



PLEASE LIST EVERYONE IN YOUR FAMILY WITH WHOM YOU PRESENTLY LIVE:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS TREATMENT DATES FOR MENTAL HEALTH, OUTPATIENT CARE \_\_\_\_\_

HOSPITALIZATION DATES \_\_\_\_\_ FACILITY \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

<u>SUBSTANCE USE HISTORY:</u>	<u>CURRENT/AMOUNT</u>	<u>PAST USAGE/DATE</u>
ALCOHOL	_____	_____
MARIJUANA	_____	_____
COCAINE/CRACK	_____	_____
OTHER	_____	_____

LIST ALLERGIES, IF ANY \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

WHAT ARE THE PRIMARY PROBLEMS YOU ARE PRESENTLY EXPERIENCING? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHAT DO YOU EXPECT FROM THERAPY? \_\_\_\_\_

\_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE CLIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE BEHAVIORAL HEALTH SERVICES OF LKN TO FURNISH INFORMATION TO INSURANCE COMPANIES AND REFERRING PHYSICIANS CONCERNING MY TREATMENT AND I HEREBY ASSIGN TO THE PROVIDER ALL PAYMENTS FOR PROFESSIONAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. THERE WILL BE NO DIVISION OF ACCOUNTS.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**Service Agreement & Professional Disclosure Statement for Counseling**

**Deanna M. Cuccinello, MA, LCMHC, NCC**  
**107 Kilson Drive Suite 202**  
 **Mooresville, NC 28117**  
**704-660-8321**

You have taken the important first step to pursue counseling with Deanna Cuccinello, MA, LCMHC, NCC. I realize that starting counseling is a major decision, and you may have many questions. This document contains valuable information about my background, professional services, and your rights. If you have any questions about what is stated in this document or about something not covered in this document, please ask so we may discuss it.

**Counseling with Deanna Cuccinello:**

I view counseling as a move toward life enhancement. Counseling can improve physical, mental, and spiritual wellness, as well as interpersonal relationships. You may have specific issues you are seeking help with, or just want to enhance your general health and wellbeing. I wholeheartedly believe that seeking counseling shows significant strength. Counseling can help you uncover strengths and offer strategies about how to utilize them. I consider it an honor to be an empathetic, non-judgmental presence in an environment where you allow yourself to courageously explore your life. Thank you for the privilege of providing you with counseling.

I earned my Masters Degree in Clinical Mental Health Counseling from the University of North Carolina at Charlotte in December of 2014. I am a member of the American Counseling Association (ACA) and a National Certified Counselor (NCC #340745). I am a Licensed Clinical Mental Health Counselor (LCMHC#A11370). I have been providing counseling services as an LCMHC since June 2017, as and LCMHCA since January of 2015 and as an intern from August 2013 until January 2015.

I approach my clinical practice from an integrated theoretical model, using elements from a number of theories incorporating those that are applicable and relevant to your needs and goals. I also recognize that the individual is part of a family, community, and society as a whole and is influenced by the impact of these groups on his or her life.

**Professional Orientation:**

I am bound by the rules and ethical codes of the American Counseling Association, the North Carolina Board of Licensed Clinical Mental Health Counselors, and the National Board for Certified Counselors, and I take these responsibilities seriously. The ACA Code of Ethics (2005) states, *“The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.”* A.1.a. ([www.counseling.org](http://www.counseling.org)). You may refer to the remainder of rules and the code on the website provided. While professional counseling has been scientifically shown to have many benefits such as solutions to specific problems, healthier relationships and improved overall health, there are no guarantees that your problems will be solved by participating in counseling with me. Growth is not an easy process, and you may experience unpleasant feelings as you encounter obstacles; things may become more emotionally difficult before they get better during our work together.

**Services Offered:**

I am trained and experienced in working with individuals and groups presenting with a wide range of issues. I have worked with individuals dealing with grief and loss, anxiety, depression, sexual orientation issues, substance abuse, domestic violence, and trauma through my counseling experience with individuals residing at the homeless shelter and the battered women’s shelter. I work with adolescents and adults dealing with various challenges. Some areas of focus include building self-esteem, transitioning through life changes, setting healthy boundaries, identifying warning signs of unhealthy relationships, and developing healthy coping skills. The integrated model does not conform to one school of thought or system. Instead it embraces contributions from a variety of sources according to their validity, applicability, and whether they are appropriate interventions. The populations served are children (age 12-17) and adults (age 18 and older). Particular areas of expertise are domestic violence, adult survivors of childhood sexual abuse, and trauma recovery.

There are many different approaches to therapy. The theories and techniques most often used by Deanna Cuccinello include: Cognitive Behavioral Therapy, Motivational Interviewing, Reality Therapy, Mindfulness-Informed Eye Movement Desensitization and Reprocessing, Rational Emotive Behavior Therapy, and Psycho education.

Counseling is collaborative between the counselor and client. In my role as your counselor, I can offer a safe and supportive environment in which to help guide and assist you in understanding your thoughts, feelings, behaviors as well as your interpersonal relationships. Throughout the therapeutic process you will be asked to challenge yourself not only in session but outside of session as well, where homework, written exercises, verbal exercises and other types of tasks may be assigned. Diagnosis is established using the guidelines identified in the DSM-V. If a diagnosis is identified it is communicated to the client and will become a PERMANENT PART of the client's record.

### **Appointments and Cancellations:**

A counseling session is usually 50 minutes. A missed appointment is a lost opportunity for both you and the counselor. The counselor has reserved that time for you. Other clients have not had access to that appointment time because it was held for you. In addition, your counselor considered that appointment time as an important part of your counseling. While unforeseen emergencies occur, please make every effort to keep your appointment as scheduled. When on occasion I will be unavailable for appointments, I will make every attempt to inform you of this in advance. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary. ***To avoid being charged for a scheduled appointment it must be rescheduled or canceled at least 24 hours in advance; however, a fee of \$50 will be applied to your account for no-shows and cancellations made with less than 24 hours notice.*** This additional fee is not reimbursable by insurance and will be due prior to the start of the next scheduled session. If you miss a session and owe a no show or late cancellation fee your credit card on file with IvyPay will be charged. IvyPay is a secure processing system specially designed for therapists and will be covered during the initial session. Please initial below indicating that you understand that your card will be charged for late cancellations.

Please Initial:

\_\_\_\_\_ I understand I will be charged \$50 for no show/late cancellation fees as detailed above.

\_\_\_\_\_ I will update my credit card information on file with IvyPay if it changes.

**Unfortunately, I am not available 24/7 so if you are in an emergency and need immediate assistance, call 911 or go to the nearest emergency room.** Additionally, if you are experiencing a mental health, substance abuse, or developmental disability crisis, you may call Iredell County's Mobile Crisis Team at **866-275-9552**, and they will assess your urgent needs. Mobile Crisis is available 24/7.

### **Professional Fees and Payment:**

A therapy hour is equal to 50 minutes of direct contact with the remaining 10 minutes generally devoted to documentation. The rates for Individual Therapy are set at \$120 an hour and \$150 for the initial assessment. Reduced rates are available for economic hardship and can be discussed during the initial assessment. Payments may be made by cash, check, credit card or debit card.

### **Confidentiality:**

Mental health professionals have an ethical responsibility and a professional duty to safeguard clients from unauthorized disclosures of information given in the therapeutic relationships. As part of our relationship, I will keep confidential anything stated to me. There are limitations to the scope of confidentiality and privileged communication with the counseling relationship. These limits include:

1. You direct me in writing to disclose information to someone else.
2. It is determined you are a danger to yourself or others (including child or elder abuse)
3. I am ordered by a court to disclose information.

The American Counseling Association (ACA) Ethical Standards also require that counselors secure the safe and confidential maintenance of client record. This includes creating, maintaining, transferring, or destroying records whether they are written, taped, computerized or stored in another medium.

**Registering Complaints:**

Although I encourage you to discuss any concerns with me, you may file a complaint if the issue is not resolved. If the issue remains unresolved, you may file a complaint with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics

(<http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>).

North Carolina Board of Licensed Clinical Mental Health Counselors

P.O. Box 77819

Greensboro, NC 27417

Phone: 844-622-3572

Fax: 336-217-9450

E-mail: [LCMHCinfo@ncblcmhc.org](mailto:LCMHCinfo@ncblcmhc.org)

You may also notify the American Counselor Association about a possible complaint or breach of ethics by the counselor. The standard ethics complaint form will ask for you to include the following: (a) your name, address, phone number and email address (b) the name, address, and phone number of the professional counselor about whom you are filing the complaint, and (c) a brief description of the reason why the complaint is being filed. The ACA Ethics Committee liaison will then guide you through the ACA's process of determining whether an ethics violation has taken place. For additional information, please call the ACA at 800-347-6647, ext. 314 or email at [plr@counseling.org](mailto:plr@counseling.org). The ACA address is noted below:

ACA Professional Learning & Resources ACA Ethics

5999 Stevens Avenue

Alexandria, VA. 22304

Attn: ACA Ethics Committee Liaison (Confidential)

Fax: (703) 823-0252

**Acceptance of Terms**

We agree to these terms and will abide by these guidelines.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

**DEANNA CUCCINELLO, LCMHC**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of DEANNA CUCCINELLO'S Notice of Privacy Practices. This notice describes how Deanna Cuccinello may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

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(Signature of Patient, or Personal Representative) (Date)

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(Relationship to Patient)

FINANCIAL WAIVER:

INSURANCE INFORMATION NEEDS TO BE CURRENT AND ACCURATE. OUR OFFICE WILL FILE INSURANCE CLAIMS AS **A COURTESY TO YOU**. YOU ARE EXPECTED TO **PAY ALL DEDUCTIBLE AND CO-PAYMENT AMOUNTS AT THE TIME OF EACH VISIT. ALL COSTS NOT COVERED BY YOUR INSURANCE COMPANY WILL BE YOUR RESPONSIBILITY** OR IN CASE OF A MINOR, THE PARENT/GUARDIAN'S RESPONSIBILITY.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **PATIENT RIGHTS AND RESPONSIBILITIES**

DEANNA CUCCINELLO, LCMHC  
107 KILSON DRIVE, SUITE 202  
MOORESVILLE, NC 28117

### **Confidentiality**

*Privacy and confidentiality are of the utmost importance to the clinical relationship. Information given by the client remains private and confidential. The therapist will not share information with any person without your written permission, except as required by law or in a situation deemed potentially life-threatening. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life-threatening.*

### **Financial**

*Insurance information needs to be current and accurate. Our office will file insurance claims as a courtesy to you unless you indicate otherwise. You are expected to pay all deductible and co-payment amounts at the time of each visit. Clients are responsible for the payment of all applicable fees at the time of the visit. If you are the parent or guardian of a minor, all costs not covered by your insurance company will be your responsibility. The office does not become involved with division of accounts between divorced parents.*

### **Appointments**

*Appointments are scheduled as a forty-five to fifty-minute therapeutic hour. In the event that you must cancel an appointment, please call the office at **704-660-8321** at least 24 hours in advance. **Failure to give adequate notice may result in your being billed for the appointment.***

*Office hours begin at 9AM weekdays and evening hours are determined by each individual therapist. Due to the limited space for evening hours, please be mindful of the importance of advance notice if you are unable to keep an evening appointment.*

### **Managed Care Clients**

*Most managed care plans require pre-approval for mental health and chemical dependency services. Non-compliance could lead to denial of benefits (payments for services). If you have entered therapy with this office under a managed care plan, please check with the office manager to verify approval for services.*

*Under some managed care plans, the therapist is required to provide clinical information to a case manager after the initial session if additional sessions are needed. If you have any questions about this procedure, please feel free to discuss this with the therapist. Managed care companies are often required to carry out quality assurance practices. Audits by the managed care plan may be conducted, but information identifying your participation in the program will not be disclosed to the auditor.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DEANNA CUCCINELLO, LCMHC MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DEANNA CUCCINELLO, LCMHC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Deanna Cuccinello, LCMHC or received by Deanna Cuccinello, LCMHC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Deanna Cuccinello, LCMHC will abide by the terms of this notice, or the notice currently in effect at the time of the use or disclosure of your protected health information.

Deanna Cuccinello, LCMHC reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised notices upon request. An individual may obtain a copy of the current notice from our office at any time.

### Uses and disclosures of your protected health information not requiring your consent

Deanna Cuccinello, LCMHC may use and disclose your protected health information, without your written consent or authorization for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Deanna Cuccinello, LCMHC may determine that you require the services of a specialist. In referring you to another doctor, Deanna Cuccinello, LCMHC may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Deanna Cuccinello, LCMHC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Deanna Cuccinello, LCMHC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Deanna Cuccinello, LCMHC may use your diagnosis, treatment and outcome information to measure the quality of the service that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Deanna Cuccinello, LCMHC may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Deanna Cuccinello, LCMHC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.  
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.  
Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities.  
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records including treatment records or HIV test results to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.  
We may disclose healthcare records, including treatment records, in response to a written request by any federal or state government agency to perform legally authorized functions such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state government agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings.  
Patient healthcare records, including treatment records or HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death.  
We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigation a death. HIV test results may be disclosed under certain circumstances.
- For research.  
Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety.  
We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation.  
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Deanna Cuccinello, LCMHC will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Deanna Cuccinello, LCMHC has taken action in reliance thereon. Any revocation must be in writing.

#### YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Deanna Cuccinello, LCMHC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Deanna Cuccinello, LCMHC may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Deanna Cuccinello, LCMHC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Deanna Cuccinello, LCMHC not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Deanna Cuccinello, LCMHC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Deanna Cuccinello, LCMHC for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with Deanna Cuccinello, LCMHC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Deanna Cuccinello, LCMHC, please contact the Privacy Officer at the following:

DEANNA CUCCINELLO, LCMHC  
ATTN: PRIVACY OFFICER  
107 KILSON DRIVE, SUITE 202, MOORESVILLE, NC 28117  
704-660-8321

It is the policy of Deanna Cuccinello, LCMHC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003

Deanna Cuccinello, LCMHC  
 107 Kilson Drive, Suite 202, Mooresville, NC 28117

Client Name: _____
DOB: _____ Record #: _____

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

I \_\_\_\_\_ hereby authorize Deanna Cuccinello, LCMHC to release specified information below  
 (Client or Personal Representative)  
 to \_\_\_\_\_. I also hereby authorize \_\_\_\_\_  
 to release specified information to Deanna Cuccinello, LCMHC.

Reason for Referral	History of Psychotropic Medication Use
Psychiatric	School Academic Achievement and Behavior
Psychological	Complete Medical Record for Monitoring and Review
Social	Complete Administrative Record
Medical Information	Substance Abuse Information
Current medications	Other:
HIV or AIDS related Information	Other:

I understand this information will be used for: \_\_\_\_\_.

I understand that this authorization will expire on the following date, event or condition: \_\_\_\_\_.

*I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.*

*I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.*

*I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.*

I further understand that I may request a copy of this signed authorization.

\_\_\_\_\_  
 Signature of Client  
 \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Personal Representative/Relationship  
 \_\_\_\_\_  
 Date

**Annual Renewal or Change of Guardianship:**

\_\_\_\_\_  
 Signature of Personal Representative  
 \_\_\_\_\_  
 Signature of Personal Representative  
 \_\_\_\_\_  
 Signature of Personal Representative

\_\_\_\_\_  
 Date  
 \_\_\_\_\_  
 Date  
 \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Personal Representative Relationship/Authority  
 \_\_\_\_\_  
 Personal Representative Relationship/Authority  
 \_\_\_\_\_  
 Personal Representative Relationship/Authority

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NOTE: This Authorization was revoked on \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Staff