Sarah LeBoon MSW LCSW RPT-S
1220 Valley Forge Road
POB 987 PMB 91
Valley Forge PA 19482
610-745-0318

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read the following information, initial where appropriate, and sign at the end stating you have fully read and understood this information and consent to treatment.

Services: Sarah LeBoon, MSW, LCSW, RPT-S (Therapist) provides counseling and psychotherapy services. The purpose of these services is to develop coping mechanisms, reduce feelings of emotional distress, and improve social, romantic, and/or family relationships.

Risks: There are risks and limits to counseling and psychotherapy services. Risks include unpleasant memories, sadness, guilt, anxiety, fear, anger, frustration, and other negative feelings. In couples or family therapy, secrets may be told, and relationships may sometimes worsen. However, we believe that most clients benefit greatly from therapy. They learn important problem-solving skills that help them improve many areas of their lives, such as relationships, academic achievement, or careers. We do not begin or continue a therapeutic relationship unless we believe the therapy will help.

Alternatives: Other therapists may use different methods that could be beneficial to you. In addition, some problems may be caused by medical issues that should be addressed by your doctor. In an emergency, you should dial 9-1-1.

Fees: Information on the fee schedule and collection policy is attached to this form.

Right to Withdraw Consent. You may withdraw consent to the Therapist's treatment at any time. However, we ask that if you withdraw consent, you do so in writing.

Confidentiality: The Therapist has an obligation to protect the client's right to confidentiality and privacy as established by law and professional standards of practice. In the case of a minor or a holder of power of attorney, the individual receiving therapy is the client.

Disclosure: Generally, confidential and private information shall only be revealed to others when the client, or the client's parent, guardian, court-appointed representative or the holder of the client's power of attorney, has given informed consent. However, confidential information may be revealed in circumstances where failure to do so would violate a court order or specific federal or state privacy statutes or regulations, or result in clear and present danger to the client or others.

Initials:_____ I have discussed with the Therapist the nature of confidentiality and the limitation on my/the client's rights to confidentiality, including when confidential information may be requested and when disclosure of confidential information is legally required.

Consent to Release Medical Records Information. I acknowledge and agree that the Therapist and the social workers, counselors or staff working with her are hereby authorized to disclose all or any part of the undersigned client's medical record and protected health information for the purposes of treatment, payment and health care operations, including but not limited to disclosures to other treating providers and to such insurance companies, organizations or agencies as may be concerned with the payment of the cost of treatments by the individuals engaged by the Therapist.

Assignment of Insurance Benefits. The undersigned certifies that the information provided by the client or client's representative in applying for payment under Title XVIII of the Social Security Act, if applicable, is correct. The undersigned authorizes any holder of medical or other information about the client to release to the Centers for Medicare and Medicaid Services, the Social Security Administration or its intermediaries or carriers, any information to determine these benefits or the benefits payable for related services. If the client is a Medicare beneficiary, the undersigned requests that payment of authorized Medicare benefits be made on behalf of the client to the Therapist, as applicable, and authorizes the Therapist and her agents and employees, to submit claims to Medicare for payment to the client. If the client is not a Medicare or Medicaid beneficiary, the undersigned expressly authorizes payment directly to the Therapist for health care benefits otherwise payable to the client under the terms of the client's policy. In making such assignment, the undersigned agrees that in consideration for services to be rendered to the client by the Therapist, the client hereby individually obligates himself or herself to promptly pay the Therapist any amounts charged by her for the services provided by that are not paid under the client's insurance policies unless prohibited by law. The undersigned also agrees that if the nature of the client's illness or injury is such that it is not covered at all by his or her Medicare, Medicaid or other insurance policies, the client will be responsible to the Therapist for payment of the entire bill.

Insurance Coverages. The undersigned submits that the client is covered by the insurance policies listed below and that, as set forth above, the client assigns all benefits due to the client to the Therapist, related to the provision of covered services by the Therapist to the client:

Company: _____

Policy No.: _____

Group No.: _____

Initials:_____

Company: _____

Policy No.: _____

Group No.: _____

Initials:_____

Company: _____

Policy No.: _____

Group No.: _____

Initials:_____

Please read and sign below. You may request a copy for your records.

I have read and understand the information above, and I consent to treatment with Sarah LeBoon, MSW, LCSW, RPT-S (Therapist) as well as to the policies described above. This consent shall be valid until withdrawn in writing by the client or the client's representative.

Signed: _____

Printed name: _____

Relationship to client: _____

Date: _____

Address: _____

_____

phone number: _____

SARAH LEBOON, MSW, LCSW

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices for Sarah LeBoon, MSW, LCSW:

_____
Name of Patient

_____ _____
Signature of Patient
(or Patient's Personal Representative)

Date of Receipt

Personal representative information (if applicable):

_____
Name of Personal Representative

_____
Relationship to Patient or Description of
Authority to Act on Patient's Behalf

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility)	Phone Number (if known)
Sarah LeBoom MSW LCSW RPT-S	

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorizetion for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Last Updated: 09/20/06