Welcome Letter

Thank you for choosing me to work with you on your therapy goals. My hope is that during our time together you will find comfort, healing and effective skills and strategies to help you navigate through life.

Important Information

**Client Portal** gives you the ability to request, cancel, and reschedule appointments at any time without needing to call me. Once I confirm the request, you will be notified immediately. Client Portal also allows you to complete paperwork at your convenience. Intake paperwork, handouts, treatment plans and agreements can be reviewed and signed electronically. Go to: <https://www.therapyportal.com/p/growgolife/>

***If you struggle with electronic processing of the intake paperwork, please download and complete the attached Intake Packet and bring it with you to your first appointment.***

**Structure of Therapy:**

*Intake Session is always 75 minutes long.*

Intake Phase – Go over presenting issue(s) and paperwork

*Remaining Sessions are 50 minutes long unless a 75-minute session is scheduled ahead of time*

Assessment Phase – Biopsychosocial Assessments & Symptoms Checklist

Development of Treatment Plan

Intervention Phase - Treatment plans reviewed every 3 months

Graduation/Discharge/Termination

**Fees & Payment Options:**

Self-Pay Only. Payment is due at the time of service. I accept cash, credit card, HSA, PayPal or check made out to Cherie Burgess. Superbills available upon request.

Intake Session 75-Minutes is $100. Remaining 50-Minute sessions are $75.

Additional Fees: $20 will be charged for every 15 minutes past agreed upon time.

*Unless it’s an absolute emergency - sessions that are cancelled within 24 hours of service are billed at full rate (see therapy consent and client agreement).*

**Additional Services:**

Life Coaching

Email/Phone Counseling

MTSS, 504 and IEP Parent Consultation

Online DCF-Approved Co-Parenting Class

Please feel free to contact me at 321-804-1119 or at cherie@growandgolifecoach.com

Cherie Burgess, LMHC

**CONSENT FOR THERAPY & CLIENT AGREEMENT**

**PART I: THERAPEUTIC PROCESS**

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one’s ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness.

Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

**EXPECTATIONS:** For clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. **Therapy is not a quick fix.** It takes time and effort, and therefore, may move slower than your expectations. **During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.**

**RISKS**: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

**STRUCTURE OF THERAPY**:

* **SEED SESSION (Intake Phase)** – During the first 75-minute session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
* **GROW SESSION (Assessment Phase)** – Remaining sessions are typically 50 minutes in length. The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
* **GROW PLAN (Development/Treatment Planning)** – After gathering background information, we will collaborative identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy. GROW plans will be reviewed every 3 months to assess progress.
* **GROW SESSIONS (Intervention Phase)** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
* **GO SESSION (Graduation/Discharge/Termination)**– As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

**LENGTH OF THERAPY**: Therapy sessions are typically weekly or biweekly for **50** minutes depending upon the nature of the presenting challenges and your financial and scheduling needs. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

**FEES**: The fee for the first 75-minute session is **$100**. Remaining sessions are each 50-minute therapy session is $**75**. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $25 for any returned check), Paypal, HSA card, or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the “Appointments and Cancellations”. The clinician reserves the right to terminate the counseling relationship if more than 2 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed. Services will be billed and an invoice will be provided to the client.

**APPOINTMENTS AND CANCELLATIONS**: You are responsible for attending each appointment and agree to adhere to the following policy: *If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. If you cancel of reschedule more than 2 times, we may re-evaluate your needs, desires, and motivations for treatment at this time.*

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

**Superbill:** Per your request, I can provide you with a Superbill to submit to your health insurance company for possible reimbursement of services. A superbill does not guarantee that an insurance provider will pay for the services provided. Each insurance plan is different, and it is your responsibility to contact your insurance provider and find out exactly what will be covered. Should you choose to submit a superbill, you are releasing medical information that is protected by law. This means you are waiting some of your rights to privacy and confidentiality. It is standard for your insurance company to keep a record of your diagnoses stated on the superbill as part of your permanent medical file.

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION**: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of **$250** to include travel time, court time, preparing documents, etc.

**COPIES OF MEDICAL RECORDS**: Should you request a copy of your medical records, the cost is $.50 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

**PHONE CONTACTS AND EMERGENCIES**: Office hours vary. If you need to contact the clinician for any reason please call 321-804-1119, leave a voicemail, and a return call will be made within 24 Hours or as soon as possible). In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911.

**PART II: CONFIDENTIALITY*:***

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

* **Child Abuse** - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
* **Vulnerable Adult Abuse** - Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
* **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client’s safety, which may include disclosure of confidential information.
* **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
* **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
* **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
* **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual “psychotherapy/process notes”, except if the third party is part of medical. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
* **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
* **Couples Counseling & “No Secret” Policy:** On the few occasions that I work with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a “secret” that is detrimental to couple’s therapy goal. If one partner requests that I keep a “secret” in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive.
* **Dual Relationships & Public**: There is a likelihood that our personal paths may cross. We may attend the same church, be in the same life group, see each other at the gym or attend the same community event. In order to preserve this relationship, it is imperative that we limit the relationship outside of the counseling relationship (social, business, or friendship). If we run into each other in a public setting where other people are present, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
* **Social Media**: Unless you participate in one of my Facebook coaching groups, please do not friend request me on personal social media outlets (e.g. Facebook, LinkedIn, Pinterest, Instagram, Twitter). I will not be able to accept current or former clients. If you choose to comment on my professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
* **Electronic Communication:** If you need to contact me outside of our sessions, please do so via phone or through HIPPA-compliant email.
	+ We use a HIPPA-compliant E-mail called Hushmail. Hushmail requires that clients create a pass phrase to secure encrypted communication.
	+ Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship. Texting is not a substitute for sessions. Please DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client’s phone. With client consent, texting can be used for scheduling purposes.
	+ **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room.
	+ **Do not use your work computer to send an email**. Your employer has the legal right to read it. E-mail is a part of your medical record.
* **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). This can put your confidentiality at risk. This is especially true for clients who choose “Walk & Talk Therapy”

**CONSENT / AGREEMENT**

By signing this Client Information, Consent and Agreement Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form.

I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child’s mental health care and treatment, Cherie Burgess, LMHC will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

Signature – Client/Parent Print Name Date

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Signature – Spouse/Partner/Parent Print Name Date

Signature of Therapist/Witness Print Name Date

**FINANCIAL AGREEMENT**

The following document outlines the financial practices of Cherie Burgess, LMHC and the financial agreement between Cherie Burgess and the client.

Individual/Couples Therapy Payment - All fees are due at the time of the session. Payment can be made through Paypal, check, credit card or cash. Checks can be made payable to Cherie Burgess. If a check is returned for insufficient funds a fee of $25 will be charged. Fees: 75 Minute Initial Session: $100 / 50 Minute Session $75/$20 for every additional 15 minutes. *Cancellation Policy: To help with efficient and effective scheduling, we require that any changes or cancellations be made at least 24 hours in advance or the full fee will be charged.*

Insurance: Cherie Burgess, LMHC will gladly provide clients with an invoice to provide their insurance company, however insurance information must be on file for this to occur. This invoice contains the information needed to submit to insurance for out-of-network reimbursement. Prior to the first appointment, it is the responsibility of each client to contact the insurance company to determine their mental health benefits.

By signing below I, the client, acknowledge that I have read or had read to me the issues and points in this form. I hereby agree to abide by the financial agreement outlined in this form and consent to services provided by Cherie Burgess, LMHC as shown by my signature below.

**I understand that as a SELF-PAY client, payment must be made in full at time of service.**

Agreed upon rate of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The client chooses to pay through the following means: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_

Billing Street Address: \_\_\_\_

City: State: Postal Code: \_\_\_\_

Country: Email: \_\_\_\_\_\_\_\_\_\_\_

Direct Telephone: \_\_\_\_\_\_\_\_\_\_\_

 I authorize a one-time charge against my credit card for the follow amount $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I authorize a recurring charge against my credit card for services for the following amount

$ once every day(s)/week(s)? months(s) /year(s) beginning

 / / until / / or service(s) are completed.

**CREDIT CARD AUTHORIZATION**  MasterCard Visa Discover Card American Express

GGLCC uses a PCI Compliant Electronic Health Record System called Therapy Notes to secure credit card information. If you wish to use credit card or HSA Card, please list the last 4-digits of your card and present your card at the initial date of service.

Number: Cardholder Signature X Date: / /

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 THIS NOTICE CAREFULLY.**

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

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, 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 one to you at your next appointment.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**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.

**For Payment.**We may use and disclose PHI 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.

**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.

**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.

**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.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW*

*Code of Ethics*and HIPAA.

**Child Abuse or Neglect.**We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, when disclosure is mandated by the Child Abuse and Neglect or Elder/Dependent Adult Abuse Reporting law.

**Judicial and Administrative Proceedings.**We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Clients.**We may disclose PHI regarding deceased clients 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 clients 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.

**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.

**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.

**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 payers based on your prior consent) and peer review organizations performing utilization and quality control.

**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.

**Specialized Government Functions.**We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**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.

**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.

**Research.**PHI may only be disclosed after a special approval process or with your authorization.

**Verbal Permission.**We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**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.

 **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.

**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 our office if you have any questions.

 **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.

 **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.

**Right to Request Confidential Communication.**You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

**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.

 **Right to a Copy of this Notice.**You have the right to a copy of this notice.**Complaints**

Please contact HIPPA Toll Free Call Center: 1-800-368-1019

**Signature/Date**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Client Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECTION A:  Treatment Summary Notes

* Check if this authorization is for treatment summary notes.

SECTION B:  The Use and/or Disclosure Being Authorized

**Protected Health Information to be Used and/or Disclosed:**  Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:

* Discharge Summary
* Biopsychosocial Assessment
* Treatment Plan Evaluation

Other Assessment:

SECTION C:  Entities Authorized to Receive, Use or Disclose:

Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Cherie Burgess, LMHC who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above:

I authorize information to be: (*check one or both*)

* **Released To Cherie Burgess, LMHC  To**

(Name/Title/Organization)(Address)

(*Receipt of protected health information is limited to one health care provider per authorization form.*)

* **Released From Cherie Burgess, LMHC To**

(Name/Title/Organization) (Address)

(Name/Title/Organization)(Address)

* **Receive From Cherie Burgess To**

(Name/Title/Organization)(Address)

(*Receipt of protected health information is limited to one health care provider per authorization form.*)

* **Received From Alive and Well Corp To**

(Name/Title/Organization) (Address)

 (Name/Title/Organization)(Address)

 SECTION D:  Purpose

The information is being used/disclosed for the following purpose:

 SECTION E:  Expiration and Revocation Expiration:

This authorization will expire (complete one):

* On \_\_\_\_\_\_\_\_ (DD/MM/YR). *(Expires in a Year)*
* On occurrence of the following event:

*(which must relate to the patient or to the purpose of the use and/or disclosure being authorized*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Right to Revoke:***  I understand that I may revoke this authorization at any time by giving written notice of my revocation to Cherie Burgess, LMHC. I understand that revocation of this authorization will not affect any action taken by Cherie Burgess, LMHC in reliance on this authorization before my written notice of revocation was received.  Written revocation should be sent to:

Cherie Burgess, LMHC               207 N US Highway 27; Minneola, FL 34715; 321-804-1119

SECTION F:  Alcohol & Drug Abuse Information

 I understand that this authorization may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse.  I also understand that HIV, or AID’s-related information may be released.

SECTION G:  Facsimile Communication

I understand that this information may be communicated by facsimile.

SECTION H: The Patient (or the Patient’s Legal Representative) Confirming the Authorization

I understand that:  this authorization is voluntary (you may refuse to sign);  my health care and payment for my health care will not be affected if I do not sign this form;  if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.  Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected.

SIGNATURE:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Alive and Well.  I understand that, by signing this form, I am confirming my authorization that Madison State Hospital may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Client:   Date:

Signature of Legal Representative:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART 2:

*This information is from records whose confidentiality is protected by federal law.  Federal regulations (Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.  A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT