Holly L. Pankratz, MA LMHC **206-715-0915**
Reflection Counseling PLLC **HollyPankratz@outlook.com**

Reflection Counseling PLLC
Holly L. Pankratz, MA, LMHC
19125 North Creek Pkwy, Suite 112
Bothell, WA 98011

To new clients:

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason you are unable to complete the paperwork before our first session, I will have copies in my office, and we will use your session time to complete the paperwork.

The ***Disclosure Statement*** outlines my policies regarding financial matters, confidentiality of information, and other administrative issues.

The **Intake Form** provides me with your basic identifying and contact information.

If you would like for me to consult with other therapists you have worked with, please complete the **Authorization to Release Health Care Information** form. We will discuss the possibility of my having contact with your former therapists in your initial session.

Please complete this paperwork prior to our initial meeting so we can spend our time together on your personal concerns. I look forward to meeting with you.

Holly L. Pankratz, MA

Checklist for completing paperwork:

- Read my **Disclosure Statement** found on pages 2-6. Please sign and date on page 6.
- Complete the **Intake Form** found on pages 7-8.
- Complete **Emergency Notification** on page 9.
- If you would like me to communicate with other health care providers about your therapy, please complete the **Authorization for Release** on page 10.
- On page 11, please read through the **Revocation of Consent** and *only sign when applicable.*
- Read through the **HIPAA Notice & Notice of Privacy Practices** regarding your therapy on pages 12-14 and sign the **Acknowledgement & Receipt of HIPAA Notice & Notice of Privacy Practices** on page 15
- **Please initial** all pages in upper right-hand corner to indicate that you have read and understand the information provided.
- **Optional:** For added convenience, if email communication is also preferred, please complete the **E-Mail Release of Information** on page 16.

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DISCLOSURE STATEMENT

Welcome to the therapeutic practice of Holly L. Pankratz, MA, LMHC, who is providing services to you through Reflection Counseling PLLC.

In the state of Washington, RCW 18.19 requires that all counselors, counselor interns, and volunteer counselors to be registered. WAC 246-810-031 requires all clients to sign a copy of a client disclosure information form. WAC 246-810-030 requires all clients to be provided certain disclosure information, which is described in WAC 246-810-031. I follow all codes as described above and enforced by Washington State. This document contains important information about my professional services and business policies. It also contains information about your health information privacy rights. Please read it carefully and let me know if you have any questions or concerns.

1. Training and Degrees: I received my Bachelor of Science in Elementary Education from Moorhead State University. After spending five years teaching children, I shifted direction and began a women's ministry at my church. During my seven years working with women and seeing the great heartache in the lives of many, I decided to pursue a degree in counseling. I received my Master of Arts in Counseling Psychology from The Seattle School of Theology& Psychology in 2008. I then held a Mental Health Counselor License Associate credential until 2012. Since then, I have held a Mental Health Counselor License (LMHC) credential, in the state of Washington (LH60313495).

2. Counseling Orientation & Approach: I believe that we are created to be in relationship with others. It is in these past and present relationships with others that we are wounded and often have a difficult time moving beyond our pain. I believe that in the relationship we form during therapy sessions, while addressing past and present wounds – together, we can find a path of healing.

Counseling may involve helping you identify, develop, and implement more effective strategies for problem solving and how to make healthier decisions. At times I may ask you to do some specific activities outside our sessions, such as reading a book that I think would be helpful, journaling, etc. The length of time you would be in treatment cannot be known early-on.

Counseling is understood to be a choice you've made among available options. Other options include: Receiving therapy from another counselor, using other therapies, using support groups, seeking self-help resources, and other modes of treatment.

3. Risks and Benefits: Counseling can be a disruptive process, as it often involves discussing unpleasant aspects of your life or parts of your life that you have never before addressed. You may experience uncomfortable feelings, such as sadness, guilt, anger, loneliness, or helplessness. On the other hand, counseling has also been shown to have many benefits. It often leads to improved relationships and can provide solutions to specific problems. You may also experience a significant reduction in emotional distress. It is important to acknowledge that progress in not linear in counseling and that symptoms or concerns may increase for a time, as a normal part of healing.

You have the right to ask questions about treatment at any time throughout the period of our counseling sessions. You have the right to refuse or end counseling at any time subject to the

cancellation policies stated in this agreement. I ask you to discuss concerns or questions about our counseling session before cancelling or terminating our counseling relationship.

The duration of treatment over time cannot be known early on. Some clients need only a few sessions to achieve their goals, while others may benefit from more long-term counseling.

4. Appointments, Fees, and Payment. Counseling appointments are 50 minutes in length. The fee for individual counseling is $180 and for couples and family counseling $210. These rates include fees for credit card processing. If I have not received cash/check by the time of service, I will charge your credit card on file. Please have the cash/check ready at the beginning of the hour. If a payment by check does not clear due to insufficient funds or any other reason, you shall reimburse me in full for any related bank fees which includes the original amount owed plus a $35.00 return check fee.

a. **Good Faith Estimates & Rate Increases**: Rates are adjusted annually on January 1 and will increase $10 per year from current published pricing. Washington state requirement of a Good Faith Estimate will be provided in December of the year prior for budgetary planning.

b. **No Insurance Reimbursement**: To provide you with the most personal and confidential therapy services, I do not submit billing to insurance organizations. Your insurance provider may pay for out-of-network therapy services, depending on your plan. Alternatively, you may use your FSA or HSA to cover services. Please check your coverage carefully. If requested, I can give you a bill that you can turn into the insurance company.

c. **Additional Services and Fees**. In the event you require additional counseling sessions or services, in addition to the sessions stated in Section 4 of this agreement and disclosure, such additional counseling sessions and services shall be billed or charged as follows [LINK]:

i. Request to complete forms and letters outside of scheduled sessions are billed at the basic office visit rate of $180 (per published 50-minute session),

ii. Requests for searching or handling records are billed at a $28 flat fee per request,

iii. A copying fee for up to but less than 30 pages of $1.24 per page and $0.94 per page for pages that exceed 30 pages; and

iv. Requests to edit confidential information are billed at the basic office visit rate of $180 (per published 50-minute session).

5. Cancellation or Missed Appointments. If you are not able to make your appointment, please notify me 24 hours in advance. If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session. If you are late for your appointment, I will stop at our regular appointment ending time. If you are billing insurance, please

know that insurance does not cover missed appointments, so you will be fully responsible for that session.

6. Confidentiality: In addition to this *Disclosure Statement*, you received my *Notice of Privacy Practices*, which describes how I might use and disclose your health information. There are legal exceptions to confidentiality. The following situations are those in which the information you have shared with me may be shared with others:

a) To report suspected abuse of a child, developmentally disabled person, or vulnerable adult.
b) To interrupt potential suicidal behavior.
c) To intervene against threatened harm to oneself or someone else, including knowledge that a client is HIV positive and unwilling to inform others with whom he/she is intimately involved.
d) If required by court order or other compulsory process.
e) If the client makes a complaint with the State of Washington or Department of Health
f) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
g) In the case of your death or disability, I may disclose information to your personal representative.

If you wish for me to release information about you outside of the above cases, I will require you to sign the *Release of Information* form.

7. Consultations: I periodically consult with a group of therapists. You name is not used in these sessions and it is only to make sure you are receiving the best care. All these consultations are done in such a way that confidentiality is maintained. If you have any questions or concerns about this throughout the process, please communicate them to me, as my highest aim is to make sure this is a safe place for you.

8. Social Media: In order to ensure your confidentiality, I do not accept friend, contact, or follow requests from current of former clients on any social networking sites (Facebook, LinkedIn, etc.). If you have questions or concerns about this, please communicate them to me when we meet.

9. Telephone, Email, Text & Voicemail: In the regular conduct of practice, I may make use of a cellular phone or other portable communication device to communicate with clients. In such cases, I will limit the information stored in any portable communication device to the least necessary. Please be aware that such forms of communication do have inherent risks to client confidentiality. If you would prefer that I do not store you name and telephone number in a portable communication device, or if you would prefer that I do not communicate with you via cellular phone, please inform me so that I can make alternative arrangements. At your request, for your convenience, and if it is therapeutically appropriate, I may make use of technology assisted distance counseling tools such as telephone communications and the internet.

If you wish to have me communicate with you via email, please complete the *Email Release of Information*. Since texting is not a secure form of communication, please email me rather than texting. If you choose to text, please use it only to inform me if you are running late to our session. You can leave a voicemail for me at (206)715-0915. I will check these messages and return your call within 24 hours.

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10. Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You have the right to request a change in counseling approach, referral to another counselor, or terminate counseling at any time. If you elect to terminate treatment with me, I strongly recommend a minimum of one final meeting to discuss your progress and your future goals.

11. Terminating Treatment: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will generally not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, when appropriate, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. If, without having made prior arrangements, I have not heard from you in 30 days, I will assume that you would like me to terminate our current episode of care and close your active clinical file. In such cases, I may re-open the file and initiate a new episode of care once we meet in person.

12. State of Washington Disclosures: The State of Washington requires that I provide you with the following information.

- You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want.
- You have the right to choose a provider who best suits your needs and purposes.
- A copy of the acts of unprofessional conduct can be found in RCW 18.130.180.
- Complaints about unprofessional conduct can be made to:

  Health Systems Quality Assurance Complaint Intake
  Post Office Box 47857
  Olympia, WA 98504-7857
  Phone: 360-236-4700
  E-mail: HSQAComplaintIntake@doh.wa.gov

I will provide you with a referral to another provider if your needs are beyond the scope of my expertise, or if you request such referral information.

13. Emergencies: If you are experiencing an emergency and cannot reach me, please call one of the following numbers for help:
911 (General Emergencies)
(206) 461.3222 (King County Crisis Line)
(425) 258.4357 (Snohomish County Crisis Line)

14. Minors: At this time Reflection Counseling PLLC limits its practice to adults only. I am happy to make a referral for a therapist who specializes with youth.

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15. Testifying in Court: If you become involved in a legal proceeding that requires my participation, you will be expected to pay for all my professional time, including preparation and transportation time, even if I am called to testify by another party. The rate for legal depositions, requested by either by you or your attorney is $1,000.00 for a maximum of 4 hours. The rate for a requested court appearance, with or without counselor testimony, is $2,000.00 per day. All requested deposition and court appearance fees must be paid in full thirty (30) days prior to the scheduled deposition or trial, unless other arrangements have been made in writing.

16. Informed Consent and Authorization for Counseling: With my signature, I acknowledge that I have read, and I understand the attached disclosure statement describing the profile, qualifications, and policies of Reflection Counseling PLLC with regards to Holly L. Pankratz psychotherapy practice. I have had the opportunity to ask questions, and I have received a copy of this agreement and disclosure form. Having read and understood this information, I consent to counseling with Reflection Counseling PLLC and Holly L. Pankratz, MA LMHC according to the terms described here.

The following materials pertaining to therapy have been reviewed (please initial each).
____ Disclosure Statement
____ HIPAA Notice and Notice of Privacy Practices

_____ _____
Signature Date
Print Name:_____

_____ _____
Second Client Signature (if applicable) Date

Reflection Counseling, PLLC

_____ _____
Holly L. Pankratz, MA LMHC Date
Its Member

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INTAKE FORM: PART I

Full Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

E-mail Address:_____
Can I e-mail you here for scheduling purposes? ☐ Yes ☐ No

Home Phone _____
Can I call you here? ☐ Yes ☐ No
Can I leave a message? ☐ Yes ☐ No

Cell Phone _____
Can I call you here? ☐ Yes ☐ No
Can I leave a message? ☐ Yes ☐ No

How were you referred to me? _____

Partner Name (if applicable) _____

Relationship Status: ☐ Single ☐ Living Together ☐ Married ☐ Informally Separated
☐ Legally Separated ☐ Divorced ☐ Other: _____

Briefly tell me about the concerns that have brought you here. Please check any current or past issues that still affect you.

☐ Childhood Abuse (i.e. physical, sexual, emotional)
☐ Phobias (type: _____)
☐ Sexual Assault/Rape
  ☐ Recently (when: _____)
  ☐ In the past (when: _____)
☐ Death of a someone close
  ☐ Recently (when: _____)
  ☐ In the past (when: _____)
☐ Relationship Concerns
  ☐ Family ☐ Friend ☐ Suicidal Thoughts ☐ Other: _____
☐ Family Issues (i.e. divorce, alcoholism, domestic violence)
  ☐ Parent ☐ Significant other ☐ Roommate ☐ Other: _____

☐ Eating Disorders
☐ Academic Issues
☐ Stress/Anxiety
☐ Alcohol/Other Drug Use
☐ Pregnancy Issues
☐ Depression
☐ Spiritual Concerns
☐ Pornography
☐ Sexual Identity Issues

Current medical problems _____
List any medications you are currently taking including herbal
_____
_____

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INTAKE FORM: PART II

Are you currently working with a Personal Physician? ☐ Yes ☐ No
If yes, what is your physician's name? _____
Phone Number:_____ What for?_____

Have you been on any medications in the past for mental health issues? ☐ Yes ☐ No
If yes, please list them: _____

Have you previously seen a counselor or therapist? ☐ Yes ☐ No
Who/Where?_____ How long ago? _____
For what types of issues?_____

Are you currently seeing a therapist? ☐ Yes ☐ No
Nearest Relative, other than Spouse/Partner _____ Phone _____

Have you ever been hospitalized for physical or mental health issues? ☐ Yes ☐ No (If yes, briefly describe)

_____
_____

Have you had any previous suicide attempts? ☐ Yes ☐ No (If yes, briefly describe)

_____
_____

If you currently experience any of the following symptoms, please rate them using this scale:
Never = 0 Seldom = 1 Often = 2 Always = 3

___ Difficulty concentrating	___ Crying	___ Missing classes
___ Feeling helpless	___ Feeling uptight	___ Worrying
___ Feeling hopeless	___ Feeling afraid	___ Lying to others
___ Feeling out of control	___ Feelings of self-doubt	___ Injuring self
___ Nervous around others	___ Suicidal Thoughts	___ Difficulty sleeping
___ Memory loss or blackout	___ Stealing	___ Anger
___ Eating binges	___ Drinking heavily	___ Guilt feelings
___ Other drug use	___ Sexual preoccupation	___ Social Withdrawal

___ Physical symptoms (i.e. headaches, digestive) List: _____
Other: _____

Have you seen a health care provider for any of these symptoms? ☐ Yes ☐ No
(Briefly describe)

_____
_____

Please use the scale below to answer the following questions.
Not at all true = 1 Somewhat true = 2 Mostly true = 3 Very true = 4
___ My current concerns affect my success in life
___ My current concerns affect my ability to interact and connect with others
___ I am optimistic that I will be able to make some positive changes as a result of counseling

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EMERGENCY NOTIFICATION

In the event of an emergency, notify:

Primary contact:

Name _____

Personal Phone _____

Work /Home Phone _____

Relation to Client _____

Address _____

_____

E-Mail Address _____

Secondary contact:

Name _____

Personal Phone _____

Work /Home Phone _____

Relation to Client _____

Address _____

_____

E-Mail Address _____

Client Signature _____

Printed Name _____

Date Signed _____

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AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Client Name	Client Date of Birth

This is to authorize that the information specified below regarding the above person be disclosed between:

Reflection Counseling, PLLC
Holly Pankratz, MA LMHC
19125 North Creek Pkwy, Suite 112,
Bothell, WA 98011

Phone: (206) 715-0915

Attention: _____

_____
Person or Facility

_____
Street

_____
City State Zip

Phone: _____

Attention: _____

Specific Information to be Disclosed:

☐ Intake Evaluation	☐ Psychiatric Evaluations	☐Laboratory Results
☐Discharge Summary	☐ Psychological Evaluations	☐Progress Notes
☐Treatment Plan	☐ Medical History	☐Other: _____
☐Medications	☐ Medical Diagnosis	☐Other: _____

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____
Client _____ Parent _____ Legal Guardian _____

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REVOCATION OF CONSENT FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

Client Name: _____ Date of Birth: _____

Previous Name (where applicable) _____

I no longer want Holly L. Pankratz, MA to use and disclose health care information about me for treatment, billing and payment, and health care operations.

I understand that:

- This request only applies after I sign the document.
- Holly L. Pankratz, MA, may have already acted based upon my earlier permission.
- Holly L. Pankratz, MA, is allowed by law to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the "Consent for Use and Disclosure of Health Care Information" or the "Acknowledgement of Receipt of Notice of Privacy Practices".
- Holly L. Pankratz, MA, is allowed or required by law to release health care information without my permission under certain situations.
- Holly L. Pankratz, MA, does not have to provide any further health care services to me.

_____ _____
Signature of Client or Legally Authorized Individual Date

_____
Relationship to client if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

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HIPAA NOTICE AND 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.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (also called "Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for the purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **TREATMENT**: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. **PAYMENT:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health insurance provider. For example, I may disclose PHI to enable your health insurance provider to take certain actions before it approves or pays for treatment services.

3. **HEALTH CARE OPERATIONS:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, and licensing or credentialing activities.

4. **REQUIRED OR PERMITTED BY LAW:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; disclosures to health and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions, or otherwise as authorized by law.

5. **COMPULSORY PROCESS**. I may be required to disclose your PHI if a court of competent jurisdiction issues an appropriate order, and if the rule of privilege has been determined not to apply. I may be required to disclose your PHI if I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, no protective order has been obtained, and a competent judicial officer has determined that the rule of privilege does not apply.

B. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

1. **PSYCHOTHERAPY NOTES:** I may keep your psychotherapy notes ("Psychotherapy Notes") as a separate record. In this case, I must obtain your authorization to use or disclose Psychotherapy Notes with the following exceptions: i) I may use the notes for your treatment; ii) I may also use or disclose, without your authorization, Psychotherapy Notes for my own training, to defend myself in legal or administrative proceedings initiated by you; iii) as required by the Washington Department of Health or the US Department of Health and Human Services to investigate or determine compliance with applicable regulations; iv) to avert a serious and imminent threat to public health or safety; v) to a health oversight agency for lawful oversight; vi) for the lawful activities of a coroner or medical examiner or as otherwise required by law.

2. **MARKETING COMMUNICATIONS:** I will not use your health information for marketing communications without your written authorization.

3. **OTHER USES AND DISCLOSURES:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. RIGHT TO INSPECT AND COPY. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under some circumstances, I may deny access to your records. I may charge a fee for the cost of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. RIGHT TO ALTERNATIVE COMMUNICATIONS. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

D. RIGHT TO ACCOUNTING OF DISCLOSURES. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes

other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. RIGHT TO REQUEST AMENDMENT. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. RIGHT TO OBTAIN NOTICE. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

G. QUESTIONS AND COMPLAINTS. If you desire further information about your privacy rights or are concerned that I have violated your privacy rights, you may contact me. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services or the Washington Department of Health. I will not retaliate against you if you file a complaint with the director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. EFFECTIVE DATE. This Notice is effective on January 31, 2020.

B. CHANGES TO THIS NOTICE. I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new Notice. You may also obtain any revised Notice by contacting me.

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ACKNOWLEDGEMENT & RECEIPT OF HIPAA NOTICE & NOTICE OF PRIVACY PRACTICES

I, _____ (Client), acknowledge that I received a copy of the Notice of Privacy Practices for Reflection Counseling PLLC / Holly L. Pankratz LMHC.

_____ _____
Client Signature (or Parent/Legal Guardian) Date

If a personal representative signs this acknowledgement on behalf of the client, please complete the following:

Name of personal representative: _____

Relationship to Client: _____

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E-MAIL RELEASE OF INFORMATION

If you wish to have me communicate with you via e-mail, please complete this form. In compliance with HIPAA regulations, I will not be permitted to e-mail you or respond to e-mails sent to me without a signed e-mail release form. Be aware that I do have encrypted e-mail software for greater protection. By signing this form you are agreeing not to hold Reflection Counseling PLLC / Holly L. Pankratz, MA LMHC responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any e-mails sent to me from you or from me to you.

Texting is even less secure. Please email me rather than texting, and if you choose to text, please use it only to inform me if you are running late.

I, _____, have read the above and agree to hold Reflection Counseling PLLC / Holly L. Pankratz, MA LMHC harmless for any breach of confidentiality that may result from someone accessing confidential information in the form e-mails sent to or from me.

_____ _____
Client Signature (or Parent/Legal Guardian) Date

Address _____

City _____ State _____ ZIP _____

E-mail Address _____

This release may be revoked at any time by producing a written revocation and is valid until such revocation is received.