account becomes delinquent, we have the option of using legal means to secure payment. This involves contacting my attorney, which would require me to disclose otherwise confidential information. In most cases, this is limited to name, other demographic information, nature of services, and amount due. You should be aware that you are fully

_____Initial here

responsible for any and all costs associated with the collection process.

INSURANCE REIMBURSEMENT

If you choose to utilize your health insurance as a source of payment for services, you should be aware that your contract with your health insurance company likely requires that we provide it with information about our services to you. We are usually required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. We will provide you with a copy of any report we submit, if you request it. If you wish to withhold such information from your insurance company, you might consider paying the full cost of your treatment out-of-pocket.

Health/Mental Health insurance represents a contact between the insurance company and the patient/policyholder. It is your responsibility to know your benefits and limits of coverage prior to the provision of services. Failure to learn these limits does not relieve you of financial responsibility. If: 1) your insurance company requires you to obtain an authorization from them before receiving services and you do not do so; or 2) you fail to inform the office staff of any changes in your insurance information; and, as a result, claims are denied, you are responsible for payment in full for the services rendered. If you request, staff will obtain benefits information and/or authorization from your insurance company. Tri-City Family Counseling and/or staff are not financially responsible for incorrect benefits information given to them. Final responsibility for payment is yours for any portion of fees not covered or not reimbursed by your insurance company.

INFORMED CONSENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE ATTACHED HIPAA PRIVACY NOTICE FORM.

If you are a parent/guardian completing this form for a minor, you certify that you are legally authorized to consent to treatment for the minor patient.

If you wish to utilize health/mental health insurance as a source of payment for services rendered, your signature below indicates that you authorize the release of any information by Tri-City Family Counseling and/or our agents necessary to verify the availability of insurance benefits and to submit and process insurance claims. It also indicates that you authorize Tri-City Family Counseling and/or our agents to bill your insurance on your behalf for services rendered by us. You authorize payment be made directly to us. You understand that you are financially responsible to us for charges not covered or not reimbursed by your insurance company. You permit a copy of this authorization to be used in place of the original.

You may revoke this agreement in writing at any time. That revocation will be binding unless: 1) Tri-City Family Counseling or staff have taken action in reliance on it; 2) if there are obligations imposed on Tri-City Family Counseling by your health insurer in order to process or substantiate claims made under your policy; or 3) if you have not satisfied any financial obligations you have incurred.

_____	_____	_____
Signature of Patient/Legal Guardian	Printed Name and Relationship to Patient	Date
_____	_____	_____
Signature of Witness (Provider)	Printed Name	Date

_____Initial here

HIPAA PRIVACY NOTICE

Notice of Providers' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment/Payment/ Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"*—information in your health record that could identify you
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. Ex: When I consult with another health care Psychologist, such as your family physician or another Psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Ex: When I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Ex: Quality assessment and improvement activities, business-related matters such as audits/ administrative services, and case management/care coordination.
- *"Use"* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. When I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing it. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I treat a child who I suspect to be the victim of physical or sexual abuse, I am required by law to report this to the nearest law enforcement agency or Oklahoma Department of Human Services.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect or exploitation, I am required by law to make a report to either the Oklahoma Department of Human Services, the district attorney's office, or the municipal police department as soon as I become aware of the situation. A "vulnerable adult" means an individual who is an incapacitated person or who, because of physical or mental disability, incapability, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him or herself, or is unable to manage his or his property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him or herself from abuse, neglect, or exploitation without assistance from others.
- **Health Oversight:** If you file a disciplinary complaint against me with the Oklahoma State Board of Examiners of Psychologists, they will have the right to view your relevant confidential information as part of the proceedings.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- **Worker's Compensation:** If you file a worker's compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, the Attorney General, a district attorney (or a designee for any of these) to examine your records relating to the claim.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (Ex: You may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address you provide.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties/privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice by mail or in person.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me to discuss your concerns. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on **April 14, 2003.**

_____Initial here

Tri-City Family Counseling
Anna Waller MS, LPC | EMDR Certified Licensed Professional Counselor

Consent for Treatment

I consent to medical and/or therapy treatment services for myself or the patient/client for whom I am the parent/legal authorized representative. I understand that Tri-City Family Counseling and Tri-City Family Care will share patient/client health information according to federal and state law for treatment and operations.

Further, I understand the following information discussed in the appointment is held confidential and will not be shared without written permission except under the following conditions:

- The patient/client threatens suicide.
- The patient/client threatens harm to another person(s), including murder, physical harm, or assault.
- The patient/client reports suspected child abuse, including but not limited to, physical abuse and/or sexual abuse.
- The patient/client reports abuse of the elderly.
- The medical provider is required by court order to provide privileged information.
- Based on clinical judgement, the provider may see fit to consult with another clinical and professional provider regarding your treatment.

State law mandates that mental health professionals must report these situations to the appropriate persons and/or agencies.

Communication between the provider and patient/client will otherwise be deemed confidential as stated under the laws of Oklahoma.

By signing below, I understand the above, and agree to these limits of confidentiality.

Signature of patient/Legal authorized representative: _____

Printed Name:_____

Date: _____