BAYVIEW COUNSELING SERVICES

Consent for Treatment
and Limits of Liability

clear form

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Date

I have received a copy of this signed confidentiality notice. ☐ Yes ☐ No Initials _____

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No Show, Late Cancellation and Copayment Policy

I understand that I will be charged a LATE CANCELLATION fee of **$10** if I fail to give at least 24-hour notice prior to cancelling my appointment.

I understand that I will be charged a NO-SHOW fee of **$25** if I fail to show up for my appointment.

If I choose to use my healthcare insurance benefits for these services, I understand that I am responsible for:

A. verifying that my insurance carrier has authorized use of this provider for these services. (proof of insurance authorization must be presented ***before*** the initial intake).
B. knowing my co-payment amount and deductible amount.
    a. My co-payment amount per session is _____; my deductible amount per year is _____.
    b. Have you met your deductible for this year? □YES □ NO
        i. If not, how much more do you have to pay towards your deductible? _____

I understand that if my insurance carrier does not cover these charges, then I am financially responsible for the out-of-pocket expense (please refer to the Self/Private Fee Schedule for more information).

I understand that I will be charged a **$5.00 service charge per week** if I fail to make my payment and/or co-payment at the time the invoice is delivered. Invoices are delivered via the email provided by the client. Invoices can be mailed to the client at the client's request.

A therapy session is typically **45-50** minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I agree to the above stated terms and stipulations regarding the services I receive from this therapist.

_____

Signature of Responsible Party

_____

Date

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CLEAR FORM

Authorization for Use or Disclosure of Protected Health Information

Client Information

Last Name: First Name: MI:

DOB:

Address:

Home Phone:

Cell/Work Phone:

Client Email Address:

Recipient Information

I (Client Name) do hereby authorize **Anita K. Morris, LMFT** permission to release a copy of my mental health information to the person or facility below:

Name of person/facility to receive medical information:
Phone:
Address:
Date of Authorization:

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request*):

☐ My entire mental health record

☐ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other: _____

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Purpose of Information Release:

- ◯ **Further mental health care**
- ◯ **Applying for insurance**
- ◯ **At the request of the individual**
- ◯ **Payment of insurance claim**
- ◯ **Legal investigation**
- ◯ **Vocational rehab, evaluation**
- ◯ **Disability determination**
- ◯ **Other (specify): _____**

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name:

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is (please check all that apply):
minor (client is under the legal age of consent) ☐ incompetent ☐ disabled ☐ deceased

Legal authority (please check all that apply):
☐ parent ☐ legal guardian ☐ representative of deceased

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Client Copy

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such an authorization must be separate from an authorization to release other medical records.

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Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____
_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

11. What significant life changes or stressful events have you experienced recently? _____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

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Please check "yes" or "no" for each item listed

	yes	no	List Family Member
Alcohol/Substance Abuse	☐	☐	_____
Anxiety	☐	☐	_____
Depression	☐	☐	_____
Domestic Violence	☐	☐	_____
Eating Disorders	☐	☐	_____
Obesity	☐	☐	_____
Obsessive Compulsive Behavior	☐	☐	_____
Schizophrenia	☐	☐	_____
Suicide Attempts	☐	☐	_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____
_____

3. What do you consider to be some of your strengths? _____
_____
_____
_____

4. What do you consider to be some of your weaknesses? _____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy? _____
_____
_____