Pre-Session: Client Self Report

Please Print Clearly Your Full Name: _____

- What **time** did you **last eat**? _____ am / pm. Are your **eating patterns at regular times**? **Yes** **No**
- **What was eaten?** _____
- Amount of: **Caffeine** today? _____cups **Nicotine today**? _____ (Circle which applies) ***Cigarettes*** or ***chewing tobacco***
- Are you currently on any medications: **Yes** **No** If yes indicate what **meds** you are **taking** & **how often & reasons taking the med.**: _____

_____

_____

- Have your **medications and/or frequency** of taking them **changed**? **Yes** **No** If yes indicated **what** has **changed?**

_____

- How many **hours** did you **sleep last night**? _____ Did you have **difficulty falling asleep? Yes No**
- Did you **wake up through the night**? Yes No **If yes**, how many **times**? _____ **Why?** _____
- Did you **dream last night**? **Yes** **No** **If yes**, were your dreams: (Circle which applies) **restful, fitful, nightmares**

Briefly Explain (if not restful sleep): _____

_____

- Have you had **any accident, falls,** or **injuries** since your last session? **Yes No, If yes**, what? _____

_____

- **Are you involved in any CPS, governmental, or law enforcement situation(s)?** Yes No If so: what & the status: _____

_____

_____

Mood Levels:

Rate your levels from **0 to 5** (**0** = ***NOT*** ***experiencing*** **anything & 5** = ***experiencing the highest level)***

What is your **Energy Level**?	0	1	2	3	4	5
How **Alert** do you feel?	0	1	2	3	4	5
How **Tired** are you?	0	1	2	3	4	5
How **Anxious** are you?	0	1	2	3	4	5
How **Depressed** are you?	0	1	2	3	4	5
How **Happy** are you?	0	1	2	3	4	5
How **Sad** are you?	0	1	2	3	4	5
How **Angry** are you?	0	1	2	3	4	5
Any **Craving for Drugs?**	0	1	2	3	4	5
The desire to consume **Alcohol?**	0	1	2	3	4	5
Having any **Family Problems**?	0	1	2	3	4	5

- Do you have any thoughts of harming yourself or others? Yes or No If yes, briefly explain: _____

_____

- Any thoughts of **Suicide**? **Yes or No** (If yes, do you have a plan) **Yes or No (If so d*escribe these thoughts*)**

_____

_____

- **Circle all that apply of how you feel TODAY. Alert Calm Content Focused Happy Hopeful Joyful Relaxed Angry Annoyed Anxious Confused Depressed Frustrated Helpless Hopeless Irritated Sad Tired Unfocused Other (Describe):** _____

- **What concerns and/or situations do you feel are important to discuss in today's session?** _____

_____

_____

- (If you have had more that one session) Are you satisfied with your sessions so far? **Yes** **No**

_____ _____

Client Signature **Date**

Client Intake/Bio (Psychosocial Questionnaire)

Please complete the below information and questions as accurately as possible. If you need additional space, you may use the back & reference the question number you are continuing to answer. Thank you!

Client Name: _____ Date of Birth _____ Your Age: _____
(Please Print Your Full Name

Address: _____ City: _____ State: _____ Zip: _____

Mobil Phone: _____ (Other/Home/Work) _____

Email: _____

Social Security # _____ Employer: _____

Driver's License # _____ State Issued: _____ Expiration Date: _____

Marital Status: (**Circle**) Single (Never Married), Married, Separated, Divorced, Other _____

Presenting Concern(s): _____

Are you a self-pay Client? Yes or No (*if Yes, Please skip the insurance questions*)

◆ **(Please Circle)** Are you are using a **Health Insurance Provider** or **E.A.P.** for session(s)? **Yes or No** If **Yes**, please complete the insurance information below.

(Note: Authorization of services must be verified prior to services rendered.)

Insurance Company: _____ Who's Name is the Policy Under?: _____
Their relationship to you if this person is not you? _____
Is this policy from TX or another state? _____ If from another state are you covered in TX? Yes or No
Do you have mental/behavioral health coverage? Yes or No
What is your deductable? $_____ If you do not know indicate **with a ?** If known, what amount is met? $ _____
(On the ins. card; ID#: _____ Group #: _____
Your Co-Pay amount for Mental/Behavioral Health (if known): $_____ If you do not know leave blank
(On the back of your insurance card) Provider Phone #: _____, Benefits Phone # _____
Preauthorization Phone # _____

Do You Have A Secondary Insurance or Other Payer? Yes or No (if Yes complete the below information:
2nd Insurance Company: _____ Who's Name is the Policy Under?: _____
Their relationship to you if this person is not you? _____
Is this policy from TX or another state? _____ If from another state are you covered in TX? Yes or No
Do you have mental/behavioral health coverage? Yes or No
What is your deductable? $_____ If you do not know indicate **"Do Not Know"** If known amount met? $ _____
(On the ins. card; The ID#: _____ Group #: _____
Your Co-Pay amount for Mental/Behavioral Health (if known): $_____ If you do not know indicate **"Do Not Know"**
(On the back of your insurance card) Provider Phone #: _____, Benefits Phone # _____
Preauthorization Phone # _____

Are You using an Employee Assisted Program (E.A.P.) Insurance Company: Yes or No (if Yes complete the below information:
Insured Person's Name: _____ Relationship to you (if not under your name) _____
Insurance Co. Phone # _____ The number of sessions authorized _____
Phone # of the E.A.P. _____
Insurance Co. Person you spoke with for services: _____
Authorization Number # _____
(Note: Please bring any and all paper work that you have been provided from the E.A.P. insurance company as authorization of services must be verified prior to services rendered.)

Client Intake/Bio (Psychosocial Questionnaire) cont.

- 1. List any medical aliment(s)/condition(s)/concern(s) you have had and/or are experiencing and how long it's existed: _____
- 2. List any physical restrictions _____
- 3. Ever contracted a disease/condition Yes or No If yes, what _____
- 4. Are you currently employed/working? Yes or No If yes, what is your job title: _____
- 5. If employed do you have concerns, problems and/or any conflicts there? Yes or No If yes, what are they? _____
- 6. Do you have financial concerns? Yes or No If yes, briefly describe: _____
- 7. Do you have housing concerns? Yes or No If yes, briefly describe: _____
- 8. Who do you currently live with? _____
- 9. Are there issue(s)/concerns you have in the household you live? Yes or No If yes, briefly describe: _____
- 10. Do you have children? Yes or No If yes, how many? _____ Their name(s) & age(s)? _____
- 11. If you have children, how is your relationship with them & any concerns? _____
- 12. Are parents alive: Yes or No If yes are they still together? Yes or No
- 13. How long have *or* were your parents together? _____
- 14. If your parents are alive how do they get along with each other? _____
- 15. What was your **past** relationship like with your parent(s)? _____
- 16. What is your **current** relationship like with your parent(s)? _____
- 17. Do you have any siblings? Yes or No If yes, who are they, their age & what is the relationship like? _____
- 18. Is there any mental illness in your family (including yourself?) Yes or No If yes, please indicate who/what it is: _____
- 19. Have you or anyone in your family been hospitalized for mental illness? Yes or No If yes, who, when & the reason: _____
- 20. Do you or anyone in your family/household have a substance abuse issue? Yes or No If yes, who & explain: _____
- 21. Do you have or have had in the past involvement with the authorities? Yes or No If yes, (Circle which apply;) CPS, IRS, Court, Law Enforcement, Other _____ When & briefly describe: _____
- 22. Have you or any family member been arrested? Yes or No If yes, Who, When & for What? _____
- 23. Have you ever experienced abuse in your life? Yes or No If yes, please indicate (verbally, physically, sexually, mentally) when & briefly describe: _____
- 24. Have you ever ***had thoughts*** of harming yourself? Yes or No If yes, briefly describe & when _____
- 25. Have you ever ***harmed yourself***? Yes or No If yes, briefly describe & when: _____
- 26. Have you ever had ***thought(s) of harming others***? Yes or No If yes, briefly describe the thought(s) & when?: _____
- 27. Any violence in your household currently and/or in the past? Yes or No If yes, briefly describe _____
- 28. Do you ever feel trapped? Yes or No If yes, for how long has this gone on? _____
- 29. Do you ever feel helpless? Yes or No If yes, for how long has this gone on? _____
- 30. Have you experienced any deaths within last 2 years? Yes or No If yes who? _____
- 31. Do you have anger issues? Yes or No If yes, for how long has this gone on? _____
- 32. Is there a family and/or household member that **had, or currently has** anger issues? Yes or No If yes, who & for long has it gone on? _____
- 33. Would you consider yourself an ***Extravert*** or an ***Introvert***? _____
- 34. How would you rate your self-esteem? (on a **scale of 1 - 5** with ***1 = low*** & ***5 = high***) _____

Client Intake/Bio (Psychosocial Questionnaire) cont.

- 35. On a scale from **1-10 (10=extreme)** what is usual stress level _____
- 36. What is the source of your stress? _____
- 37. What do you do when you are stressed? (briefly describe) _____
- 38. Have you ever been in counseling/therapy? Yes or No If yes, when & what was the reason & who did you see? _____

_____

- 39. Are you on any medications? Yes or No If yes, what, how often taken & the reason? _____

_____

_____

- 40. Have you ever been hospitalized? Yes or No If yes, when & for what? _____
- 41. Do you have or have you ever had any addiction(s)? Yes or No If yes, what? _____
  & have you addressed it and/or gotten help with it? Yes or No If yes, when & how was it addressed? _____

_____

- 42. Have you or anyone in your family been diagnosed with a mental health condition? Yes or No If yes, who, what was the diagnoses and when? _____

_____

Below Please Circle which applies in each category:

- 43. ***Chief Concerns:*** anxiety, relationships, employment, memory, concentration, substance use, medical issues, recent event, sycosis, other; _____

- 44. ***Reported Mood:*** euphoric, cheerful, tranquil, apathetic, dour/down, depressed, lists, suicidal, panicky, fearful, anxious, apprehensive, worried, calm, irritable, angry, enraged, other; _____

- 45. ***Recent Stressors:*** finance, housing, conflict, work, losses, medical transitions, legal, other; _____

- 46. ***Reported Coping Ability:*** resilient, growing, normal, exhausted, overwhelmed, other; _____

- 47. ***Attitude Toward Therapy:*** hardworking, thoughtful, cooperative, passive, dependent, uninterested, preoccupied, irritable, resistant, guarded, defensive, suspicious, manipulative, argumentative, other; _____

- 48. ***Medication Use:*** overuse, as prescribed, forgetful, inconsistent, resistant, dissatisfied, discontinued, other:

- 49. ***Alcohol Use:*** in recovery, non drinker, occasional, social, regular, heavy use, alcoholic

Please provide how much consumption and what type: _____

- 50. ***Tobacco Use:*** non user, occasional, social, regular, heavy use, cigars, chews, other; _____

Please provide how much you consume: Circle; Daily or Weekly, quantity: _____

- 51. ***Street Drug Use:*** in recovery, non user, Oks in all, recreational, regular use, heavy use, addicted, other: _____

Please provide what is consumed; _____ &
frequency, _____ & how much consumed; _____

- 52. ***Physical Health:*** robust, healthy, pain, infection, chronic illness, cancer, sensory deficit, cold/flue.

Still related to physical health please describe ailments: _____

- 53. ***Physical Activity:*** regular exercise, active, fit, average, inactive, lethargic.

Still related to physical activity please describe what you do as an activity: _____

- 54. ***Sleep:*** heavy sleeper, adequate, insomnia. Please indicate amount of sleep achieved each night: _____

- 55. ***Social Activity:*** nonstop, highly active, involved, occasional, rare, isolated. Please describe activity you are involved in:

_____

Client Intake/Bio (Psychosocial Questionnaire) cont.

- 56. ***Work Activity***: workaholic, overworking, fulltime, part time, sporadic, unemployed, refusing work, keeping house, in school, retired, other _____

Still related to work activity please define; (Please circle which apply): overwhelmed, stressed, satisfied, underemployed, board, searching for work, unemployable, working from home

- 57. ***Hobbies/Sports Activity:*** over involved, highly active, good balance, occasional, rare, absent.

Still related to hobbies please report what you're involved in: _____

- 58. ***Virtues:*** **(Please circle all that apply)** integrity, leadership, gratitude, creativity, vitality, forgiveness/mercy, hope, curiosity, love, humility/modesty, open mindedness, kindness, prudence, spirituality, love of learning, social intelligence, self regulation/self control, perceptive/wisdom, social responsibility/teamwork, bravery, persistence, fairness, appreciation of beauty/excellence.

- 59. ***Support System:*** **(Please circle all that apply)** spouse, nuclear family, extended family, close friend, group of friends, church/mosque/temple/religious, 12 step, other: _____

Still related to support system please list those in your support system: _____

- 60. How did you here about our services? **(Circle ALL that apply below)**

Psychology Today, Another Ad **(which one?)** _____
Referral **(Who referred you?)** _____
A web/Internet site **(Which one?)** _____
Directly from Motivational Foundations web site **(How did you find out about the web site?)** _____
(Circle which applies) From a **doctor/therapist/psychologist/psychiatrist (Who?)** _____
Google Ad **(What did the ad say?)** _____
A search you made on the web? **(What words did you use in your search?)** _____
Other **(Please specify)** _____

Thank you for completing this form

_____ _____

Client Signature: **Date:**

Care Counseling/Motivational Foundations, Inc./Darleen Lortz, MS, CRC, NCC, CART, LPC
Mailing Address: P. O. Box 1885, Pilot Point, TX 76258
817-403-3130

Darleen Lortz, M.S., CRC, NCC, CART, LPC, (hereafter also referred to as Darleen Lortz, Ms. Lortz, I, me, and/or myself) serves the community in both the public, governmental, and private sector with counseling, biofeedback, evaluations, trainings and/or services. Within this professional disclosure statement, you the Client will be hereafter referred to in the 1st party as you, your and at other times the client. Services will be provided to you through Care Counseling which is a dba of Motivational Foundations, Inc. (hereafter also referred to as MFI.)

Qualifications & Experience: I, Darleen Lortz am a Certified Rehabilitation Counselor (hereafter referred to as CRC), a National Certified Counselor (hereafter referred to as NCC) Certified Anger Resolution Therapist (hereafter referred to as CART) and a Licensed Professional Counselor (hereafter referred to as LPC) and hold a Master's degree in Rehabilitation Counseling with a secondary concentration in Biofeedback Therapy. I have experience working in the public and private sector with individuals, and groups. Through MFI, I provide services to include adult individuals, couples and groups with, but not limited to; anxiety, stress management, coping skills, boundary setting, relationship building, communication skills, divorce and relationship recovery, faith based/Cristian counseling, career counseling, life skills coaching, workshop training seminar(s), as other modalities when addressing client needs. Additionally, my clientele and service delivery is to the: general public, individuals in correctional facilities, court referral(s), colleague, client and physician referrals. I am also a Professional Public Speaker who develops, coordinates, implements and instructs various self-help workshops seminars.

Nature of Counseling &/or Therapy: I utilize a multi-model approach in service delivery with a focus on Cognitive Behavioral Therapy (CBT). All services are conducted in English. If you should need a translator to an alternative language and/or other accommodations are needed to understand the services provided, you will be personally responsible for obtaining what you need as well as to personally pay for the same. Session(s) will vary in time intervals per the service rendered. The usual time will be discussed in your session. Please inquire when in doubt. Adherence to your given time slot/appointment is important and should be kept. Respect of other clients as well as business procedures must be maintained. Sessions may become intimate on a psychological level at times, however our relationship is on a professional level rather than a social one. Therefore, please do not invite me to social gatherings, ask me to write letters/notes of reference for you, offer me gifts, or ask me to relate to you in any other manner than that of a professional one. If I see you in public, I may not acknowledge that I know you to assist in confidentiality, unless you agree that this is permitted and/or acknowledge me first. Thank you for your understanding in this matter. It is not intended to develop a barrier between us, but to allow you to be aware of the standards I adhere to. You understand and agree that neither I and/or MFI do not complete any forms, fill out documents or provide services other than mental health counseling in session and that you will not ask for any exception, for any reason, at any time. Our contact in person will be centered and limited to the counseling session(s) and/or group and/or workshop services requested. You understand and agree that there may be time(s)/date(s) where we may have a telephone therapy session and due to the electronic means over the phone the session can not be secured or insured that it is strictly confidential and that you hold harmless MFI and/or me and/or anyone associated with the same form liability, damages, reproductions and the like in putridity. You agree that should a phone session occur that you give your permission to charge a charge card remotely for your session fee(s) without further authorization from you needed.

Forms of Communication: I will use the contact number(s), email(s) and other means you provided to MFI and/or me to contact you. You understand and agree that by giving this information to include but not limited to; your telephone number(s), email, texts, and/or any other technical form of communication that you are allowing MFI and/or me to leave message(s), transmit intake paperwork and/or misc. information in regards to but not limited to your session(s), scheduling/rescheduling/no shows, payment(s), payee(s), collection(s), documentation, and/or anything that needs your attention and/or for you to contact MFI and/or me. You agree and understand that if you text and/or email me and/or MFI the means which you use is not secure and that any dialog and/or information you provide is not protected or secure and that you agree to use it at your own risk and that you have been forewarned of this. Should you choose to use a non secure means of communication you agree that you are asking MFI and/or me to respond to you via the same and confidentiality can not be maintained. You understand and agree that delicate information you desire to be held confidential should be addressed in session. You agree that if you do not want information left or relayed to you via the provided information that you will provide alternative means to contact you and that you provide written documentation delivered to MFI and/or me of this. Should an expense be incurred by MFI and/or me to communicate by alternative means you understand and agree to immediately compensate MFI and/or me for this. You understand that the telephone, fax, email, text(s) and any technical means is not secure nor can confidentiality be maintained and you will not leave MFI and/or me any information that you want kept confidential.

Client Rights: Clients achieve their goals at varied lengths of service. You have the right to ask questions concerning the counseling process and to be involved in the treatment process. As a client, you may end our service relationship at any time, though I do ask that you participate in a termination session if you decide to discontinue services. You also have the right to refuse or discuss modification of any of the service techniques or suggestions that you believe might be harmful. If at any time, for any reason you are dissatisfied with services, please let me know. Should you be court ordered and/or required to be in the therapeutic mental health process and/or you discontinue attendance, have no show(s), cancelation(s), non compliance issues, and the like you must be aware that this will be documented and/or reported per the referral source and/or court. You hereby acknowledge and agree that the referral source may have access to your file at any given time without any further approval, release of information and/or documentation from you. You have the opportunity to have this clarified prior to your signing this professional disclosure & informed consent agreement. As a result of such release you agree without reservation to hold harmless MFI and/or me and/or those associated with the same form any and all liability, damages, and the like in perpetuity.

Initial(s) _____ _____

Effects of Sessions: In the event that you experience a mental health emergency, you understand and agree that you will call 911 and/or go to the nearest hospital and/or mental health hospital. You completely understand, acknowledge and agree that MFI and/or I have limited office hours as well as days to offer service(s) and may not be available to see you and/or speak with you outside of your scheduled session time/date and that you should call 911 and/or go to the nearest hospital if you are; in distress, have an emergency, are thinking of harming yourself or others, are suicidal and/or any other situation needing immediate help/assistance. At any time, you may initiate with me a discussion of possible positive or negative effects in entering, not entering, continuing, or discontinuing services. Although I am hopeful that you will benefit from the services provided, I cannot guarantee any specific results. You agree and completely understand that I cannot and will not be held to specific outcome(s), clinical outcome(s) of therapy and/or service(s). The service(s) provide a personal exploration and may lead to changes in your life, perception(s) and/or decision(s) as well as behavior modification(s) to name a few. Some of these may affect significant relationships, your job, life, and/or your understanding of yourself. You could experience a variety of emotions, both positive and/or negative. You could possibly feel distressed at times, by areas of discussion and/or from uncovering information, and/or changes you make. Due to the nature of service(s) the exact nature of change(s) resulting from the service(s) cannot be predicted. Likewise there are no implied or express guarantee(s) that the services will provide the outcome you are looking to achieve and you understand this. Your commitment to the process and service(s) is important and an element that must be adhered to for maximum involvement. You understand and agree that when you demonstrate and/or indicate that you are not commitment to service(s) and/or compliance(s) and/or demonstrate noncompliance with the same, I retain the option to discontinue such service(s) and will document accordingly. You understand and agree that this information may be relayed to insurance carrier(s), payees and/or those associated with you service(s) and you hold MFI and me and those associated with the same completely harmless from any and all liability and/or damages/loss.

Billing, Scheduling & Fees: The standard mental health counseling/therapy fee is two hundred dollars in U.S. dollars ($200.00) (and may have add on fee(s) per other service(s) provided) and is subject to change. You understand and agree that you should inquire if you have a question. You understand and agree that a therapy session fee (herein after also referred to as, service fee) may change and should this occur you will be informed a.s.a.p. and/or prior to your next session should you be a self-pay client otherwise you will be responsible to personally contact your insurance carrier on the allowable amount of your insurance product. Should she be utilizing insurance for services, fees will be reflected per the insurance contract agreement that MFI and/or Darleen Lortz is contract it on and the discounted rate will be honored until such time as you are no longer covered by the insurance carrier, MFI and the no longer participates with the insurance carrier, you are a self-pay a client or another situation arises at which time you will be responsible for the full session fee without a discount. You understand that your first session is an evaluation session and that there is required paperwork to be completed by you which you agree is your sole responsibility to acquire, complete and bring to your first session and that if not complied with you may be refused services until completed. Such paperwork is available on MFI's website at www.motivationalfoundations.com for you to download and print in order to complete and when not available may be available to email you. You will need to make the necessary arrangements to acquire and complete such paperwork prior to your first scheduled session and bring with you to your first session without exception. You understand and agree that MFI and/or I have limited hours and days of operation which does not include overnights, holidays or weekend hours. You understand and completely agree without reservation or restriction that ***keeping your scheduled appointment is of utmost importance and not doing so without a 24 hour notice will be considered non compliant and billable to you directly as well as immediately owing by you for the allowable session fee (which is not your co-pay or deductable but the full session fee).*** *If an appointment is canceled, less than twenty four (24) hours in advance, or a* ***no show*** *results you understand and agree that you will be solely and immediately responsible for the* ***entire session fee, without exception which also includes but is not limited to an affiliation with an Employee Assisted Program (E.A.P.) or insurance provider.*** *You understand and agree that if you are using an insurance company for service payment assistance they do not pay for no-shows nor your fee if you do not call 24 hours in advance for canceling and/or rescheduling and it is you sole responsibility to pay for such. Should a cancelation and/or rescheduling be needed by you, you understand and completely agree that you MUST contact MFI/me at the direct office telephone number(s) at 817-403-3130 at least 24 hours in advance and in circumstances where I am unavailable to take your call directly your call will be transferred to the phone delivery device where you should leave a detailed message and a return contact phone number. Your call will be recorded as to the date and time of your call. When calling during operating hours/days, please allow at least 24 hours for a return call. To reiterate; YOU UNDERSTAND AND AGREE THAT IF YOU ARE EXPERIENCING AN EMERGENCY YOU SHOULD CALL 911 OR GO TO THE NEAREST HOSPITAL.* ***Session fees and/or co-pay amounts and/or your financial responsibility and/or amounts due are required at the beginning of each the session***. Should you arrive late to your scheduled appointment you understand and agree without exception that your session fee will not be discounted or prorated and the entire session fee will remain owing and due, and your session end time will remain the same as if you arrived on time. A session will typically be forty-five (45) minutes long and may be longer per varied reasons. There may be situations where a session will run over the typical session time at which time you agree to be billed and/or the insurance carrier and/or third party payer will be billed at the extended time/rate and not the typical forty-five (45) minute rate. *If your insurance carrier, is being utilized and/or another responsible payment source is being billed for services you need to be aware that in the event that payment is denied for whatever reason, the session fee(s) will be remain due and payable by you and you understand and agree that it will be your sole responsibility to resolve such issues with the insurance carrier(s) and/or alternative payment source and that you will remain immediately responsible for payment of service(s) to MFI and/or me and that MFI or I will not be expected to wait for your resolution to any situation(s) that arise.* A session and/or service(s) will not proceed without required co-pay payment and/or the payment for service(s) and/or owing balance to your account. You the client must maintain a zero dollar ($0.00) balance for session(s). When an insurance carrier and/or third party is involved for payment of service(s) there should not be more than a (thirty) 30 day balance on your account in order for future service(s) to continue. You understand and agree that any insurance complication(s), dispute(s), denial(s), etc. will be your sole responsibility to resolve and/or respond to. You understand and agree that when an insurance carrier, third party payer, E.A.P. and the like is involved for your service(s) and payment is not received within 30 days you will be responsible to resolve any non-payment issues with them and you will remain responsible for full payment of service(s). With your signature herein, you are hereby give MFI and/or me the authority to have your insurance carrier(s) send payment directly to MFI and/or me/Darleen Lortz which will be payable to the same for your services. When out of network insurance carriers are used, you understand and agree that you are solely responsible for any/all documentation required by that source to facilitate your reimbursement if any and that neither I nor MFI nor any affiliated with the same will be responsible for documentation and/or paperwork on your behalf and you will be responsible for full payment of each session at the beginning of each session without exception.

Initial(s) _____ _____

Billing, Scheduling & Fees (cont.): By your signature herein you agree that after 30 days of an unpaid account balance you authorize MFI and/or Darleen Lortz to add late fees and other expenses to your account as well as to, but not limited to; employing whatever means necessary to collect such debt owed and/or to employ the services of an outside collection agency and/or attorney, court, and/or legal remedy(s) available to seek payment of all unpaid fee(s) and/or any other expenses associated with the collection process and/or court costs, and/or legal fees and remedies of the same. Should you have provided a charge card number and information to be applied for a phone session or owing amounts, you authorize and understand that such account number and information will be utilized to bring your account to a zero balance as charges are applied and/or owing. You understand and agree that no prior or further authorization by you will be needed to do so.
In the event of a no show for a scheduled appointment you understand and agree that MFI and/or I may discontinue services and/or cancel any/all future appointments without further notification to me as a result of my for noncompliance. If MFI grants services to continue as a result a no show and/or not giving a 24 hour notice for cancelation and/or rescheduling, you understand and agree that this will in no way grant you an additional tolerance of such. You further understand and agree that any no show(s) will remain as an owing and due amount of the full value of the session as well as due immediately. Should you become insolvent and/or file bankruptcy and/or death results by your signature herein you certify, attest and agree that you will not discharge such fee(s) for service(s) to include any and all outstanding indebtedness to MFI and/or me/Darleen Lortz and you will not discharge such in bankruptcy and/or that your estate dismisses owing balances. You understand and agree that MFI and/or me and/or those associated with the same in filing with an insurance carrier for payment toward rendered services is not a right, but a courtesy to you which can terminate at any time. I agree and give my permission that MFI/Darleen Lortz and/or those associated with the same can provide, correspond with, speak with and correspond with my insurance company('s) and those associated with the same in regards to my session(s) as well as file information to include but not limited to progress note(s), pertinent information, session note(s), date(s) of service, payments(s), treatment plan(s), documentation and any other file and session information requested, required and/or needed. As a result I will at all times hold harmless MFI and/or Darleen Lortz and/or those associated with the same of any and/or all damages, liability and/or complications in perpetuity. It remains your sole responsibility to inform MFI and/or me/Darleen Lortz in the event that your insurance changes in any way as you understand and agree it is not MFI and/or me/Darleen Lortz responsibility to keep track of this in any way. Should any other personal information change you agree to immediately inform MFI and/or me/Darleen Lortz.

Legal Matters: You understand and agree that if you are involved in any court proceeding(s) and/or hearing(s) and/or deposition(s), and/or investigation(s) of any kind, and/or CPS and the like that you will not ask or involve MFI and/or me and/or anyone associated with the same to be involved in any way and/or to assist with any documentation, paperwork, completing documentation, testifying, interview(s) and the like. You understand that the therapeutic counseling process is sensitive, personal and confidential in nature and it is therefore agreed by you not to involve me, MFI and/or anyone associated with the same without exception in perpetuity. You further more agree that you, your attorney, representative, etc., or any other person who acts on your behalf will not contact MFI and/or me in any format with the same as above and/or to ask and/or expect the same to testify on your behalf either in and/or out of court for and/or on your behalf and/or at any type of proceeding(s), and/or though a request or demand of disclosure. You understand and agree that you must sign a release of information for your session notes to be released and that it may include information of a delicate and personal matter that could be used for and/or against you and/or others and that you will at all times without exception hold harmless MFI, me and/or those associated with the same for any and all liability, damages, harm in perpetuity. You agree that in the event that I am court ordered to provide testimony and/or your records in any legal matter you will immediately be responsible to pay in advance MFI and/or me/Darleen Lortz the sum of $1600. 00 (one thousand six hundred dollars) for a half day time span which is in the town service(s) were rendered and a higher fee for out of the area, or the current rate charged at that time, whichever is greater (when in question you agree that you should ask.) Additionally charges will be added for but not limited to: preparation, transportation, accommodations, fees to others for prep and/or care of misc. to accommodate such, any time spent in any proceeding and/or court proceeding regardless of waiting to be called or called in a proceeding. This amount will be payable fourteen (14) days prior to any preparatory services, dialog with those representing you and/or any proceedings and must be paid in certified cashiers check or in the form of a credit card which will add the credit card processing fee to amount owed. Additional time required beyond the initial time frame paid will be immediately due (within the week of rendered services) without exception. You understand and completely agree that any such testimony may not be positive for you and that any and/or all that you shared in session(s) may be submersible to disclose and that it could be damaging in nature as well as damage the therapeutic relationship. You therefore without exception completely agree to hold harmless MFI and/or me/Darleen Lortz and those associated with the same form any and all liability, repercussion(s) and/or damage(s), harm in any way/form of any kind and in perpetuity. You further understand that MFI and/or I will not be bias for or against you and will/may reflect any and/or all confidential information brought to any and/or all sessions and that by your signature herein, you hereby agree, consent to and/or allow any such information and/or documentation to include this professional disclosure & informed consent agreement, presession forms and/or anything from any session and/or discussion(s) either in and/or out of session to be disclosed and that you are providing by your signature herein your agreement, consent to a release of information to any/all sources that inquire per any such proceedings and that you agree to hold harmless MFI and/or me/Darleen Lortz and those associated with the same form any/all damages and/or liabilities, and/or injury of any form/kind as a result in putridity.

Conditions of Ongoing Services: I reserve the right to postpone and/or terminate services to you if you come to the session under the influence of alcohol and/or drugs and/or other substances. In addition, I reserve the right to terminate services to you if you do not comply with the medication recommendation(s) and/or prescription(s) of a psychiatrist or physician. I may terminate services at my own discretion if it does not appear that you are benefiting from services and/or you are noncompliant in any format and/or conditions to continue with services are not being adhered to, which include but not limited to, outside processing work and/or homework, processing in session, applying work from session discussion(s). Appropriate behavior on your part must be adhered to in order to continue with services. If inappropriate behavior (determined by me) or the like results from you and/or those you invite to your session(s), it is hereby stated that no notification will be given to you and that the situation will be documented and/or may be reported to appropriate sources and/or authorities and/or for the protection and/or remedying the situation for myself and/or MFI and/or other(s). You agree to waive any and all rights against me/Darleen Lortz and/or MFI and/or those associated with the same form any/all liability, retribution and/or remedies if terminated and/or for reporting.

Initial(s) _____ _____

Conditions of Ongoing Services (cont.): If you have been in counseling and/or psychotherapy and/or have been or are seeing a psychiatrist during the past five (5) years, you agree to indicate this to me and sign a release of information so I may communicate with them and/or receive copies of records from them if I deem it important to do so. By signing this form, you are agreeing to disclose all previous medical, and/or mental health treatment and to reimburse me and/or MFI for any expenses charged by such medical and/or mental health professional(s) for supplying copies of your records. You understand and agree that I may be working in conjunction with a referral source which referred you to my services. You hereby authorize me to converse, consult with, coordinate with and work with any/all persons associated with such referral source in regards to you and your service(s) without any other written permission from you nor any reservation and/or restriction from you, thus by your signature below provides MFI and/or me and/or those associated with the same a release of information to have interaction and communication with the entities you have had contact with for mental health as well as physical health. If you decide to maintain or establish a professional relationship with another mental health professional, you will immediately inform me of such and as a result I may have the option of terminating such service(s). You understand and completely agree without reservation that MFI and/or I reserve the right to postpone and/or terminate services with you and/or report to alternative sources, agencies, and/or authorities if any of the following circumstances occur and/or are occurring, (together with what has been herein been previously described): **1)** If you come to session under the influence of alcohol or drugs; **2)** if you do not comply with the medication recommendations of your psychiatrist or physician; **3)** if I believe you are not benefiting form counseling and/or therapy; **4)** if, I learn that you are battering your partner/spouse; **5)** if I learn that there is abuse of child and/or elder and/or a person with a disability, **6)** If you disclose that you intend physical harm on yourself, another person, me and/or those associated with the same, and/or an animal, and/or if you are suicidal and/or have a plan for self harm of yourself or those indicated, **7)** if I am impaired in providing competent counseling and/or therapy to you, **8)** In the case of group counseling, I reserve the right to deny group entry to anyone I consider inappropriate for the group and/or to terminate form the group to anyone whose behavior I consider detrimental, harmful and/or inappropriate to the therapeutic effectiveness of the group, and/or process of the same, **9)** if your absence(s) from session(s) is consistent and/or I believe service(s) is impaired, or **10)** if you have any outstanding and owing accounting balance(s), service(s) fee(s), other fee(s) and the like which are not brought current immediately, **11)** you indicate that you had and/or are involved with having relations and/or consensual sex with any person under the age of 17 years old, and/or that a health care provider has a sexual or inappropriate relationship with you or a minor. **12)** if you are under the age of 17 years old and have had or are contemplating an abortion, or having consensual sex, and as a result your parent(s) and/or legal guardian(s) and/or authorities and/or other source(s) may be notified, **13)** if under the age of 17 year old and your parent(s) and/or legal guardian require(s) a report and/or to review the file it may be provided, **14)** if the CIA, CPS, FBI Home Land Security, court(s), correctional facility and/or law enforcement agency, attorney and/or the like subpoena my record(s) on you, they may be turned over and you hereby understand, grant and agree with your signature below that you are in agreement with this and completely hold harmless MFI, me/Darleen Lortz and those associated with the same for any and all liabilities, damages, harm in perpetuity, **15)** should you bring to any session any weapon(s) of any kind, they will likewise confiscated (taken from you and you will not resist in surrendering such item) and such weapon **Will Not** be returned to you, and may be reported to authorities and/or service(s) terminated, **16)** If you have a communicable disease and/or HIV/AIDS and/or any such condition, and/or have put others at risk and/or will put others at risk. **17)** You are in my sole discretion not benefiting from the service(s) provided and/or are non-compliant on any level. In all of the aforementioned cases involving termination, I will try and provide you with referral(s) (when/where available/possible.) You may choose to decline the referral(s). **18)** In the event that you have had a no show and/or a cancelation without 24 hour notice and/or have not paid any owing amounts on your account you agree and understand that any and/or all future appointments may be canceled.

If I terminate service(s) due to having to report to authorities and/or any of the herein mentioned area, you hereby understand, agree and state that you waive any/all rights to be notified, as well as agree to hold me, MFI and/or those associated with the same without exception or duration completely harmless from any and all liability, damage, harm and the like in perpetuity. If MFI and/or I believe that you would be served better in another capacity and/or with another health care professional/provider and the like, I may refer your service(s) and/or elect to alter the service(s) MFI and/or I provide. In the case that you have a medical and/or mental health care condition, you must reveal the information to me for documentation and related issues. I reserve the right to terminate any service(s) to you in the event that I feel in my sole discretion that I am not the mental health provider that would best suit your needs. If you have medications, which have been prescribed, you must adhere to your doctor's protocol unless otherwise advised by them that it is acceptable to alter set protocols.

Consent to Disclosure: By your signature below you agree that should there be an investigation involving you and it involves law enforcement, governmental agency(s), Child and/or elder and/or a disabled person protection agency(s) and the like, by your signature herein this professional disclosure & informed consent agreement, you agree that MFI, me/Darleen Lortz and/or those associated with the same do not have to acquire a separate release of information document and/or signature form you to allow those involved in the investigation to have access to your file(s). As a result of such release you agree to completely hold harmless MFI, me/Darleen Lortz and/or those associated with the same form any and all liability, damages, and the like in perpetuity.

Referrals: I recognize that not all conditions presented by you are appropriate for treatment. You agree that that where I in my sole discretion feel that I am not the correct provider for you and your condition(s) that I may choose to discontinue service(s) and attempt to provide referral(s) where available to you. For this reason, a referral may be needed and/or that another entity may need to intervene and/or take over service(s). You may also be provided some alternatives, which may include programs, and/or people to assist you (where available.) You will be solely responsible for contacting and evaluating those referrals and/or alternatives for yourself and/or making the necessary steps to coordinate services.

Initial(s) _____ _____

Cancellation: In the event that you will not be able to keep an appointment, you understand and agree that you must directly notify MFI and me ***at least*** 24 hours (twenty four hours) in advance. If a reminder is sent to you to confirm your appointment and you do not confirm, you agree and understand that this is not and will not constitute direct notification of any cancelation of an appointment and that you will agree to always directly contact MFI/me to cancel at least 24 hours in advance of a scheduled appointment. In the event that you are absent for two or more sessions, MFI and/or I will consider your commitment level to be diminished and you understand and agree that I have the sole discretion to discontinue providing services to you. You completely understand and agree to be consistent, respectful and committed to your sessions and that your participation is a vital component for progress and follow through. In the event that in my sole discursion I determine that you are resistant and/or not compliant and/or not benefiting for services provided you agree and understand your services may be terminated without recourse from you or anyone representing you without exception. You are hereby agreeing by signing this document that you will commit to keeping scheduled appointment(s), and if termination results you agree to and understand that services will be evaluated on an individual basis and at my sole discretion. I may additionally have to place you on a waiting list to provide further service(s) as a result if service(s) continue. Likewise, if you intend to discontinue service(s), you agree to immediately inform me to avoid complications. You understand and fully agree that you will be immediately responsible for any and all service fee payment(s) and that should any collection means result and/or legal remedies at law, you will be responsible for such compensation of expenses in association with you, your service fee(s), collection and the like without delay and/or resistance.

Records and Confidentiality: All communication(s) and/or service(s) may become part of your client/case file. The record(s) are property of MFI and/or me. Generally your record(s) and our communication(s) are confidential in nature and protected. You agree and understand that MFI and/or I may utilize and electronic clearing house and/or system to document your session notes, submission of insurance claims, for bookkeeping, etc. In the event that you want a third party to have access to your records and/or for MFI and/or me and/or those associated with the same to communicate with them you will be required to complete and sign a release of information form that MFI or Darleen Lortz or those associated with the same will provide or by your written permission. There are exceptions to this of which can be and/or will be and/or must be reported to the authorities which include but not limited to; 1.) The actual, active or suspected physical, emotional or sexual abuse and/or neglect of a child, elderly, person with a disability or a dependent adult. 2.) Sexual misconduct and/or abuse of a patient by a health and/or mental health professional. When you and/or a client/patient present that they intend serious or suicidal harm to themselves and/or others. 3.) When you and/or a client/patient threatens serious bodily harm to another person. With this both the authorities and necessary entities will be notified as well as the potential victim. 4.) Court ordered testimony or the release of records. You understand and agree that your case file can/may be used and/or authorities and others notified and/or involved: 1) for the purposes of education, supervision, professional development, and/or research and/or to consult with other professionals about a case. In such cases, to preserve confidentiality, MFI and/or Darleen Lortz will to the best ability identify you by first name and last initial where possible; 2) determine that you are a danger to yourself or someone else; 3) you disclosed abuse, neglect or exploitation of a child, elderly, or disabled person(s); 4) You disclose sexual contact with another mental health professional; 5) MFI and/or Darleen Lortz is ordered by a court to disclose information; 6) learning that you are infected with a potentially life-threatening illness that could be transmitted to another and/or specific uninformed person; 7) testifying in a child custody or visitation case involving you; or actual and/or alleged child or elder abuse, 8) MFI and/or Darleen Lortz testifying in a; proceeding, court of law and/or lawsuit in which your mental health is at issue and/or service(s) provided; 9) you have been charged with a crime; 10) you bring a negligence suit and/or any other suite and/or complaint against me; 11) you have a communicable disease which may endanger yourself or another, 12) you direct MFI and/or Darleen Lortz to release your records. Should you wish to discuss any situation it should be done in session as anything discussed on any electronic means or through any means other than personally in session as MFI and/or Darleen Lortz cannot provide confidentiality to you otherwise, and you hereby acknowledge this and hold harmless MFI and/or Darleen Lortz and those associated with the same. 13) with a written request, you may request a copy of your file and after paying for copying and administrative fees, then such can be made available to you within a reasonable length of time. You understand and agree that if you would like other parties to have any part of your file that you will personally obtain your file information and you will not ask and/or require MFI and/or Darleen Lortz to do so for you, 14) If MFI and/or Darleen Lortz is otherwise required and/or directed by the law/court(s) to disclose information, 15) I have to report you for inappropriate, indecent, and/or a situation I feel that I need to protect MFI and/or myself and/or those associated with the same from, 16) You present yourself in a manner that MFI and/or Darleen Lortz and/or those associated with the same feel threatened and need to report. 17) MFI and/or Darleen Lortz may present and/or publish article(s) on a counseling, therapy, and/or service topic(s) which may require MFI and/or Darleen Lortz to utilize the situation(s) and/or information which present themselves within session(s). In this situation, MFI and/or Darleen Lortz will refer to you by first name basis and/or an alias to preserve confidentiality. 18) You understand that your session(s) may be recorded for consistent service application. 19) Where you have already herein agreed the release of information per individual section(s) of this document.

If MFI and/or Darleen Lortz and/or those associated with the same have services, information and/or something that you may be interested in and/or that are available to you now and/or in the future, you give permission to contact you and/or inform you through all media means you have supplied and/or that are available. You may opt out of notifications by a written request to do so.

In the event MFI and/or Darleen Lortz believe that you are in danger emotionally and/or physically to yourself and/or to another, you hereby give me full consent to do what is necessary to warn another and/or others of the danger(s), to alert authorities, as well as to refer you to appropriate sources and/or professional(s) to render assistance and you agree to hold harmless MFI and/or Darleen Lortz and/or those associated with the same from liability, damage(s) and/or harm in perpetuity.

If you provide MFI and/or Darleen Lortz with a person, who you wish for contact in an emergency you should provide their name and telephone number(s) herein give your full permission/consent (as a release of information) to contact this person and provide them with information concerning you and your file and/or condition. In providing this information you understand that it is not the responsibility of MFI and/or Darleen Lortz and/or those associated with the same to make contact with this person but as an aid if needed and you agree that this name and information can be provided to any other
source (s) needed and/or assisting with helping you if the need arises. Name: _____,
address/city/state/ _____, phone: _____.

Initial(s) _____ _____

Records and Confidentiality: In the event of Darleen Lortz's death your records will be given to a colleague of mine for safe keeping until the legal limit of time to retain your file has expired. I am required to retain client records per state statue required years and after that period of time the records will no longer be available and/or destroyed. You may examine your file and/or receive a copy of your record when you request to do so in writing and pay the administration, copying and processing cost(s) associated with doing so. The fee is currently $.25 a page for copying plus an administration fee and if mailing needed there is a handling and postage fee. (Please inquire as to the current fee for such as fees may be subject to change.) Except in certain circumstance MFI and/or I may restrict certain record information if in my opinion it may be harmful for your review and per my discretion. In the event that services were rendered to a couple, it is completely understood and agreed to by your signature herein that each individual will be required to sign a release of information for such release of the file. In the event that both individuals do not sign a release the file will be crossed out which involves the non signing party which may render the file unusable. Except by the provisions herein stated there are exceptions to the release. By your signature below you hereby give your consent to share your service(s) information health care carrier as it relates to service date/time/coding etc. for payment and authorization for service(s) and/or entity required to receive documentation on your behalf. By your signature below are releasing MFI and/or me and/or those associated with the same form any liability as well as departure from your right(s) of confidentiality that may result from working with such entity. You understand and agree that if you disclose something about yourself that may be damaging to the counseling profession, MFI and/or me and/or others you understand and agree that I will act on that information without retribution or recourse from you in any form. You understand and agree that any and all paperwork completed by you, MFI, me is a part of your file and can be uploaded and/or kept by a outside vendor source which MFI and/or I utalized for administration, billing and organizational means and you hold harmless MFI, me and those associated with the same should any briech occur.

Conjoint Session(s): Should you invite and/or request that another individual(s) be present in and/or at any session(s) and/or to listen in on your conversations with and/or those associated with the same for whatever reason, you agree to release MFI and/or Darleen Lortz and/or those associated with the same form any lack of confidentiality, harm, liability, damage, repercussions and the like. You agree to assume full responsibility with any and all that is revealed, shared and/or released in session and/or any communication(s). You acknowledge that with this invitation and/or when involved in group session(s) confidentiality can not be guaranteed, nor protected. The presence of any such person you invite or allow in session or to hear your conversation(s) will hereby constitute that you give full permission to include them and you therefore assume full responsibility and/or reproductions (if any exist at that time and/or in the future). MFI and/or Darleen Lortz reserve the right to exclude such other person(s) into any session(s) and/or to be a party to conversation(s). In the event that you have another individual in any session or in any conversation(s), you will be completely responsible for informing them of the terms within this agreement which they will be expected to abide by and that you will assume full responsibility for any and/or all noncompliance and/or situations that arise. MFI and/or Darleen Lortz reserve the right at all times to terminate the session(s) and/or conversation(s) if in our sole discretion the therapeutic process and/or session and/or communication has been compromise in any way.

Other provisions: You acknowledge and agree that for any reason that MFI and/or Darleen Lortz should decide that a phone session take place you agree to this and that it is acceptable in place of being seen in person in the office and that MFI and/or Darleen Lortz will place the call to me and/or you may place such call whichever is agreed upon for such session to the phone number you have provided previously in your file. Should there be an alternative number that should be contacted you agree that it is your sole responsibility to provide such number in order for it to be added to your file prior to any phone session. You agree to be available for any session(s) scheduled for without delay and when a phone session occurs you agree to be free from any distraction(s) and be fully engaged in such session. If for any reason you do not keep any scheduled appointment(s), you completely understand and agree to be solely responsible for the entire session charge and/or any charges applied to your account and should you be utilizing an insurance company will include but not limited to; EAP, primary and/or secondary insurance company payment(s) you understand and agree that insurance does not pay for no-shows or cancellations resulting in less than 24 hours advance notice and as a result you will be solely responsible such session payment(s) and such charges will be immediately due by you to MFI and/or Darleen Lortz without restriction, delay or reservation. You understand and agree that at any time MFI and/or Darleen Lortz decides that the weather is potentially questionable and/or is and/or may be problematic, in MFI and/or Darleen Lortz's sole discretion, a phone session will take place instead of having a face to face session in the office and that this is completely acceptable and agreeable with you without reservation or exception. I understand and agree that MFI and/or Darleen Lortz may contact me prior to, or as soon as possible (if possible) to let me know that my session will be a phone session, in place of an office session. You agree that any session that takes place via the phone or any other means will be submitted for payment to your insurance company (if one is utilized) as if the session took place in the office. You agree and will be expected to pay for your portion of any session at the beginning of each session when in person and at the end of the session (with the charge card information you will have provided at the end of the session), without exception. You agree to supply MFI and/or Darleen Lortz with charge card information needed to process payment(s) for any session without exception. In the event that you have paid cash for any session when seen in person, should a phone session take place or any other means than in person, you will be expected to and agree to supply MFI and/or Darleen Lortz with my charge card information to process any payment without exception. You agree to and authorized MFI and/or Darleen Lortz to be able to obtain, keep and charge your charge card information for future session payment(s), and/or other charges associated with my account and/or file where necessary and/or to apply for any outstanding balances that are associated with your account.

You hereby understand, agree and give permission to have MFI and/or Darleen Lortz keep, retain and file your name, phone number(s), e-mail address and any other information you have provided. Such may be kept in a hard copy file and/or but not limited to; a Software System utilized for file and/or record keeping and/or for submission of insurance claims and data, file, cell phone, computer, and any other means MFI and/or Darleen Lortz has available. You hereby give permission and agree that MFI and/or Darleen Lortz may communicate with you and/or those that you provided permission, through any means that you have provided without exception or restriction. This is to include but not limited to; text messaging, cell phone, home/work phone and/or any telecommunication, e-mail, etc. You understand and agree that any such correspondence(s) may not and/or cannot be secure. You hereby agree that at all times that you will hold harmless MFI and/or Darleen Lortz and/or those associated with the same form any and/or all liabilities, damages and/or problematic situations that may arise from, or as a result of what has been described herein, and/or that takes place, without exception and in perpetuity.

You agree to of all herein stated without reservation and restriction in perpetuity. Should any portion of this agreement be void, you agree that the remainder will remain intact and enforceable.

Initial(s) _____ _____

Other provisions (cont.): You understand and fully agree to immediately notify MFI and/or Darleen Lortz of any changes in any way concerning form(s) of payment for services, your insurance carrier (if applicable) and any and all relevant information to include but not limited to; payment source(s), co-pay, deductible, meeting or exceeding deductible and/or out of pocket amounts, credits and any relevant information that corresponds to the insurance carrier. You agree to consistently and immediately provide a copy of your insurance card as well as a current driver's license to be added to my file. You understand and agree that you will at all times be responsible for updating this and/or any/all information as well as my personal information immediately without delay and without fail. Your personal information will constitute but will not be limited to my currant physical and mailing address, cell and home phone number, email address, driver's license, insurance carrier(s), any physician, mental health provider(s) and facilities who have or will provided services, marital status, employer and any other relevant information. You agree that any default of providing any or all information which may result in the delay of service payment(s) or denial of payment(s) from an insurance carrier for whatever reason, you will be solely, immediately and completely responsible for any/all balance(s) owed, fee(s), cost(s), time spent by MFI and/or Darleen Lortz and/or those associated with the same to work on my file in whatever capacity, as well as any/all damage(s)/loss(es), administration fee(s)/cost(s), time spent on my behalf and/or any situations MFI and/or Darleen Lortz and/or those associated with the same address and/or deal with any/all issues.

You understand and agree that you will be billed current full session charge of a self-pay client should MFI and/or Darleen Lortz and/or those associated with the same have to address any/all issues arising from any of the above mentioned information not being provided immediately and/or having to intervene and/or correspond to my insurance company for whatever reason except for the individual initial electronic billing per session otherwise you will be immediately and solely responsible for any owing balance(s) on your account without exception in perpetuity.

If you have any question(s) as to information to be provided or updated, you agree and understand it is my sole responsibility to inquire. understand at a minimum even if no changes have occurred, you will verify such with MFI and/or Darleen Lortz and/or those associated with the same on a semi-yearly (every 6 months) basis even if no changes have occurred.

You agree that if any credits exist on my account they will be applied to current and/or future session financial charges/responsibilities. I agree that there will not be any refund of credit and that I agree to use any and/or all credits toward session(s). I understand and agree that whenever I make any payment(s) via my debt, health savings account (HSA) card and/or credit card I must ask for a receipt prior to the processing of the payment otherwise I will not be able to receive a receipt as it is made at the time of the transaction via electronic verification sent directly to an email I provide at the time of the transaction processing. I understand and agree that as a courtesy service, I may receive an appointment reminder of a scheduled session, but that there may/will be times were a reminder may not or will not be set. I understand and agree that a reminder is not a requirement by MFI and/or Darleen Lortz and unless you am contacted that a scheduled appointment date/time is canceled it will be your responsibility to make sure that you are present and/or available for any/all scheduled appointment. You agree that should you have a no show or cancel an appointment without at least a 24 hour notice advance notice, you will be solely responsible to immediately pay for the full session fee that Motivational Foundations, Inc. /Care Counseling/Darleen Lortz would have been paid had the session taken place. In the event and you have provided charge card account information to pay funds for any/all session charge(s), or outstanding balances, you herein state and agree that do not require any notice to have the account charged for any/all outstanding financial responsibilities.

You agree and give your permission that Motivational Foundations, Inc. /Care Counseling/Darleen Lortz and/or those associated with the same can provide, correspond with, speak with and correspond with your insurance company(ies) and those associated with the same in regards to my sessions as well as file information to include but not limited to progress note(s), pertinent information, session note(s), date(s) of service, payments(s), treatment plan(s), documentation and any other file and session information requested, required and/or needed. You agree that any payments for such services provided should be sent directly to Motivational Foundations, Inc. /Care Counseling/Darleen Lortz and not pass to you. You will at all times hold harmless Motivational Foundations, Inc. /Care Counseling/Darleen Lortz and/or those associated with the same of any/all damages, liability and/or complications in perpetuity.

You understand and agree that Motivational Foundations, Inc. /Care Counseling/Darleen Lortz and/or those associated with the same may cancel at their discretion your appointment(s) in advance and/or the day of your session for various reasons. You agree to session(s) being conducted via phone on a per needed basis or may be canceled. Should the session be conducted via a phone session and you have a financial obligation for such session(s), you agree to provide Motivational Foundations, Inc. /Care Counseling/Darleen Lortz with your debit/charge card information where different to any information previously provided to meet your financial responsibility.

Consent to Treatment: By your signature below you state that you are voluntarily agreeing to receive service(s) through MFI and/or Darleen Lortz, and understand as well as agree that you will participate appropriately for such service(s) and that you may at any time stop such service(s) by letting MFI and/or Darleen Lortz know. You agree that you have read this professional disclosure & informed consent agreement and state that you fully understand as well as agree without reservation to the content presented herein and that you have had the ability and ample opportunity to ask questions about areas you have or had question(s) about and/or not understood and/or that needed clarification and/or that was unclear. You agree and state that if the event that you asked questions, that those questions were answered to your satisfaction. You understand and agree that you were provided the ability to obtain a copy of this document and any other document(s)/paper work. You agree that by your signature below, you completely understand and agree to all herein and that you are not under duress and are of a sound mind to sign below. You agree that you have voluntarily come to MFI and/or/Darleen Lortz for services and will fully participate in such service(s), as well as abide to all terms stated herein, without reservation. You agree that should any portion of this professional disclosure & informed consent agreement be found to be unenforceable and/or invalid and/or void you agree and acknowledge that the remainder will be preserved intact and enforceable without reservation and/or restriction.

_____

1.) Client: Print Name

_____ _____

Client's Signature; Date:

Initial(s) _____ _____

2.) Client: Print Name

Client's Signature; Date:

Service Provider Date:

Initial(s) _____ _____

Care Counseling dba to Motivational Foundations, Inc.
&
Darleen Lortz, MS, CRC, NCC, CART, LPC

Notice of Privacy Practices

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

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer at P.O. Box 1885, Pilot Point, TX 76258.

INTRODUCTION

Care Counseling/Motivational Foundations, Inc./Darleen Lortz is required by law to maintain the privacy of Protected Health Information ("PHI"), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and relates to the provision of health care or payment for the provision of health care for your past, present or future physical or mental health or condition and related healthcare services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, obtain payment or perform our health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

Care Counseling/Motivational Foundations, Inc./Darleen Lortz is required to follow the terms of this Notice currently in effect. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

OUR PLEDGE

The privacy of your personal health information (PHI) is important to us. Your PHI includes, but is not limited to, medical, dental, pharmacy, and mental health information. This Notice describes our privacy practices. Our privacy practices must be followed by all of our employees and staff. This Notice tells you about the ways in which we may use and disclose your PHI. Also described are your rights and certain obligations we have regarding the use and disclosure of your PHI. We use and disclose your PHI in compliance with all applicable state and federal laws.

HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose PHI. For each category of use or disclosure, an explanation of what is meant and some examples are provided. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall within one of the categories.

For Treatment. We may use or disclose your health information to provide and coordinate the mental health treatment and services you receive. For example, if your mental health care needs to be coordinated with the medical care provided to you by another physician, we may disclose your health information to a physician or other healthcare provider.

For Payment. We may use and disclose your health information for various payment-related functions, so that we can bill for and obtain payment for the treatment and services we provide for you. For example, your PHI may be provided to an insurance company so that they will pay claims for your care.

For Healthcare Operations. We may use and disclose your health information for certain operational, administrative and quality assurance activities, in connection with our healthcare operations. These uses and disclosures are necessary to run the practice and to make sure that our patients receive quality treatment and services. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

For Special Purposes. We are permitted under federal and applicable state law to use or disclose your PHI without your permission only when certain circumstances may arise.
We are likely to use or disclose your PHI without your permission for the following purposes:

- **Individuals Involved in Your Care or Payment for Your Care**. We may disclose PHI to a close personal friend or family member who is involved in your medical care or payment for your care.
- **Disclosures to Parents or Legal Guardians.** If you are a minor, we may release your PHI to your parents or legal guardians when we are permitted or required under federal and applicable state law.
- **Worker's Compensation.** We may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Public Health.** We may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities.
- **Health oversight activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state law.
- **Law Enforcement.** We may disclose your PHI for law enforcement purposes as required by law or in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of our workforce; and in emergency circumstances, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.
- **Judicial and administrative proceedings.** If you are involved in a lawsuit or a legal dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **United States Department of Health and Human Services**. Under federal law, we are required to disclose your PHI to the U.S. Department of Health and Human Services to determine if we are in compliance with federal laws and regulations regarding the privacy of health information.
- **Research.** Under certain circumstances, we may use or disclose your PHI for research purposes. However, before disclosing your PHI, the research project must be approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
- **Coroners, medical examiners, and funeral directors.** We may release your PHI to assist in identifying a deceased person or determine a cause of death.
- **Organ or tissue procurement organizations**. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Notification.** We may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.
- **Correctional institution**. If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

- **Military and Veterans.** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.
- **National Security, Intelligence Activities and Protective Services for the President and Others.** We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, provision of protection to the President, other authorized persons or foreign heads of state, and other national security activities authorized by law.
- **As required by law.** We must disclose your PHI when required to do so by applicable federal or state law.
- **Treatment Alternatives**. We may use and disclose PHI to tell you about or recommend possible alternative treatments, therapies, health care providers, or settings of care that may be of interest to you.
- **Health-Related Benefits and Services**. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.
- **Appointment Reminders.** We may use or disclose PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters). You have a right, as explained below, to request restrictions or limitations on the PHI we disclose. You also have a right, as explained below, to request that information be communicated with you in a certain way or at a certain location.

Other Uses and Disclosures of PHI

Your Authorization. We will obtain your written authorization before using or disclosing your PHI for purposes other than those described above (or as otherwise permitted or required by law). If you give us an authorization, you may revoke it by submitting a written notice to our Privacy Officer at the address listed below. Your revocation will become effective upon our receipt of your written notice. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by the written authorization. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Psychotherapy Notes. We will not use or disclose psychotherapy notes without your written authorization, and only as permitted by law.
Marketing Health-Related Services. We will not use or disclose your protected health information for marketing communications without your written authorization, and only as permitted by law.
Sale of PHI. We will not sell your protected health information without your written authorization, and only as permitted by law.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changed Notice effective for all health information that we maintain, including health information we created or received before we made the changes. When we make a change in our privacy practices, we will change this Notice and make the new Notice available to you.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

You have privacy rights under federal and state laws that protect your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think that your rights are being denied or your health information isn't being protected. Providers and health insurers who are required to follow federal and state privacy laws must comply with the following rights:

To Request Restrictions on Certain Uses and Disclosures of PHI. You have the right to request restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business. We must agree to the request to restrict disclosure of PHI to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or another individual other than a health plan on behalf of you, has paid us in full.

To Request Confidential Communications. You have the right to request that PHI be communicated to you by alternative means or at alternative locations. For example, you can ask that you only be contacted at work or by mail. We will accommodate all reasonable requests.

To Access PHI. You have the right of access to inspect and obtain a copy of your PHI. You may not be able to obtain all of your information in a few special cases. For example, if your treatment provider determines that the information may endanger you or someone else. In most cases, your copies must be given to you within thirty (30) days, but may be extended for another thirty (days) if you are given a reason by us in writing. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request.

In accordance with Texas law, you have the right to obtain a copy of your PHI in electronic form for records that we maintain using an Electronic Health Records (EHR) system capable of fulfilling the request. Where applicable, we must provide those records to you or your legally authorized representative in electronic form within fifteen (15) days of receipt of your written request and a valid authorization for electronic disclosure of PHI. You may request a copy of an authorization from the Privacy Office at the address below.

To Obtain a Paper Copy of the Notice Upon Request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from the Privacy Office at the address below. A reasonable fee may be charged for the costs of copying, mailing or other supplies associated with your request.

To Request an Amendment of PHI. If you feel that PHI we have about you is incorrect or incomplete, you may request an amendment to the information. Requests must identify: (i) which information you seek to amend, (ii) what corrections you would like to make, and (iii) why the information needs to be amended. We will respond to your request in writing within 60 days (with a possible 30-day extension). In our response, we will either: (i) agree to make the amendment, or (ii) inform you of our denial, explain our reason, and outline appeal procedures. If denied, you have the right to file a statement of disagreement with the decision. We will provide a rebuttal to your statement and maintain appropriate records of your disagreement and our rebuttal.

To Receive an Accounting of Disclosures. You have the right to request an accounting of your PHI disclosures for purposes other than treatment, payment or healthcare operations. Your request must state a time period. The time period for the accounting of disclosures must be limited to less than 6 years from the date of the request. We will respond in writing within 60 days of receipt of your request (with a possible 30-day extension). We will provide an accounting per 12-month period free of charge, but you may be charged for the cost of any subsequent accountings. We will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.

To Notification in the Event of a Breach. You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI.
We will provide notice to you as soon as is reasonably possible and no later than sixty (60) calendar days after discovery of the breach and in accordance with federal and state law.

To File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our privacy officer, listed below. You may also file a complaint directly with any or all of the following federal and state agencies: the Secretary of the Department of Health and Human Services, the Office of the Attorney General of Texas, or the applicable Board of the Texas Department of Health and Human Services: Texas State Board of Examiners of Professional Counselors, Texas State Board of Examiners of Marriage and Family Therapists or Texas State Board of Social Worker Examiners. We will provide you with the addresses to file your complaint with the Secretary, the Office of the Attorney General of Texas and the or the applicable Board of the Texas Department of Health and Human Services: Texas State Board of Examiners of Professional Counselors, Texas State Board of Examiners of Marriage and Family Therapists or Texas State Board of Social Worker Examiners, upon request. You will not be penalized in any way for filing a complaint.
If you want more information about our privacy practices or have questions or concerns, please contact us.
Privacy Officer: P.O. Box 1885, Pilot Point, TX 76258

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I have been given a copy of Care Counseling/Motivational Foundations, Inc./Darleen Lortz's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Care Counseling/Motivational Foundations, Inc./Darleen Lortz has a right to change this Notice at any time. I may obtain a current copy by contacting the practice's Privacy Officer, or by visiting Care Counseling/Motivational Foundations, Inc./Darleen Lortz's website at: www.motivationalfoundations.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title
(e.g. guardian, executor of estate, health care power of attorney

---

For practice use only: Complete this section if you were unable to obtain a signature.

If patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____

Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

_____

_____

_____ _____

Signature of Practice Representative Date

_____

Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____) _____ **ALT. PHONE** (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Release of Confidential/Protected Information

I hereby give my permission for those indicated herein and below to supply Care Counseling dba of Motivational Foundations, Inc, and/or Darleen Lortz, and/or representatives, assignees, employees, facility, operators and the like, any information on me and in regards to service(s) rendered to me, (i.e. herein delineated but not limited to: therapy notes/records, psychological records, medical information, neurological information and/or testing, psychological testing, records, diagnosis, case notes, insurance data, office and/or file information, evaluations, medications and the like.) I authorize this information to be sent to Motivational Foundations, Inc. (attn: Darleen Lortz) at the current mailing address. Any fee/costs encured for this service will be my sole responsibility and not that of Motivational Foundations, Inc. and/or Darleen Lortz. I will immediately reimburse Care Counseling/Motivational Foundations, Inc. and/or Darleen Lortz for any costs incurred. I hereby authorize and accept that Care Counseling/Motivational Foundations, Inc. and/or Darleen Lortz, and/or representatives, assignees, employees, operators and the like, to correspond and share my records and/or nessessary information with:
as well as any payee, insurance carrier that I am associated with and/or third party source(s) who participate in the payment of services. As a result of my authorization for release of information I completely release form any liability and hold harmless Care Counseling/Motivational Foundations, Inc. and/or Darleen Lortz, and/or representatives, assignees, employees, facility treatment team, operators and the like in perpetuity (without end or an expiration date.)

Primary Insurance Carrier: _____ Contact # _____
Policy #_____ Name of Insured: _____
Co-Pay $_____

Secondary Insurance Carrier: _____ Contact # _____
Policy #_____ Name of Insured: _____
Co-Pay $_____

Medical Doctor:
Name: _____, Phone: _____ Address: _____
City: _____, State: _____ Zip: _____

Mental Health Professional:
Name: _____, Phone: _____ Address: _____
City: _____, State: _____ Zip: _____ Relationship: _____

Others you want access to your information/records:
Name: _____, Phone: _____ Address: _____
City: _____, State: _____ Zip: _____ Relationship: _____

Name: _____, Phone: _____ Address: _____
City: _____, State: _____ Zip: _____ Relationship: _____

This release of information shall be in effect for the period of time from the time of initial services until revoted in writing and personally delivered by me and a receipt provided for verification and/or by certified mail to the above referenced or current mailing address.

_____

Print Name:

_____ _____ _____ _____
Address: City: State: Zip:

_____ _____
Signiture: Date Signed: