**NEW CLIENT INFORMATION**

**WELCOME TO OUR OFFICE**

**THERAPIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**LAST M FIRST**

**HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STREET CITY STATE ZIP**

**EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK/CELL (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS: MARRIED \_\_\_\_\_\_\_ SINGLE \_\_\_\_\_\_\_ DIVORCED \_\_\_\_\_\_\_ WIDOWED \_\_\_\_\_\_\_ OTHER \_\_\_\_\_\_\_**

**EDUCATION COMPLETED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE/PARENT EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE/PARENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIVE TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

*PLEASE PRESENT INSURANCE CARD TO OFFICE STAFF*

**INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID# (SS#) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURED NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_**

**RELATIONSHIP TO CLIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**NAME RELATIONSHIP NAME RELATIONSHIP**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUBSTANCE USE HISTORY: CURRENT/AMOUNT PAST USAGE/DATE**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Professional Disclosure Statement**

**Michael E. Rife, LCMHC, LCAS, SAP**

License 2215

It is required by the North Carolina Board of Licensed Mental Health Counselors that you are provided with the following statement, prior to receiving services. Please read the following statement carefully and sign and date the form at the bottom.

* Education and Licensing
  + Licensed Professional Counselor 1995
  + 2012 – EMDR Training – Part One
  + 1993 – M.Ed. – Community Agency Counseling from East Tennessee State University
* Work with the following populations:
  + Children/Adolescents 12-19 years old
  + Adults
* Experience and training:
  + Children and Adolescents – Individual and Group
  + Grief, Loss and Trauma Counseling
  + OCD
  + Couples and Family Counseling
  + School-based Counseling
  + Various types of Group Counseling – grief, anger management, social skills and life transitions
  + Anger and Stress Management
* Theoretical orientation is based primarily on a Client-Centered, Rational Emotive Therapy, and CBT\*
  + Listen to clients in an empathic, nonjudgmental way
  + Respect the client’s current emotional state and provide a safe and secure environment for our sessions
  + Explore the client’s spiritual belief system
* The techniques used will vary based upon client’s emotional and mental state, age, issue(s), goals and time restraints. The following are the techniques most commonly used.\*\*
  + CBT and RET - explore behavioral patterns and exposure to assist with anxiety reduction
  + Dream Analysis - utilizing dreams to uncover unconscious emotions
  + EMDR - process to aid in recovery and processing of traumatic memories
* Sessions are fifty minutes in length and the fee is $150.00 for initial session and $120.00 for all other sessions. Payable by cash, check, or credit/debit card. A $25.00 fee will be applied for NSF. Additional fees may be applied for administrative tasks and school meetings.
* Payment is due at time of session. Please kindly give 24-hour cancellation notice. *Missed appointments may be charged $50.00*.
* Diagnosis is used primarily to provide client with a proper treatment plan and may be necessary for insurance coverage. The diagnosis becomes part of the client’s record.
* Confidentiality is kept between the counselor and client except in the following cases:
  + Client reports or indicates any ideations or actions which involve harm to self or others
  + Any indication of child or elder abuse
  + Court Order
  + As noted above insurance may require a diagnosis and treatment plan for coverage
* In the event that the client feels a complaint must be filed the following procedure applies:
  + Discuss the issue with the counselor – every effort will be made to resolve the issue
  + If the issue is not resolved the client may submit a complaint in writing to North Carolina Board of Licensed Mental Health Counselor at P.O. Box 77819, Greensboro, NC, 27417. Phone: 844-622-3572

\*Other theoretical modalities may be used depending upon client needs and situation

\*\*Many other techniques may be used throughout treatment

\*\*\*Therapy is not a guarantee of mood, emotion, or behavior change.

Client’s Signature and date Counselor’s signature and date

**PATIENT RIGHTS AND RESPONSIBILITIES**

*BEHAVIORAL HEALTH SERVICES OF LKN*

*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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**BEHAVIORAL HEALTH SERVICES OF LKN**

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

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_acknowledge that I have received a copy of Behavioral Health Services of LKN’s Notice of Privacy Practices. This notice describes how Behavioral Health Services of LKN 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.

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

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

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

(Relationship to Patient)

***MICHAEL E. RIFE, LCAS, LCMHC, SAP***

***107 KILSON DRIVE, SUITE 202***

***MOORESVILLE, NC 28117***

***PHONE: 704-660-8321 FAX: 704-660-8323***

***RELEASE OF INFORMATION FORM***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Michael E. Rife, LCAS, LCMHC, SAP to release to/obtain from:

(Client name)

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

(Name of provider, facility, or individual)

The following information:

\_\_\_\_\_Discharge Summary \_\_\_\_\_Assessment, Tx Plans/Summary of Patient Progress

\_\_\_\_\_Psychiatric History \_\_\_\_\_Physician Orders

\_\_\_\_\_Medical History/Physical Exam \_\_\_\_\_Progress Notes or Summary of Progress Notes

\_\_\_\_\_Clinical Lab, X-Ray, EKG, EEG, CT Scan \_\_\_\_\_Occupation/Recreational Therapy

\_\_\_\_\_Consultations (Psych, Neuro, etc.) \_\_\_\_\_Educational Information

\_\_\_\_\_Compliance with treatment/recommendation \_\_\_\_\_Attendance

\_\_\_\_\_Other \_\_\_\_\_Drug Screen Results

This authorization shall become effective \_\_\_\_\_\_\_\_\_\_\_\_\_ and is subject to revocation in writing by the undersigned at any time except to the extent that action has already been taken and shall TERMINATE ONE YEAR from the effective date if not earlier revoked.

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

(Specify date or circumstances under which consent will expire)

I understand that the information designated above will be the only information released and will not be disclosed to any other person or agency without my written permission. I understand that I have the right to receive a copy of this consent upon request. I understand that, upon disclosure by Michael E. Rife of information released pursuant to this authorization, Michael E. Rife no longer has control of such information.

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

Signature of Client Date

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

Signature of Parent/Guardian Date

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

Signature of Therapist/Witness Date

**MICHAEL E. RIFE, LCAS, LCMHC, SAP**

**107 KILSON DRIVE, SUITE 202**

**MOORESVILLE, NC 28117**

**PHONE: 704-660-8321 FAX: 704-660-8323**

**PERMISSION TO CONTACT PRIMARY CARE PHYSICIAN**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Michael E. Rife, LCAS, LCMHC, SAP to release to/obtain from:

(Client name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ my primary care physician.

Purpose of this contact is to coordinate treatment.

Providers Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Providers Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall become effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is subject to revocation in writing by the undersigned at any time except to the extent that action has already been taken, and shall TERMINATE ONE YEAR from the effective date if not earlier revoked.

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

(Specify date or circumstances under which consent will expire)

I understand that the information designated above will be the only information released and will not be disclosed to any other person or agency without my written permission. I understand that I have the right to receive a copy of this consent upon request. I understand that, upon disclosure by Michael E. Rife of information released pursuant to this authorization, Michael E. Rife no longer has control of such information.

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

Signature of Client Date

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

Signature of Parent/Guardian Date

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

Signature of Therapist/Witness Date

# 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_