SAMPLE FORM
(Therapist Name)
Sugarloaf Counseling and Psychotherapy Associates
18 Executive Park Court
Germantown, MD 20874
e-mail: (Therapist Name)@sugarloafcounseling.com
Telephone: 301-428-3557
Fax: 301-972-6635
https://sugarloafcounseling.com

HOW TO USE THESE FORMS - Orientation to the forms packet for new clients

Welcome to our practice. To get necessary information about you and to comply with federal privacy regulations, we must ask you to read and sign a series of forms in this packet. This page lists those forms and what we are asking you to do with them. If you have questions about any of this, you can email me or ask me when we are meeting for our first session. The forms are in the following order:

1. Personal Information Form, which has several pages of personal contact and insurance/billing information. **Please complete this form and return it to me**.

2. Policies and Procedures form, which explains our policies about privacy, payment, appointments, and treatment. **Please keep a copy of this form for yourself and send me a signed copy.**

3. Medical History form. **Please complete that and return it to me**. Two copies are provided in case more than one person will be participating in treatment.

4. Informed Consent for Teletherapy. This form covers the policies and procedures we use when conducting telehealth sessions**. Please sign and return this form.**

5. Notice of Privacy Practices. This form describes your Privacy Rights under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). **This is yours to keep.**

6. Acknowledgement of Receipt of Notice of Privacy Practices. This form documents that you were given a copy of the Notice of Privacy Practices. **Please sign this and return it to me.**

7. Credit Card/Debit Card form. This will be used to pay for your copayments and other charges, if any, with our practice. This form will permit us to charge your Mastercard or Visa, including a Flexible Spending Account or Health Savings Account. **Please sign this and return it to me.**

8. The Authorization for Exchange of Information form is **optional** and is only necessary for you to complete if you wish me to speak with someone on your behalf regarding your treatment (i.e.: a physician, psychiatrist, therapist, family member, etc.). If you complete this form, please indicate the name and phone number, email address and fax number of the person with whom you wish me to have contact. **Please complete this if you choose and return it to me**.

   Thank you.

(Therapist Name)
Sugarloaf Counseling and Psychotherapy Associates
18 Executive Park Court
Germantown, MD 20874
Phone: 301-428-3557 Fax: 301-972-6635
e-mail: (Therapist Name) @sugarloafcounseling.com

PERSONAL INFORMATION Date: _____

Name_____

Age_____ Date of Birth _____

Gender (as listed with your insurance): M____F___

(If your gender identity is different than what is listed with your insurance, please specify: _____)

How did you hear about our service? _____

Home Address_____City_____Zip_____

Home Phone _____ Mobile Phone _____

May we contact you at home? By phone? Yes No By mail? Yes No

On your mobile phone? Yes No

Employer/School_____

Work/School Address_____

Work phone: (_____)_____

May we contact you at work? By phone? Yes No By mail? Yes No

E-mail address_____

Emergency Contact - name & number: _____

If the client is under age l8, or if a spouse/partner will be involved in therapy, please provide the following information on the parent/spouse/partner:

Family Member's Employer: _____

Work Address_____

Work Phone (_____) _____ Cell (_____)_____

May we contact you at work? By phone? Yes No By Mail? Yes No

Continued next page….

Other Household Members

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children Living Outside Home

Name	Age	Name	Age
_____	_____	_____	_____

Financially Responsible Party (complete this section if patient is a minor or is not responsible for payment):

Name: First_____ Last_____ MI_____

Date of birth_____

Address_____City_____Zip_____

Employer: _____

Telephone: (Home) _____ Work_____

Insurance Information:

(Complete this section if you will be using any health Insurance plan as part of your payment for services):

Insurance Co. Name_____

Insurance Co. Policy Number_____

Insurance Group, Payer, or Plan Number (or name) _____

Insurance Company's Benefits Phone Number_____

Insurance Co. Address (if on your card) _____

Client's relationship to Insured: _____Self _____Spouse _____Child _____Other

(Continued on next page)

Signature on File & Authorization of Benefits Statement

I am the client or a person responsible for the client. I authorize the use of this form on all my insurance submissions for services from this practitioner, (Therapist Name). I authorize the release of medical or other information to my insurance company. I understand that I am responsible for my bill. I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies. I authorize payment of medical benefits directly to my therapist. I permit a copy of this authorization to be used in place of the original. I have read and understand this agreement.

Signature_____ Date_____

(If you are a parent, or otherwise acting on behalf of the client, state your relationship:

_____)

(*If you have secondary insurance, complete the following section):*

Insurance Co. Name_____

Insurance Co. Policy Number_____

Insurance Group, Payer, or Plan Number (or name) _____

Insurance Company's Benefits Phone Number_____

Insurance Co. Address (if on your card) _____

Client's relationship to Insured: _____Self _____Spouse _____Child _____Other

Signature on File & Authorization of Benefits Statement

I am the client or a person responsible for the client. I authorize the use of this form on all my insurance submissions for services from this practitioner, (Therapist Name). I authorize the release of medical or other information to my insurance company. I understand that I am responsible for my bill. I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies. I authorize payment of medical benefits directly to my therapist. I permit a copy of this authorization to be used in place of the original. I have read and understand this agreement.

Signature_____ Date_____

(If you are a parent, or otherwise acting on behalf of the client, please state your relationship:

_____)

(Therapist Name)
18 Executive Park Court
Germantown, MD 20874
Phone: 301-428-3557 Fax: 301-972-6635
e-mail: (Therapist Name)@sugarloafcounseling.com

OFFICE POLICIES AND PROCEDURES

Welcome! I want to make your visits for therapy a helpful experience for you. I believe open communication and clear agreements will facilitate this. This memo contains the key administrative guidelines and agreements regarding your therapy.

Missed Appointments and Cancellations: Since a specific time is reserved for you, **there will be a charge for all missed appointments unless they are canceled at least 24 hours in advance.**

---- If an appointment is **canceled with less than 24 hours notice, but with notice given to me before the appointment time, a Late Cancellation charge of $50 will apply.** This charge reflects the fact that, while giving me some notice does free me to do other things during the meeting time (paperwork, phone calls, etc.), I can't realistically make the time available to another client on such short notice.

--- **If you miss an appointment without giving <u>any</u> prior notice at all, you will be charged the full normal fee for the session ($150).** Since your insurance company cannot be billed for missed appointments, the entire fee will be your responsibility. Exceptions, which may be made for emergencies, are at my discretion.

---Repeated late cancellations or missed appointments may be cause for the termination of treatment.

Confidentiality / Release of Information: Maryland law recognizes that the clinical social worker - client communication is privileged and, as such, any information concerning your treatment can only be released with your written consent. There are also federal laws regarding the privacy of your health information, which we cover in a separate document you received from me. I take your privacy seriously and will not violate legal or professional standards of confidentiality.

There are some exceptional circumstances in which I am legally required to disregard the treatment confidentiality and to contact authorities or to testify in court without my client's consent. Specifically, in cases regarding child abuse or child neglect, I may be legally required to contact the Child Protection Authorities or to testify in court. In cases where an elderly or disabled adult may be being abused or neglected, I am legally required to contact the Adult Protective Services. I may also be required to violate confidentiality, if I believe that my notifying authorities will prevent someone from committing a serious violent crime.

For parents of minors: you have the right to information concerning your child in therapy, except where otherwise stated by law. Please know that this therapist believes in providing a minor child with a private environment in which to disclose him/her self to facilitate therapy. You are therefore giving permission to this therapist to use my discretion, in accordance with professional ethics and law, in deciding what information revealed by your child will be shared with you. I will inform you of any risk to your child with which you can help.

Continued next page….

Confidentiality / Release of Information (continued)

If you use your health insurance to pay for part of the cost of therapy, your signature on the insurance claim form gives me permission to provide clinical information to the insurance company, and the insurance company will have the right to access your treatment records.

There may be occasions where – at your request or at my suggestion – you will authorize me to discuss your treatment with another professional involved in your care. I will have you sign a document authorizing this exchange of information in these situations. If we are doing family therapy (including family work with a couple), I will need permission from all the adults involved in the therapy to release clinical information about the treatment, or to release records, if the information or the records released contain details on other family members who participated in treatment.

When we use the internet to store or transmit data about your treatment (for example, with our electronic billing provider, or in email communications), we specifically use systems that meet high security standards, and which comply with the Health Insurance Portability and Accountability Act (HIPAA). We have experienced no breaches of information with the systems and providers we use. However, no system is entirely secure, and I cannot absolutely guarantee the privacy of your information. On social media platforms (Facebook, etc.) it is my policy to not interact with current or former therapy clients.

Photocopies of your records are available to you on your written request, subject to fees authorized by state law.

Please feel free to raise any questions or concerns you have about the privacy of your treatment.

Fees and Payments:

Unless otherwise agreed upon, fees are due and payable at the time of the session.

The usual fee for a psychotherapy session is **$150**. Sessions are typically 45 minutes long. Members of some insurance plans, HMOs and PPOs may have lower fees based on contracts between your insurance company and myself. Any other fee adjustments, exceptions, or extended payment plans must be negotiated with me in advance.

Returned checks will be subject to a $30 administrative fee. Accounts behind in payment by more than 60 days may be referred to a collection agency; if I do have to use a collection agency or attorney to collect fees due me, you agree to pay the attorney and court costs.

Extended telephone and email consultations, and written reports, are not covered services under health insurance, and these will be subject to separate charges based on the time required, measured as a pro-rata share of our standard $150/session fee. Court appearances or depositions, if necessary, are charged to you at a higher rate: $300/hour, including preparation, travel, and waiting time. We may require an advance retainer for court-related fees.

Continued next page…

Methods of Therapy - Informed Consent - Insurance Limitations on Treatment

The therapy methods that I will be using are generally accepted professional practices. The specific therapy approach and techniques used with you will be chosen to best meet your needs and situation; feel free to ask me any questions you have about treatment methods, alternative techniques that would be available, and the risks and benefits of therapy approaches.

If you are using a health insurance plan to pay for part of the cost of therapy, the insurance company has the right to authorize, or not authorize, insurance coverage for therapy based on their own contracts and criteria. Services not covered by your insurance plan are your financial responsibility. Telehealth is normally covered by insurance plans, but if it is not covered by your plan, it will be considered a non-covered service to be paid by you.

How to Contact Me - routine and emergency situations:

Please either email me (therapist.name@sugarloafcounseling.com) or call my office (301-428-3557) and leave me a message on the voice mail. I don't answer the phone or pages when I'm in session, but I check my messages often and will get back to you as soon as possible.

If it's an urgent situation **and it's late at night or on the weekend,** you may also contact me by following the prompts in my outgoing voicemail message.

As an individual clinician specializing in outpatient psychotherapy, I can't promise to be immediately accessible at all times. While I'll return urgent calls as promptly as I can, if you are in a life-threatening emotional or behavioral emergency and you cannot reach me quickly, go to the nearest hospital emergency room, where a mental health professional will be able to evaluate the situation and help you. (Montgomery County residents can also call the County Crisis Center at 240-777-4000. The National Suicide and Crisis Hotline Number is 988)

If I'm on vacation or otherwise unavailable to return calls, my office voice mail will direct you to a backup professional colleague.

<u>Statement of understanding regarding office policies and procedures:</u>

I have read Office Policies and Procedures of ((Therapist Name)). I understand them and agree that they will be in effect during my treatment with ((Therapist Name)).

Signature_____ Date_____

Please Print Name_____

If there will be more than one adult participating in the therapy, the other adult should sign here:

I have read Office Policies and Procedures of (Therapist Name). I understand them and agree that they will be in effect during my treatment with (Therapist Name).

Signature_____ Date_____

Please Print Name_____

Please sign this form; keep a copy and return it to (Therapist Name) for his/her files. Thank you.

MEDICAL HISTORY

Please print (Fill out separate medical history sheet for each person)

Date: _____

Name: _____

Currently under doctor's care: Yes No

Name of doctor(s) involved in your care

Health problems (including allergies): _____

Medication currently used: None_____ (check if none)

Medication	Dosage	Doctor prescribing	Why prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous counseling or chemical dependency services: None_____(check if none)

Date(s)	Facility/Therapist	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past hospitalizations- Medical, psychiatric, chemical dependency: None_____(check if none)

Date(s)	Reason(s)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

Please print (Fill out separate medical history sheet for each person)

Date:_____

Name:_____

Currently under doctor's care: Yes No

Name of doctor(s) involved in your care

Health problems (including allergies): _____

Medication currently used: None ____ (check if none)

Medication	Dosage	Doctor prescribing	Why prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous counseling or chemical dependency services None_____(check if none)

Date(s)	Facility/Therapist	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past hospitalizations- Medical, psychiatric, chemical dependency: None_____(check if none)

Date(s)	Reason(s)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Therapist Name)
18 Executive Park Court
Germantown, MD 20874
Phone: 301-428-3557 Fax: 301-972-6635
e-mail: (Therapist Name)@sugarloafcounseling.com

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the Internet or the telephone. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone sessions. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is practicing social distancing during a health crisis, for convenience in attending sessions, or for other reasons. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks. For example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. (In some cases, clients have participated in teletherapy from their car, to ensure privacy).

- Issues related to technology. There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. If we are meeting online and you are using a computer, it is advised to keep a cell phone nearby, so we can stay in contact if the computer video connection fails.

- Crisis management and intervention. If you are currently in a crisis situation requiring high levels of support and intervention, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

Continued next page…

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our teletherapy. The teletherapy technologies that I use are secure and meet Federal standards for privacy under the HIPAA legislation. The nature of electronic communications technologies is such that I cannot absolutely guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will use updated methods (secured networks, password-protection, etc.) to keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy).

The extent of confidentiality and the exceptions to confidentiality that I outlined in the Policies and Procedures agreement still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

Legal Requirement for Location
Due to State laws, you must be physically located in one of the states where I am licensed to practice telehealth (name states here) at the time of our session. If you will be in another state, we will need to cancel the appointment, and a minimum of 24 hours' notice is required to avoid any late cancellation fees.

Records
The teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general Policies and Procedures agreement that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Client Date

(Signature or typed name)

Therapist Date

Please keep a copy of this form for yourself and return the other to (Therapist Name). Thank you.

(Therapist Name)

18 Executive Park Court, Germantown MD 20874

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice will tell you about how we handle information about you. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. We are also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For more information about my privacy practices, or for additional copies of this Notice, please let me know your questions as soon as they arise.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

What we mean by your medical information: Each time you visit us or any doctor's office, hospital, clinic, or any other "healthcare provider", information is collected about you and your physical and mental health. It may be information about your past, present or future health or conditions, or the treatment or other services you got from us or from others, or about payment for healthcare. The information we collect from you is called, in the law, PHI, which stands for Protected Health Information. This information goes into your medical or healthcare record or file. We use this information for many purposes. For example, we may use it:

--To plan your care and treatment.

--To decide how well our treatments are working for you.

--When we talk with other healthcare professionals who are also treating you such as your family doctor or the professional who referred you to us.

--To show that you actually received the services from us, which we billed to you or to your health insurance company.

--For teaching and training other healthcare professionals.

--For medical or psychological research.

--For public health officials trying to improve health care in this country

--To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Continued next page…

A. Uses and Disclosures Requiring Your Written Authorization.

1. Coordination of Care with Other Professionals. It may be in your best interest for me to disclose your PHI to other professionals involved in your health care. This would include communications with your medical doctors, other therapists or clinical social workers treating you, or other professionals involved in your care. You may revoke your authorization at any time by providing me with written notification of such revocation. I will not communicate with other professionals involved in your care without your written authorization, except in certain emergency situations (described below).

. **2. Other Uses and Disclosures.** Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company or to your attorney. You may revoke your authorization at any time by providing me with written notification of such revocation.

B. Permissible Uses and Disclosures Without Your Written Authorization. I may use and disclose your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

1. Treatment. I use your medical information to provide you with mental health treatment or services. These might include individual, family, or group counseling or therapy, assessment services, treatment planning, or measuring the effects of my services.

2. Payment: I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

3. Health Care Operations: I may use and disclose your PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For, example, I may disclose disguised information about our work for training purposes.

Continued next page…

4. Required or Permitted by Law: I may use or disclose your PHI when I am required to do so by law. For example:

1. When there is a *serious* threat to *your* health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.

2. When required by law in legal proceedings. Maryland law recognizes that the clinical social worker-client communication is privileged, and almost all releases of information to a court or lawyer will require your consent. In certain cases regarding the safety of a child or vulnerable adult, a judge can order me to testify without your agreement.

C. Permissible Uses and Disclosures That May Be Made Without My Authorization, But For Which You Have An Opportunity to Object.

1. Family and Other Persons Involved in Your Care. I may use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) your personal representative, or another person responsible for your care, location, general condition, or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. I will also use my professional judgment and my experience to make reasonable inferences of your best interest in allowing another person access to your PHI regarding your treatment with me.

2. **Disaster Relief Efforts.** I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

D. Psychotherapy Notes. I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as permitted by law.

II. MY INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Continued next page…

C. Right to Request Restrictions. You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to **(Therapist Name), 18 Executive Park Court, Germantown MD 20874 or (Therapist Name)@sugarloafcounseling.com** I am not required to agree to any such restriction you may request, except if your request is to restrict disclosing your PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and should explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to **(Therapist Name), 18 Executive Park Court, Germantown, MD 20874** at any time.

G. Right to Receive Notification of a Breach. I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

H. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at **(Therapist Name), 301-428-3557.** You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on September 23, 2013.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I make any material change to this Notice, I will post it on my website, sugarloafcounseling.com, or I will provide you with a paper or electronic copy. You may also obtain any revised notice by asking me directly.

(Therapist Name)

18 Executive Park Court, Germantown MD 20874

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the **Notice of Privacy Practices**.

Printed name of client

_____

Signature of client

_____

Date_____

_____

Signature of (Therapist Name) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation or time constraints prevented us from obtaining acknowledgement; will attempt to obtain acknowledgement at a future meeting
- ☐ Other (Please Specify)

_____

_____

This form will be retained in your medical record

CREDIT / DEBIT CARD AUTHORIZATION

I agree to allow for all payments and insurance copayments, missed appointment and late cancellation fees, and miscellaneous fees for letters and records to be billed to my credit card. This card number will be kept on record, and any unpaid balances will automatically be paid by this card without prior notification.

Card Name (**circle one:**) VISA MASTERCARD

Name of cardholder:

_____

Credit/Debit Card Number:

_____

Expiration Date:

_____/_____

Three-Digit Security Code:_____ Credit or Debit?_____

(note: HSA and FSA cards are debit cards)

Billing Address for Card (Street Number and Zip Code where you receive bill):

_____

I authorize my card account to pay fees due to (Therapist Name):

Signature: _____

Print Name:_____ Date_____

(Please note that credit/debit card charges will appear on your card statement as paid to Sugarloaf Counseling & Psychotherapy Associates)

A receipt will be emailed to you whenever your card is charged. (We will use the email address you gave on the Personal Information page),

(Therapist Name)

Sugarloaf Counseling and Psychotherapy Associates

18 Executive Park Court
Germantown, MD 20874
e-mail: (Therapist Name) @sugarloafcounseling.com
Telephone: 301-428-3557
Fax: 301-972-6635
https://sugarloafcounseling.com

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Re: _____

Date of birth: _____

I give permission for, and request, the exchange of professional information between (Therapist Name), and the individuals/agencies named below. This authorization includes all information available in my clinical record, unless specifically excluded below.

Information Exchange Authorized with: (include contact information – including email, phone, and fax number, if possible,)

_____

Limitations or exclusions of information to be disclosed:

(Specify_____)

This authorization expires one year after the end of treatment, unless otherwise noted, and I have the right to revoke this authorization at any time either in writing or verbally.

I understand that if the person or agency that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by those regulations.

Signature_____Date_____

(If parent or guardian, state relationship: