**New Day Family Counseling**

*Stephanie Walsh, M.S., LPC*

**Client Registration**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer or School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message at the following? (Please circle yes or no)

Home: Yes No Work: Yes No Cell: Yes No Email: Yes No

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

***Please do not cancel appointments by email. You must call me directly at (281) 301-1843.***

If you would like to use a mailing address other than your home address for billing and correspondence,

please provide that here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about New Day Family Counseling? (Please circle all that apply)

Church: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend Spouse Work Relative Internet Seminar

Insurance Brochure Minister/Priest Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION (If Applicable)**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone Number to Verify Coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, (CLIENT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize

Family Help Counseling and Seminars to disclose diagnostic information to the above insurance company.

(Signed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This disclosure of information authorized herein is required to verify insurance benefits. Such disclosure shall be limited to diagnostic information. I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and if not revoked, this consent shall continue from the date signed unless expressly revoked.*

*9/1/2016*

**New Day Family Counseling**

*Stephanie Walsh, M.S., LPC*

**Consent for Treatment Form**

I have been provided a copy of the New Day Family Counseling policies and procedures concerning:

* Informed consent for treatment
* Confidentiality
* Office procedures
* Financial policies
* Policies to protect the privacy of your health information

I have read and hereby agree to the policies and procedures as written, and I grant consent to Family Help Counseling and Seminars to contact me as specified and for the use and disclosure of my health information as described in those policies and procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client or Authorized Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

**Consent for Treatment**

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

*I hereby voluntarily consent to mental health counseling by my counselor. I have relied on my counselor for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.*

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor Consent**

As a parent, guardian, or managing conservator, I have provided the divorce decree or appropriate documentation if necessary to hereby authorize Family Help Counseling and Seminars to provide services for:

Minor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day Family Counseling**

*Stephanie Walsh, M.S., LPC*

**Informed Consent Policies**

I am honored that you have chosen New Day Family Counseling to assist you in your personal growth. I am committed to providing quality services to my clients and ensuring that you have the information necessary to make informed decisions about your treatment process. If you have any questions regarding anything on this form, please discuss them with me before signing.

**Philosophy**

New Day Family Counseling provides a professional and emotionally safe therapeutic environment. We welcome people of all ages and stages to learn practical, theoretically sound tools to better navigate relationship and individual challenges. Sensitivity, professionalism, and respect for human dignity are fundamental to addressing the spiritual and emotional needs of couples and families. We will respect the beliefs, whatever they may be, of all clients. We see people from many different faith traditions and believe that through creating authentic relationships individuals can integrate their beliefs into a healthier emotional and spiritual lifestyle.

**Counseling**

The relationship that exists between a counselor and a client is professional rather than social. Therefore, contact with your counselor will only take place in the provision of a professional service. In order to assist in the needs of you or your family, it may be necessary to refer you to other agencies or professionals. If so, we will assist you in facilitating these referrals. Your written consent is required to disclose any information about you or your family to individuals outside of New Day Family Counseling.

Counseling is an opportunity for healing and personal growth. We believe that individuals can possess the ability to do what is necessary to take an active role in this process. The length of time needed for counseling and the amount of intervention required varies with each individual. In order to receive the maximum benefits of counseling, your regular attendance and participation is imperative. In most cases, counseling is completely voluntary, and you can discuss ending your counseling relationship at any time. However, we recommend that, when possible, all counseling relationships be ended in an appropriate and therapeutic manner, generally requiring a final session to allow for closure.

During the counseling process, your counselor may recommend books for you to read, offer handouts, or use techniques to facilitate personal growth. We encourage you to discuss with your counselor any approach, technique, or practice with which you have questions, concerns, or need clarification. Counseling can be a difficult experience for some people. The disclosure of past hurts or current struggles can cause a temporary increase in depressive or anxious symptoms. If this occurs for you, please discuss the symptoms with your counselor.

**Confidentiality**

Confidentiality is described as keeping private the information shared between a client and his/her counselor. Counseling sessions are strictly confidential. Information regarding your counseling sessions will not be discussed without your permission. ***Please refer to the Notice of Privacy Policies and Practices that details under what circumstances confidentiality is limited.***

Participants who are in couples and or/family counseling and are, or become, involved in individual counseling will have discretion over their own information becoming part of a counseling session involving other family members. Individuals involved in group counseling are required to maintain the confidentiality of the other group members outside of the group sessions.

**Consent to Disclose Information**

At times, your counselor may need to consult with other professionals or agencies on your behalf. Your signed consent to disclose information to other agencies and/or individuals is required for that consultation to take place. Exceptions may include a subpoena by a court of law. If you have received or are currently receiving mental health services and/or psychotropic medications from another health care provider, we may request your consent to speak with those professionals and/or obtain copies of previous treatment records in order to coordinate your care. Providing treatment may depend upon our ability to communicate with these professionals.

***Please read the entire Notice of Privacy Policies and Practices relating to protected health care information and records, and the Health Insurance Portability & Accountability Act (HIPAA) law of 1996.***

**Appointments**

Counseling services are by appointment only. You are responsible for keeping your appointments and arriving on time. We retain the right to discontinue services if you have missed more than two consecutive appointments, if you do not pay your counseling fees in a timely manner, if you continually refuse to comply with treatment recommendations, if it is clear that you are receiving no benefits from counseling, if you exhibit abuse behavior, if you engage in criminal behavior on the premises, or if you knowingly violate the confidentiality of another client (e.g., in group settings).

***We cannot allow unattended minors in the waiting room.*** There are no nursery services available during counseling appointments. If you do not have child care arranged, please call to reschedule your appointment.

***Parents and/or guardians must remain in the waiting room during their child’s counseling session.***

**Communication and Emergency Services**

You can reach your counselor by calling the business number (281-301-1843). If I am unavailable or you have called after hours, you can leave a message. I will return your call at my earliest convenience. ***If you are in crisis and it is after hours, please call 911 or your nearest emergency room. You can also call the Tri-County 24-Hour Crisis Line: 800/659-6994.***

**New Day Family Counseling**

*Stephanie Walsh, M.S., LPC*

**Financial Policies**

**Your Responsibility**

You are financially responsible for the services we provide to you. You will need to use cash, credit card, zelle or HAS account the complete payment before each session starts. If you would like to pay in advance, please call my business number (281) 301-1843.

**Prior Balance**

Clients with a prior balance at the time services are obtained will be asked to pay the prior balance in full before being seen. If the balance cannot be paid, you must make payment arrangements with me prior to your appointment.

**Clients without Insurance**

We are pleased to be able to provide services to clients who do not have insurance, or who have an insurance that I do not accept. In those cases, the full fee will be charged. Clients with a non-accepted insurance may be able to submit the claim to their insurance company for reimbursement as an out of network provider.

**Methods of Payment**

We accept cash, check, VISA, MasterCard, and Discover, Zelle, and Health Savings Accounts. We do not accept post-dated checks, nor will we hold checks for any length of time. For auto charges, we maintain your credit card information in your file, but do not store it electronically.

**Returned Checks**

There will be a $25 fee assessed per check for any and all checks returned from the bank for any reason.

**Missed Appointments and No-Shows**

We see clients on an appointment basis and request that you call in advance so we can reserve time for you. We make every effort to honor all commitments and request that you extend the same courtesy to us be ***calling us 24 hours in advance if you are unable to keep your appointment***. **PLEASE CALL THE BUSINESS NUMBER TO CANCEL APPOINTMENTS. EMAIL IS NOT MONITORED FOR CANCELLATIONS.** We make reminder calls; however, it is ultimately the patient’s responsibility to track their appointments. You will be charged a full session fee of the current rate for late cancellation or not attending the appointment, as our office often cannot fill your allotted time. ***Insurance does not accept billing for late cancellations.***

**Minor Clients**

For all services rendered to minor clients, the adult accompanying the client is responsible for payment. Even if the parents are divorced, the parent that accompanies the minor is responsible for the payments, regardless of the custodial agreement. If the non-custodial parent is to accompany the minor, arrangements can be made for the custodial parent to pay for the session ahead of time.

**Information Change**

Please advise me of any address, phone number, or insurance changes promptly.

**Collection Procedures**

I am available to help you with questions regarding our fees and financial policies. Once made in writing, agreements are binding. We consider payment by the client for services rendered to be an important part of the client’s role in the client/counselor relationship. Prompt payment for services rendered is expected, and failure to comply or respond to communications from our office may result in discharge from the practice. Hence, unless prior arrangements are made, prior balances must be resolved before any counseling session.

**Fee Schedule**

Therapy sessions are for 45 minutes and charged as follows, unless your counselor is contracted as in-network with your insurance as stated previously.

Regular Counseling Fee: $145

Legal Testimony Fee: $300 per hour, Initial retainer will be collected before court appearance: $1,000

Family Consultation Fee: $165 per hour

**Legal Testimony:** Should I be ordered by the court to give my opinion in any personal cases you have, fees will be charged at the rate of $300, portal to portal. This includes, but is not limited to, all time involved for preparation, parking, mileage, travel time to and from court, time in court, and all other expenses involved in testifying. This fee will apply as well to depositions or interrogatories.

**Consultation:** Records review, consultation with clients, litigants, attorneys (in person, via phone, or by email), reports, waiting at court, or any other service provided will be charged at the rate of $150 per hour in 15-minute increments.

**Miscellaneous:** Charges for other professional services not related to legal testimony are prorated at the regular counseling fee per hour in 15-minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation includes travel time to and from the appointment.

***For legal testimony and miscellaneous paragraphs above, we are not able to bill insurance for these services.***

***I have read and understand the financial policy and fee schedule of Family Help Counseling and Seminars, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by mutual agreement.***

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day Family Counseling**

*Stephanie Walsh, M.S., LPC*

**Notice of Policies and Practices to Protect**

**the Privacy of Your Health Information**

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

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

New Day Family Counseling may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your general consent. To help clarify these terms, here are some definitions:

* “PHI” refers to information in your health record that could identify you.
* “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 your counselor consults with another health care provider, such as your family physician or mental health professional.
* “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.
* “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 New Day Family Counseling that utilizes information that identifies you.
* “Disclosure” applies to activities outside of New Day Family Counseling, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, and 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, and 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 regarding a private, group, joint, or family counseling session. 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, and 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 circumstances:

* **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
* **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
* **Sexual Misconduct by a Therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
* **Regulatory Oversight:** If a complaint is filed against me with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
* **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or 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.
* **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
* **Worker’s Compensation:** If you file a worker’s compensation claim, we may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.

**IV. Client’s Rights and Our Professional Duties**

**1. Client’s Rights**

* *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
* *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 seeking our services. Upon your request, we will send bills or other correspondence to another address.
* *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in your counselor’s mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
* *Right to Amend:* You have the right to an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
* *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorizations (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

**2. Our Professional Duties**

* We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
* We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
* If we revise our policies and practices, we will post a current copy in our offices. A current copy will always be available on our website and you may request a personal copy.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your record, or have other concerns about your privacy rights, you may contact me at (281-301-1843).

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to New Day Family Counseling, 26205 Oak Ridge Drive, Spring, Texas 77380.

You may also send a written complaint to the Texas Department of State Health Services, Investigations, PO Box 141369, Austin, Texas 73714-1369 or call (800) 942-5540

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on September 1, 2016. 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 revised notice in our lobby and on our web site. You may request a personal copy at any time.

**VII. Coordination of Care Between Health Care Providers and Release of Information**

Communication between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your counselor to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

**Patient Rights**

* You may end this authorization (permission to use or disclose information) any time by providing a written revocation request.
* If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on previous permission.
* You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
* You have a right to a copy of this signed authorization.
* If you choose not to agree with this request, your benefits or services will not be affected.

**Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified client. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request.

New Day Family Counseling (Stephanie Walsh, MS, LPC) is authorized to release protected health information related to the evaluation and treatment of:

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Other Mental/Behavioral Health Provider(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***Disclosure may include the following verbal or written information (check all that apply):***

\_\_\_\_\_ All Records

\_\_\_\_\_ Face Sheet

\_\_\_\_\_ History and Physical

\_\_\_\_\_ Laboratory/Diagnostic Testing Results

\_\_\_\_\_ School Information

\_\_\_\_\_ Discharge Summary

\_\_\_\_\_ Medication Records

\_\_\_\_\_ ER Record Report

\_\_\_\_\_ Psychological Evaluation/Testing Results

\_\_\_\_\_ Psychosocial Assessment

\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Behavioral Health/ Psychological Consult Notes

\_\_\_\_\_ Substance Abuse Treatment Record

\_\_\_\_\_ Summary of Treatment Records and Contact

\_\_\_\_\_ Other

\_\_\_\_\_ I hereby refuse to give authorization for any release of information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client, Parent, Guardian, or Authorized Representative Date

*(If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law, e.g., Power of attorney, Living Will, or Guardianship papers, etc.)*