Counseling and Healing for Inspirational Living

93 Main Street Suite 1A
West Sayville, NY 11796
Phone: (631) 474-1533

www.counselheals.com

Psychological Assessment Intake Form

Thank you for choosing Counseling and Healing for Inspirational Living for your child's psychological assessment.

This Intake Packet contains the forms you will need to complete, sign, and return to Counseling and Healing for Inspirational Living prior to scheduling your first testing appointment. Please be as thorough as possible regarding your child's history and include copies of your child's IEP or 504 Plan and previous psychological assessment, if applicable. You can return these forms via email at the below listed email account only. Please sign via electronic signature and return to Assessment- Scheduling@counselheals.com.

All forms must be completed online in type written format.

What To Expect For Your Child's Psychological Assessment

Intake Appointment. After returning this intake packet, you will be scheduled for an initial intake appointment. This appointment is typically 50 minutes in length and is for parents/caregivers only. This appointment will involve a conducting a thorough interview with you regarding your current concerns as well asking about your child's history and development. At the end of this appointment, your child's psychologist will share initial impressions and more details about what the testing process will involve for your child.

Testing Appointment(s). Testing appointment(s) are scheduled during the day and children often miss all or part of the school day. The length of the appointment(s) will vary depending on the referral question. Testing will involve a combination of activities to help understand your child's current cognitive, social, emotional, and adaptive strengths and difficulties. Questionnaires will also be provided to parents/caregivers and teachers to gather more information on your child's daily functioning in different environments. For children who are age three or younger, parents/caregivers will likely be in the testing room during the appointment to help gain an accurate picture of your child's current developmental abilities.

Feedback Appointment. After testing is completed, a separate feedback session is scheduled. During this appointment, your child's psychologist will share a completed evaluation report with you, including a summary of your child's history, detailed results of testing, any relevant diagnoses, and a recommendations for treatment or accommodations. You will also have the opportunity to discuss the meaning of these results and to ask any questions that you have.

Psychological Assessment Intake Form Contents

**Indicates this item is required by every patient*

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PATIENT INFORMATION

Patient's Last Name	First	MI	☐ single ☐ married ☐ divorced ☐ widowed	Sex

Mailing Address	City	State	Zip

Phone #1	☐ work ☐ home ☐ mobile ☐ other	Phone #2	☐ work ☐ home ☐ mobile ☐ other

DOB (mm/dd/yy)	Social Security #	E-mail Address	Check here for email appointment reminders
			☐ I consent to receive email appointment reminders

Employer	Employer's Address	Employer Phone

Patient's Primary Care Physician	Physician Phone

PARENT/GUARANTOR INFORMATION

Parent/Guarantor	DOB (mm/dd/yy)	Home Phone #	Mobile Phone #

Address	City	State	Zip

INSURANCE / EAP INFORMATION

Last Name of Insured (Policy Holder)	First Name of Insured	Social Security #	DOB (mm/dd/yy)

Insured's Address	City	State	Zip

Insured's Place of Employment	Phone Number	Insured's Email Address

Name of Insurance or EAP	Customer Serv. #	Member ID #	Group #	Copay/Co-Ins.

FOR CHILDREN UNDER THE AGE OF 18

If legal custody is shared, has permission by other parent been granted for treatment?	☐ Yes	☐ No
To whom may we release information?		

EMERGENCY CONTACT (other than patient or guarantor)

Contact Name	Relationship to Patient	Home Phone #	Mobile Phone #

The information above is accurate and correct to the best of my knowledge.

Parent/Guardian Signature: _____ Date: ____/____/_____

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Consent for Treatment

This consent form is authorized by NYS Law.

1. Name of Minor: _____DOB:_____/_____/_____

2. Name of consenting adult: _____Relationship to Minor_____

3. I have authority to consent for treated as stated below (check appropriate box):
   - ☐ I am a parent of this child.
   - ☐ I am the court appointed guardian of the child. A certified copy of the order appointing me as guardian of the child is attached.
   - ☐ The child has been placed in the custody of the Department of Human Services, and I am a representative of the Department of Human Services authorized to consent to routine and ordinary care.
   - ☐ The Department of Human Services has authorized me, as a person into whose care the named child has been entrusted, to consent to routine and ordinary medical care and treatment. A copy of the document authorizing me to such care is attached.
   - ☐ The Department of Human Services has authorized _____, a facility, to whose care the named child has been entrusted, to consent to routine and ordinary medical care and treatment. I am a person authorized to consent on behalf of said facility.
   - ☐ The court has placed the child in my custody and has determined my authority to consent to routine and ordinary medical care. A copy of the court order granting me this authority is attached.
   - ☐ The court has placed the child in the custody of _____, an institution or agency other than the Department of Human Services, and has determined the authority of said institution or agency to consent to routine and ordinary medical care. A copy of the court order granting said institution or agency the authority to consent to routine and ordinary medical care is attached.

I declare under penalty of perjury under the laws of the State of New York that the statements above are true. I have read, or had read to me, and understand the following information about my rights:

- All persons receiving services from Counseling and Healing for Inspirational Living, shall retain all rights, benefits and privileges guaranteed by the laws and constitution of the State of New York and the United States of America.
- All persons shall have the rights guaranteed by the Department of Mental Health and Substance Abuse Services Client Rights, unless an exception is specifically authorized by those standards or an order of a court of competent jurisdiction. [O.A.C. 450:18]

_____

Client Signature (age 14 or older) Date

_____

Parent/Guardian/Representing Authority Signature (required if client is under age 18) Date

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Child/Adolescent Background Information

Please answer all the information below as completely as possible. If you need assistance completing this form, please contact Counseling and Healing for Inspirational Living. Your child's clinician will discuss your responses with you during the intake appointment.

Person(s) completing this form: _____ Relationship to child: _____

Referral Information

Who referred your child for a psychological assessment?_____

What are your goals for this assessment? _____

_____

Has your child had any previous psychological evaluations in the school or community? *If so, please describe briefly below, including any prior diagnoses, and provide a copy of the report(s) with this document.*

_____

_____

_____

Parent/Guardian Information

Name: _____ DOB: _____/_____/_____ Phone: _____-_____-_____

Relationship to child: ☐ Biological ☐ Step ☐ Foster/Guardian ☐ Adoptive ☐ Other _____

Occupation/Employer: _____/_____

Name: _____ DOB: _____/_____/_____ Phone: _____-_____-_____

Relationship to child: ☐ Biological ☐ Step ☐ Foster/Guardian ☐ Adoptive ☐ Other _____

Occupation/Employer: _____/_____

Primary Household/Family

Who currently lives in the home with your child? Include parents, siblings, grandparents, etc.

Name	Age	Gender	Relationship to Patient

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Secondary Household/Family (If applicable)

Who currently lives in the home with your child? Include parents, siblings, grandparents, etc.

Name	Age	Gender	Relationship to Patient

Please list any other people who are regularly involved in your child's care:

Name_____Relationship_____How often_____

Name_____Relationship_____How often_____

Child's primary language: _____ Language(s) spoken at home _____

Parent/Caregiver Relationship History

Complete this section if parents/caregivers are not living in the same home

Parents/caregivers are: ☐ Separated (Date: ____/____/_____)

☐ Divorced (Date: ____/____/_____)

☐ Other (Explain: _____)

Name of parent not living in the child's primary household: _____

Address: Street_____ State _____ Zip Code _____

***You will be required to provide custody documents with this form.**

What is the current custody agreement? Has the agreement ever changed? If so, please explain.

_____

_____

_____

How often does your child have contact with the non-custodial parent? What type of contact (phone, visitation, etc.)?

_____

_____

Describe how you and your child's other parent make decisions related to your child's school, activities, medical care, etc.?_____

_____

Do **both** of your child's parents know your child is here today and agree with you bringing your child for psychological assessment services? ☐ Yes ☐ No (Explain: _____)

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Current Concerns

In your own words, please describe your primary concerns for your child and your reason for seeking psychological assessment services. _____

_____

_____

Check the boxes below that apply to your current concerns for your child:

Problems/Symptoms

- ☐ Fears
- ☐ Nightmares
- ☐ Anxious/nervous/worried
- ☐ Compulsions (doing things over and over)
- ☐ Obsessive thinking
- ☐ Mood swings/irritability
- ☐ Elevated/overly excited mood
- ☐ Depressed mood
- ☐ Low self-esteem
- ☐ Suicidal thoughts
- ☐ Self-harming behaviors
- ☐ Bed wetting/toileting concerns
- ☐ Eating problems (purging, bingeing, restricting)
- ☐ Other:_____
- ☐ Inattention/easily distracted
- ☐ Impulsive/hyperactive behaviors
- ☐ Physical aggression toward others
- ☐ Peer relationship problems
- ☐ Family relationship problems
- ☐ Disobedient/rule-breaking
- ☐ Difficulty with daily living skills
- ☐ Hallucinations (seeing/hearing things)
- ☐ Delusions (odd untrue beliefs/thoughts)
- ☐ Addictive problems (drugs/alcohol)
- ☐ Learning difficulties
- ☐ Sexual problems
- ☐ Social skills/communication
- ☐ Developmental delays

Trauma History/Significant Stressors

- ☐ Abuse (◯ physical, ◯ emotional, ◯ sexual, ◯ other_____)
- ☐ Neglect
- ☐ Witnessed violence
- ☐ Bullying
- ☐ Natural Disaster
- ☐ Adjustment to life changes (change schools, divorce, moving, family system changes, etc.)
- ☐ Health concerns/medical problems of client
- ☐ Health concerns/medical problems of family member
- ☐ Death of a significant person in your child's life
- ☐ Financial difficulties
- ☐ Other: _____

When did you first become concerned for your child? _____

What are your child's interests and strengths? _____

_____

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Birth History

Were there complications during your child's pregnancy and delivery? ☐ Yes ☐ No

If yes, please explain: _____

_____

Length of pregnancy: _____ Birth weight _____ Was child in NICU_____

Were there any substances used during pregnancy (e.g., tobacco, marijuana, opioids, cocaine, alcohol, methamphetamine, prescribed drugs, etc.)? ☐ Yes ☐ No

If yes, please explain:_____

Early Developmental History

Did your child experience any developmental delays in the following areas?

Language Development (Explain: _____)

Motor development (Explain: _____)

How old was your child when they were toilet trained? _____ (day) _____ (night)

Please describe any other concerns you have for your child's development: _____

_____

_____

Education

Name of school_____ Grade _____

What grades does your child typically earn in their classes? _____

How many days of school has your child missed in the past 90 days? _____

Describe any attention or learning difficulties at school: _____

_____

Describe any behavioral difficulties at school: _____

_____

Has your child ever been suspended or expelled from school? ☐ Yes (Date:___/___/_____) ☐ No

If yes, explain: _____

_____

Has your child ever been retained? ☐ Yes (Grade_____) ☐ No

If yes, explain: _____

_____

Does your child have an IEP or 504 plan? ☐ Yes (**Please provide copy**) ☐ No

Other Background Information

Is your child currently involved in a legal case or does your child have a probation officer?

If yes, explain _____

Has your child ever been placed in DHS custody? ☐ Yes (Date:____/____/_____) ☐ No

If yes, explain _____

_____

Has your child ever resided outside of the parent(s) care for any reason? ☐ Yes ☐ No

If yes, explain _____

Do you have concerns about your child's social skills or social life? ☐ Yes ☐ No

If yes, explain _____

Please describe any other significant changes in your child's life that may have significantly impacted your child.

_____

_____

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Medical History

List any current health concerns for your child: _____

_____

Describe any major hospitalizations, surgeries, injuries, illnesses for your child:
_____Date/Age_____

_____Date/Age_____

_____Date/Age_____

Sleep concerns: ☐ Yes (Explain_____) ☐ No

Eating concerns: ☐ Yes (Explain_____) ☐ No

Hearing Concerns: ☐ Yes ☐ No Date of last hearing test _____

Vision Concerns: ☐ Yes ☐ No Date of last eye exam _____

Does your child use any assistive communication devices, mobility supports (wheel chairs, braces), or hearing devices? ☐ Yes ☐ No

If yes, explain: _____

_____

Does your child currently take any prescribed or over the counter medications? ☐ Yes ☐ No

Medication	Dose	Time given	Date started

Who prescribes these medications? _____

Name of Primary Care Physician: _____Phone_____/____/_____

Other medical specialists/providers involved in your child's care: _____

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History of Services

List any developmental services:

Speech therapy	Date: _____	Location:_____
Occupational therapy	Date: _____	Location:_____
Physical therapy	Date: _____	Location:_____

Mental Health services:

Counseling/therapy	Date: _____	Location:_____
	Date: _____	Location:_____
Inpatient Care	Date: _____	Location:_____
	Date: _____	Location:_____
Other_____	Date: _____	Location:_____
	Date: _____	Location:_____

Family Mental Health History

Please list any family history of mental health or developmental concerns (e.g., autism, speech delays, anxiety, depression, psychosis, substance use, ADHD, learning difficulties, etc.).

Maternal (mother's side):_____

_____

Paternal (father's side): _____

_____

Is there any other information that you would like me to know about your child?

_____

_____

_____

_____

_____

_____

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Self-Pay and Commercial Insurance Fees

Do NOT complete this page if you have Medicaid

Please contact your insurance company prior to scheduling an appointment to inquire about coverage for psychological testing, as well as your deductible and any copays or coinsurance.

Academic testing: Most insurance companies will not reimburse for academic testing. If your insurance company does not cover academic testing, you will be required to pay an out-of-pocket expense for the administration, scoring, and interpretation of any academic measures. Rates for out-of-pocket testing fees are provided below and are due at the time of the testing appointment.

Credit Card On File Policy

Deposit: Clients with commercial insurance (without Medicaid) and those who are self-pay are required to maintain a credit card on file for collecting any outstanding balances. They are also required to pay a $250.00 deposit at the time of scheduling. Any remainder of this deposit will be credited back to your card within 30 days of insurance denial or approval. Psychological testing fees are outlined below in Counseling and Healing for Inspirational Living's business policies. Your card information will be maintained securely and is only accessed under the terms specified below. Most major credit cards, personal checks, and cash payments are accepted.

Outstanding Charges: By completing the information and signing below, you give Counseling and Healing for Inspirational Living permission to charge your credit card for the amounts due for services received. If you are using insurance, these amounts will match the patient's responsibility amounts as determined by your insurance company and are reflected on your explanation of benefits
(EOB).

Late Cancellation: Appointments that are canceled or missed without 24-hour notice, will incur a late cancellation fee of $150.00 for one-hour appointment that will be charged to your credit card. If you have a multiple hour testing appointment scheduled, a late cancellation fee of $300 will be charged to your credit card. For more information, see Counseling and Healing for Inspirational Living's Policies and Procedures.

Counseling and Healing for Inspirational Living will maintain clear records of all payments and charges. If you have questions about a charge, please notify Counseling and Healing for Inspirational Living within 15 days. After 30 calendar days all charges will be assumed correct.

Continue to the next page for credit card on file agreement.

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Credit Card On File Agreement

Do NOT complete if you have Medicaid

Please check the boxes and sign below to confirm that you understand and agree with the policies above:

- ☐ I agree to keep my correct and updated credit card information on file to be used for missed appointments, records, letters, and/or outstanding balances as stated above. This information is for internal use only and will not be distributed to third parties.
- ☐ If the credit card information we have on file changes for any reason, you agree to notify Counseling and Healing for Inspirational Living as soon as possible. In the event of any declined charge, you will be asked for a new credit card number and/or payment before continuing treatment/testing.
- ☐ I am aware that a $250 deposit is required to secure testing with Counseling and Healing for Inspirational Living. Any remaining balance will be returned after all insurance claims have been processed.
- ☐ I understand that I will be held financially responsible for any charges not covered by my insurance.

Credit Card Information

Check One ☐ MasterCard ☐ Visa

Credit Card Number _____

Expiration Date_____/_____ CVC Code _____ Zip Code _____

Name as it appears on card _____

Signature _____ Date_____/_____/_____

Client's Name _____

Responsible Party _____

Signature _____ Date _____/_____/_____

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Policies and Procedures

Testing and Associated Fees

Please initial that you understand and agree to the policies below _____

1. Psychological Testing Fees
   - Initial Interview is $225.00
   - Psychological or Psychometric test administration and scoring is $150.00 per 30 minutes.
   - Psychological testing evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, report writing, and feedback session is $200.00 for the first hour and $150.00 for each subsequent hour.
   - As an estimate of total costs, you can expect your child's psychological evaluation to cost between $1,200 and $1,800 depending on the complexity.
2. Commercial insurance (without Medicaid) and Self-pay clients will be required to pay a $250.00 deposit and maintain a credit card on file. See the Credit Card On File Agreement for more information.
3. Lost or misplaced parent and teacher rating forms may incur a fee of $10.00 per form. This is not covered by insurance.
4. You will be provided one copy of the completed psychological evaluation. Additional mailed copies may incur a $15.00 fee. Copies picked up at the office may incur a $10.00 fee. These fees are not covered by insurance.
5. Services including phone calls, emails, record reviews and professional consults at times other than the scheduled appointments will be the patient's responsibility and will not be filed with insurance. These services will be billed per quarter of an hour at the rate of $150.00 per hour.
6. Payment must be made by check, cash and/or credit. Your fee or co-pay is due at the time services are provided. The patient is responsible for all fees. This includes any fees denied by insurance providers. Fees must be paid within 30 days after the dated the claim is denied.
7. Returned checks will result in an additional service fee of $25.00
8. Counseling and Healing for Inspirational Living reserves the right to utilize a collection agency to obtain unpaid balances.

Counseling and Healing for Inspirational Living reserves the right to change fees at any time.

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Late Cancellation and Missed Appointment Policy

Please initial that you understand and agree to the policies below _____

1. Appointments are considered confirmed at the time the appointment is scheduled. Reminder notifications are a courtesy and should not impact attendance.
2. We require a minimum of 24-hour notice for changes or cancellations of appointments. If you miss an appointment or do not cancel with a minimum of 24-hour notice, you will be charged our late cancellation/missed appointment fee. This fee will be charged to the card we have on file or will be billed to you. This fee is not covered by insurance and must be paid prior to your next appointment. Our late cancellation/missed appointment fees for testing are charged at the following rates:
    - $150 for one-hour appointments
    - $300 for multi-hour appointments
3. If you are more than 15 minutes late, according to our clinic clocks, you may be asked to reschedule and be charged a missed appointment fee.
4. If you cancel or miss two consecutive appointments, all future appointments will be cancelled. In this case, call the clinic to reschedule. Two missed appointments may result in the inability to reschedule.
5. If you are billing insurance for psychological testing, the assessment must be completed in a timely manner. Failure to reschedule within 30 days of a missed appointment may result in an inability to reschedule and complete the evaluation.
6. Office hours are Monday – Friday 9:00 a.m. to 5:00 p.m. by appointment only. To schedule appointment, please call (631) 474-1533.

Payments and Insurance

Please initial that you understand and agree to the policies below _____

1. Counseling and Healing for Inspirational Living bills insurance carriers they are paneled with. Copays and co-insurances are due at the time of service. It is the client's responsibility to ensure that insurance remains active throughout the assessment. In the event that insurance becomes inactive during testing you are still responsible for payment.
2. All insurance coverage must be disclosed, including commercial insurance for those with Medicaid. Failure to disclose all insurance coverage may result in fees.

Payments and Insurance Policies continue onto page 15

3. An authorized agent of an insurance carrier may be provided with information about the client's mental health and the type, cost, and dates of services so that reimbursement may be received.
4. I am aware that I may terminate treatment at any time, but that I am still responsible for payment of the services that I have received. Payment for services rendered is not dependent upon diagnostic conclusions of the psychological evaluation.
5. If the account is more than 90 days past due and payment arrangements have not been agreed to, billing procedures will be automatically forwarded to a collection agency or small claims court. You are responsible for attorney fees and court costs associated with collections.

No Recording and Penalty Policy

Please Initial that you understand and agree with the policy below_____

I/we agree that I/we will NOT audio or video record ANY portion of my/our intake appointments, psychological testing, feedback sessions, or any other services with the Counseling and Healing for Inspirational Living Clinician without their expressed written consent.

This policy applies to any other party I have included in my/our sessions or asked to provide information to any of the Counseling and Healing for Inspirational Living Clinicians on my/our behalf. I/we understand that a breach of this policy is grounds for monetary damages in excess of $100,000 US Dollars and I/we agree to pay to Counseling and Healing for Inspirational Living said damages for breaching this policy.

After Hours Instructions

Please Initial that you understand and agree with the policy below_____

I understand that, if I have an emergency, crisis situation, feel out of control, have thoughts of suicide, harming yourself, or hurting others, you will need to do/contact any of the following:

- Your local emergency response system 911
- Proceed to your nearest emergency room
- Local police department
- National Suicide Hotline: 1-800-273-8255

Email Reminder Consent

☐ Yes, send me appointment reminders by email. I understand that information sent by email could be lost, delayed, intercepted, or arrive incomplete. I understand and accept responsibility for these risks and will not my child's health care provider accountable.

☐ No, I do not want an email reminder.

Court Testimony & Custody Evaluations

Please Initial that you understand and agree with the policy below_____

- Counseling and Healing for Inspirational Living does not accept patients for psychological evaluations who are involved in legal disputes and who are seeking expert testimony or fact witness testimony or participation for **any** legal matters including, but not limited to, child custody.
- If your child's clinician is subpoenaed for testimony, even if called to testify by another party, you will be required to pay for your child's clinician's professional time. Because of the complexities involved in legal involvement, Counseling and Healing for Inspirational Living charges $500 per 60-minute hour for time spent in preparation, attendance, participation, travel, and waiting. Any and all travel expenses must be paid including, but not limited to: airfare, lodging, mileage, meals, etc. in order for your child's clinician to participate in any proceeds.
- There is a minimum 4-hour charge ($2,000) that is considered a **nonrefundable** retainer which must be paid two weeks prior to any testimony. Additional time required will be assessed at the rate of $500 per 60-minute hour.
- Your child's clinician will not respond to requests for records from attorneys without a valid release of information.

Confidentiality

Please Initial that you understand and agree with the policy below_____

I am aware that clinicians are required by state law and professional ethics to maintain confidentiality. No information about my child will be shared without the parent/guardian's written permission, except for the following:

- Suspected past or present abuse/neglect of a child, adult, and elder will be reported to the DHS and/or law enforcement.
- If there is reason to suspect the client is in serious danger of harming themselves or has threatened to harm another person.
- If your child's psychologist is court ordered to release patient information.
- To maintain continuity of care with the referral source and other medical providers.
- If required by your insurance company to receive payment for services

Please read the Notices of Privacy Practices below for a more complete description of information uses and disclosures.

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Notice of Privacy Policy

This notice describes how medical information about you may be used or disclosed and how you can access this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information is referred to as Protected Health Information (PHI) and may include information regarding your past, present or future physical or mental health or condition and related health care services.

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, American Psychological Association Code of Ethics, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing a copy to you at your next appointment.

Information about the Potential Use and Disclosures of PHI

1. For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.
2. For Payment. Your PHI may be disclosed so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
3. For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.
4. Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

5. Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.
    a. Suspected Abuse or Neglect of Vulnerable Persons. If we have reason to suspect past or present abuse/neglect of a child, vulnerable adult, or elder, we are required to report this information to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
    b. Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
    c. Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
    d. Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
    e. Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
    f. Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
    g. Public Safety. We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
    h. Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
6. Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

7. Research. PHI may only be disclosed after a special approval process or with your authorization.
8. Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
9. With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Your Rights Regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

1. Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
2. Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
3. Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4. Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
5. Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
6. Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257, or the Office of Civil Rights US Department of Health and Human Services, Independence Avenue SW, Rm: 509F, HHS Building, Washington, D.C. 20201 or by calling the OCR Hotline – Voice: 1-800-368-1019.

We will not retaliate against you for filing a complaint.

Consent for Use and Disclosure of Health Information

I have been provided with a Notice of Privacy Practices that Provides me with a more complete description of my PHI Counseling and Healing for Inspirational Living maintains and a description of PHI uses and disclosures.

I have read and understand the Notice of Privacy Practices.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.596 of the Code of Federal Regulations.

I further understand that Counseling and Healing for Inspirational Living, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.529 of the Code of Federal Regulations. Should Counseling and Healing for Inspirational Living, change their notice, they will provide me with a revised notice.

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ☐ **ACCEPT** ☐ **DECLINE** the terms of this consent.

Client Signature (age 14 and older) Date

Parent/Guardian/Representing Authority (required of client is under age 18) Date

Counseling and Healing for Inspirational Living
93 Main Street, Suite 1A, West Sayville, NY 11796
Office: 631-474-1533
www.counselheals.com

TeleMental Health Informed Consent

I, _____, (name of client/guardian) hereby consent to participate in TeleMental health with my clinician at Counseling and Healing for Inspirational Living as part of my psychological testing. I understand that TeleMental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to TeleMental health:

1. I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. There are risk and consequences associated with TeleMental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. Privacy laws that protect the confidentiality of my protected health information (PHI) also apply to TeleMental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that TeleMental health services are not appropriate and a higher level of care is required.
6. My provider may need to contact my emergency contact and/or appropriate authorities in case of emergency.

During a TeleMental health session, we may encounter technical difficulties resulting in service interruptions. If we are unable to reconnect within ten minutes, your service provider may have to re-schedule.

Emergency Protocols: Your service provider will request your location and contact information at the beginning of each appointment in case of an emergency. This information will only be used to contact you or the appropriate authorities in the event of an emergency.

I have read, understand, and agree the information and policies provided above.

Client Signature (age 14 or older) Date

Signature of Parent/Guardian/Authorized Representative Date

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Authorization to Release/Obtain Confidential Information

I understand that my records contain information about my psychological testing and mental health. I understand that all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose. Therapists will limit client's and/or guardian's access to records when there is compelling evidence that access would cause harm to the client. A photocopy of this authorization will be considered as valid as the original.

I, _____ ____/____/_____ _____-_____-_____
Client Name Date of Birth Social Security Number

Authorize: _____
Counseling and Healing for Inspirational Living
93 Main Street, Suite 1A
West Sayville, NY 11796
631-474-1533

TO RELEASE/OBTAIN INFORMATION FROM:
_____
_____
_____
Attn:_____

Information to be released/obtained:	**Check this box to release all information below as needed**
Treatment Planning	Insurance/HMO Transactions
Psychological Assessments	Insurance Care Determination Forms
Discharge Summary	Progress Notes
Psychiatric Testing/Evaluations	Psychosocial History
Health/Medication History	Other_____
Eligibility Determination of Insurance/benefits	Other_____

Purpose of Releasing/Requesting Information: _____

THIS RELEASE EXPIRES ONE YEAR FROM THE DATE SIGNED. I understand that I have the right to revoke this release at any time.

I have been informed and understand this authorization to release/obtain records and information and the implications of this release. I understand that this release is voluntary. Counseling and Healing for Inspirational Living, is hereby released of all legal liability that may arise from the release of information requested.

Client Signature (age 14 or older) Date

Signature of Parent/Guardian/Authorized Representative Date