TEEN INFORMED CONSENT FOR THERAPY SERVICES

Welcome to Flagstaff Counseling Center. These documents contain important information about our professional services and business policies. Please read them carefully and jot down any questions you might have so that you can discuss them with your therapist at your next meeting. When you sign these document, they will represent an agreement between you and your therapist.

THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you hope to address. There are many different methods your therapist may use to deal with those problems. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you and your therapist talk about both during your sessions and at home. Your participation in therapy is voluntary and can be terminated by you at any time.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees as to what you will experience.

Your first couple of sessions will involve an evaluation of your needs. Through this evaluation, your therapist will be able to offer you some first impressions of what your therapy will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. At the end of this evaluation, your therapist will notify you if they believe that they are not the right therapist for you and, if so, they will give you referrals to other therapists whom they believe are better suited to help you.

THERAPY SESSIONS

Your therapist will normally conduct an intake evaluation that will last 45 to 55 minutes. During this time, you can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If you agree to begin psychotherapy, then you will discuss how often you will meet for regular therapy sessions. Sessions typically last 45 to 55 minutes.

CONFIDENTIALITY FOR TEENS

Parent Authorization for Teen's Mental Health Treatment

In order to authorize mental health treatment for your teenager, you must have either sole or joint legal custody of your teen. If you are separated or divorced from the other parent of your teen, please inform the therapist of this when you call to establish services. Your teen's therapist will ask you to provide a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your teen.

If you are separated or divorced from the teen's other parent, please be aware that if both parents are guardians or have joint legal decision making, both will need to provide written consent authorizing therapy for the teen. Your teen's therapist believes it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their teen is receiving mental health evaluation or treatment.

Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, your teen's therapist will honor that decision, unless there are extraordinary circumstances.

Parent/Guardian/Family Communications with Therapist

In the course of the treatment of your child, your teen's therapist may meet with the teen's parents/guardians either separately or together. If your teen's therapist meets with you or other family members in the course of your teen's treatment, they will make notes of that meeting in your teen's medical records. Please be aware that those notes will be available to both parents or entities that have legal access to your teen's medical record. In family therapy, all adult clients in the therapy shall have full access to the complete clinical file.

Mandatory Disclosures of Treatment Information

In some situations, your teen's therapist is required by law or by the guidelines of their profession to disclose information, whether or not they have your or your teen's permission. We have listed some of these situations below.

Confidentiality cannot be maintained when:

- Teenagers tell their therapist that they plan to cause serious harm or death to themselves, and the therapist believes they have the intent and ability to carry out this threat in the very near future. The therapist must take steps to inform a parent or guardian or others of what the teen has told them, how serious they believe this threat to be, and to try to prevent the occurrence of such harm.
- Teens tell their therapist that they plan to cause serious harm or death to someone else, and they believe they have the intent and ability to carry out this threat in the very near future. In this situation, the therapist must inform a parent or guardian or others, and they may be required to inform the person who is the target of the threatened harm and the police.
- Teens are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, the therapist will need to use their professional judgment to decide whether a parent or guardian should be informed.
- Teens tell their therapist, or the therapist otherwise learns that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, the therapist is mandated by law to report the alleged abuse to the Arizona Department of Child Safety.
- There has been sexual contact between an adult and a minor.
- The therapist is ordered by a court to disclose information.

Privacy for Teen Clients

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for teens to have a "zone of privacy" where teens feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

Parent/Guardian Agreement Not to Use Teen's Therapy Information/Medical Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for teens. Although your teen's therapist's responsibility to your teen may require them helping to address conflicts between the teen's parents, their role will be strictly limited to providing treatment to your teen. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena therapy records or ask your teen's therapist to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing their opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring testimony from your teen's therapist, even though they will not do so unless legally compelled. If they are required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, your teen's therapist will provide information as needed, if appropriate releases are signed or a court order is provided, but they will not make any recommendation about the final decision(s). Furthermore, if your teen's therapist is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for their participation agrees to reimburse the therapist at the rate of $390 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

PROFESSIONAL FEES

Your therapist accepts some insurance, some Employee Assistance Programs and self-pay. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of your therapist. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for any professional time your therapist spends on your legal matter, even if the request comes from another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you agree otherwise or unless you have insurance coverage that requires another arrangement. Payment can be made in person with cash, check or credit card. Payment can also be made online at **www.flagcounseling.com**

Payment schedules for other professional services will be agreed to when such services are requested.

Our office has a policy of charging **$50.00** for missed appointments or appointments that are cancelled with less than 24 hours' notice. This fee will be waived if you and your therapist agree that your missed appointment was due to circumstances beyond your control.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your therapist has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information your therapist will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

Parent/Guardian Signature _____ Date_____

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers. You (not your insurance company) are responsible for full payment of all fees.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your insurance company. Of course, your therapist will provide you with whatever information they can based on their experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, your therapist may be willing to call the insurance company on your behalf to obtain clarification.

You should also be aware that most insurance companies require that your therapist provide them with your clinical diagnosis. Sometimes your therapist has to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, your therapist has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your therapist will provide you with a copy of any records they submit, if you request it. ***You understand that, by using your insurance, you authorize your therapist to release such information to your insurance company. Your therapist will try to keep that information limited to the minimum necessary.***

ELECTRONIC COMMUNICATIONS POLICY

The use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

Email Communications

Therapists at FCC use email communication only with your permission and only for administrative purposes unless we have

made another agreement. That means that email exchanges with our office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email your therapist about clinical matters because email is not a secure way of contact, unless you have made a prior agreement with your therapist to discuss clinical matters via email. If you need to discuss a clinical matter with your therapist, please feel free to call your therapist directly so you can discuss it on the phone or wait so it can be discussed during your therapy session. The telephone or face-to-face is simply a much more secure mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, Therapists at FCC do not text message to nor do we respond to text messages from anyone in treatment with us. So, please do not text message us unless we have made other arrangements.

Social Media

Therapists at FCC do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if your therapist discovers that they have accidentally established an online relationship with you, they will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

EMAIL NOTIFICATIONS FOR APPOINTMENT DATES AND TIMES

You have the option to be notified via email as to your appointment times and dates. Flagstaff Counseling Center will maintain your Protected Health Information on a secure and encrypted system. Please note that by electing to receive appointment reminders via email, Flagstaff Counseling Center does not become responsible for maintaining, deleting, encrypting, or otherwise securing your email account or your appointment reminder once it has been transmitted to your individual email account.

_____*Yes, I would like to receive email notifications reminding me of my child's appointment dates and times.*

Please send my appointment reminders to this email address: _____

_____*No, I decline receiving email reminders for my appointments.*

CONTACTING YOUR THERAPIST

Your therapist will not often be immediately available by telephone. Though your therapist is usually in the office during normal business hours they will not answer the phone when with a client. Your therapist will make every effort to return your call within one business day of the day you call, with the exception of weekends and holidays. If you are unable to reach your therapist and feel that you are in crisis and cannot wait for a return call, please call **TERROS Mobile Crisis at 1-877-756-4090**. If you are experiencing a life-threatening emergency, call 911 or go to the nearest hospital Emergency Department. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Flagstaff Counseling Center
408 N. Kendrick, Suite 4
Flagstaff, AZ 86001
(928) 774-6364 Phone (928) 556-0504 Fax

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) for Protecting Client Behavioral Health Information

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

I. Uses and Disclosures of your health information

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes without your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your medical record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - – Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - – Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. This does not apply to EAP billing.
  - – Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within FCC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of FCC such as releasing, transferring, or providing access to information about you to other parties.

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.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following limited circumstances:

- Child Abuse – We are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- Adult and Domestic Abuse – If we have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If various Arizona Boards overseeing mental health services are conducting an investigation, then we are required to disclose PHI upon receipt of a request for medical records from a Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Deceased Clients—We may disclose PHI regarding deceased clients as mandated by state law. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate.
- Medical Emergencies—We may disclose your PHI in a medical emergency to medical personnel in order to prevent serious harm.
- Family Members involved in your care--We may disclose information to family members directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- Law Enforcement—We may disclose PHI to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime or decease 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 US 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.
- Research—PHI may only be disclosed after a special approval process.
- Serious Threat to Health or Safety – If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation – We may disclose PHI as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Client's Rights

Client's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request unless the request is to restrict disclosure of PHI to a health plan for purposed 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 Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a paper or electronic copy (or both) of PHI in our mental health and billing records, and any other records used to make decisions about you, for as long as the PHI is maintained in the medical record. We may deny your access to PHI only where there is compelling evidence that access would cause serious harm to you.
  On your request, we will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the medical record. We may deny your request. You have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement.
- Right to an Accounting of Disclosures– You generally have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.
- Breach notification – If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your medical records, you may contact this office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW Washington, DC 20201. We will not retaliate against you for filing a complaint.

VI. Changes to Privacy Policy

- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a copy of the revised practices by posting a copy on our website or providing one to you at your next appointment.

_____ _____

Signature Date

TEEN CLIENT INFORMATION FORM

CLIENT INFORMATION
Name________________________________ Date __________ Date of birth___________
First MI Last
Address____ Phone #___________________________
City___________________________________State_________ Zip__________
School_______________________________ Grade_____
Child lives with: ____Both Parents ____ Parent & Stepparent or Partner
____Single Parent ____ Other Relative
____Shared Parenting ____ Other

PARENT/ PARTNER / LEGAL GUARDIAN
Name________________________________ Relationship to teen_________Date of birth ___________
First MI Last
Cell #________________ Home # _________________ Work #__________________
Address _________________________ City_____________ State__________ Zip Code______________
Education Level__________________ Employer_____________________
Occupation______________________

PARENT/ PARTNER / LEGAL GUARDIAN
Name________________________________ Relationship to teen_________Date of birth ___________
First MI Last
Cell #________________ Home # _________________ Work #__________________
Address _________________________ City_____________ State__________ Zip Code______________
Education Level__________________ Employer_____________________
Occupation______________________

PARENT/ PARTNER / LEGAL GUARDIAN
Name________________________________ Relationship to teen_________Date of birth ___________
First MI Last
Cell #________________ Home # _________________ Work #__________________
Address _________________________ City_____________ State__________ Zip Code______________
Education Level__________________ Employer_____________________
Occupation______________________

Who is the teen's legal guardian?___________________________________
Emergency contact person ______________________________________ Phone #___________________
Relationship to teen_______________________

FINANCIALLY RESPONSIBLE PARTY
☐ Employee Assistance Program ☐ Insurance ☐ Self-Pay

EAP Information
Name of Employee______________________________Date of Birth_________ Work # ______________
Address_________________________________ City_______________ State_____ Zip_______________
Employer_______________________________ Years at the company _____
Who referred you or your family member? ______________________
Has the EAP benefit been used by you or a family member this year? ____Yes ____No
Insurance Information
Name of insured________________________Address ______________________Date of birth________

Insurance name_____
ID #_____ Group # _____ Effective date _____
Deductible amount _____ Co-pay amount _____
How is the child related to the insured? _____

OTHER FAMILY MEMBERS

Name: (First, MI, Last)	Relationship to client	Sex	DOB	Age	Grade	School

Please indicate P = past C = current

___Prenatal difficulties
___Problems during delivery
___Maternal substance use or illness during pregnancy
___Toilet training
___Motor development/coordination
___Language, (speech, communication)
___Growth (height, weight)
___Socialization
___Sleep
___Eating
___Sexual development/puberty

___Seizures, fainting, neurological prob.
___Physical impairments
___Visual or hearing impairments
___Chronic health problems
___Hospitalizations, surgeries
___Serious illnesses
___Head injuries
___Other serious physical injuries
___Allergies
___Other_____

___Physical abuse or neglect
___Emotional, verbal, sexual abuse
___Lack of stability, excessive disruptions
___Substance abuse in the family
___Family employment problems

___Separation, divorce
___Significant loss, death
___Poor family communication
___Family violence
___Family legal problems

___Running away
___Sleep problems
___Excessive fears, phobias
___Anxious, worried, fretful
___Nightmares, bad dreams

___Aggressive, bullying
___Overly sensitive, cries easily
___Problems getting along with peers
___Inappropriate sexual behavior
___Lack of motivation or interest

___School behavioral problems (fighting, truancy, discipline)
___Defiant, hostile, resistant, rebellious
___Gang association, other undesirable associations
___Cheating, lying, stealing, vandalism
___Lack of foresight, judgement
___Fidgety, restless, overexcited
___Problems with attention, concentration, memory
___Difficulty understanding / following directions

___Moody, irritable
___Weight loss/weight gain
___Excessively timid, shy, dependant
___Excessive daydreaming, spacing out
___Few or no friends
___Difficulty completing tasks
___Excessively self-critical
___Withdrawn, isolates

___Learning difficulties, poor grades
___Low frustration level, impatient, tantrums
___Wets or soils self (clothing, bed)
___Perfectionist, compulsive behavior
___Suicidal talk, gestures, preoccupation with death
___Other_____

___Socially inappropriate or immature
___inability to distinguish fantasy, reality
___Unusual or bizarre thinking
___Alarming drawings / writings
___Cutting on self

Please indicate P = past C = current

USE OF ALCOHOL

___Not used by any family member
___Occasional use by _____
___Alcohol use interferes with family/job/school
___Husband/partner ___Wife/partner ___Child or adolescent (name) ___Other

Please indicate P = past C = current

USE OF DRUGS

___Not used by any family member
___Occasional use by _____
___Drug use interferes with family/job/school
___Husband/partner ___Wife/partner ___Child or adolescent (name) ___Other

Which drugs are used
___marijuana ___cocaine ___paint sniffing ___opiates ___prescription drugs
___other (specify)_____ ___don't know

Please indicate P = past C = current

FAMILY CONFLICT STRATEGY

___Conflicts rarely discussed
___Conflicts handled verbally

___Physical punishment used occasionally with children
___Physical or emotional abuse of children considered a problem
___Physical conflict between adults (hitting, pushing, etc.)
___Physical conflict has resulted in physical injuries or doctor visits
___Threatened or actual use of weapons (such as knives or guns etc.)

CURRENT MEDICATIONS

_____
_____
_____

PAST MENTAL HEALTH TREATMENT

_____
_____
_____

BRIEF STATEMENT OF THE PROBLEM

_____
_____
_____

ADDITIONAL INFORMATION

_____
_____
_____

YOU ONLY NEED TO COMPLETE THIS FORM IF YOU WOULD LIKE YOUR THERAPIST TO CONSULT WITH YOUR PHYSICIAN OR PSYCHIATRIST

Flagstaff Counseling Center
408 N. Kendrick, Suite 4
Flagstaff, AZ 86001
(928) 774-6364 Phone
(928) 556-0504 Fax

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PHYSICIAN

Client Name_____ DOB_____

I hereby authorize the release of the medical information listed below which pertains to my history, mental or physical condition, or treatment including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my physician:

_____
Physician Name

_____
Address

_____
Phone Number

I understand that the release of this information is to permit my physician to monitor my health status and to coordinate care. This authorization becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request. I understand that my therapist may not condition therapy services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of Client or Legal Guardian Date

Dear Dr. _____,

In order to coordinate care, I wish to inform you that your patient _____ was referred to me for treatment on _____.

Presenting problems: _____
_____
_____

Diagnosis: _____

Treatment Plan: _____
_____

Additional Comments: _____
_____
_____

_____ _____
Therapist's Name Signature