Talking Solutions

# Anger Management & Counseling Center

 2020 Avalon Parkway Suite #185 talkingsolutionsamcc@yahoo.com

 McDonough, GA 30253 http://www.talkingsolutionsamcc.com

 678.833.1820 **PH**  678.833.1821 **FAX**

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

 Name: \_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_\_\_

FIRST MIDDLE INITIAL LAST DATE OF BIRTH AGE

 Gender:  Male  Female

 Marital Status:  Never Married  Domestic Relationship  Married  Separated  Divorced  Widowed

 Spouse/Partner: \_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_\_

FIRST MIDDLE INITIAL LAST DATE OF BIRTH AGE

 Please list any children/age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 STREET CITY ST ZIP

 Home Phone: (\_\_\_\_) \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Workplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 NAME OF COMPANY

 **Please check off contact number(s) where we may leave a message:**  HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

 E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s SSN#: \_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_

|  |
| --- |
| **ALTHOUGH WE HAVE YOUR INSURANCE CARD, THIS SECTION MUST BE FILLED OUT COMPLETELY IN ORDER TO PROPERLY BILL YOUR INSURANCE COMPANY.**INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER ID#: \_ \_\_\_\_ EMPLOYEE HOLDING INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_  DATE OF BIRTHEMPLOYEE SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATION TO CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ DO YOU HAVE MORE THAN ONE INSURANCE CARRIER?  Yes  No **IF YOU ARE COVERED UNDER TWO INSURANCE CARRIERS, WE MUST HAVE THE FOLLOWING INFORMATION:**SECONDARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME OF POLICY HOLDER: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MEMBER ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*\*\*IF WE DO NOT RECEIVE THIS INFORMATION, YOU WILL BE RESPONSIBLE FOR ANY ADDITIONAL PAYMENTS DUE. \*\*\*** |

 Medical Information: ***I would like information about my counseling disclosed to my doctor.***  Yes  No

 Name of Doctor: Name of Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Clinic Address: Phone: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

  No

  Yes, name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Yes, number of visits this past year: \_\_\_\_\_\_\_

 Are you currently taking any prescription medication?

  No

  Yes

 Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Have you ever been prescribed psychiatric medication?

  No

  Yes

 Please list and provide dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

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

 Poor Unsatisfactory Satisfactory Good Very good

 Please list any specific health problems you are currently experiencing:

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

1. How would you rate your current sleeping habits? (please circle)

 Poor Unsatisfactory Satisfactory Good Very good

 Please list any specific sleep problems you are currently experiencing:

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

1. How many times per week do you generally exercise? \_\_\_\_\_\_\_\_

 What types of exercises do you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any difficulties you experience with your appetite or eating patterns.

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1. Are you currently experiencing overwhelming sadness, grief or depression?

  No

  Yes

 If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently experiencing anxiety, panic attacks or have any phobias?

 No

 Yes

If yes, when did you begin experiencing this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently experiencing chronic pain?

 No

 Yes

If yes, please describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you drink alcohol more than once a week?  No  Yes
2. How often do you engage in recreational drug use?  Daily  Weekly  Monthly  Infrequently

  Never

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

 If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (1 being poor and 10 being best), how would you rate your relationship? \_\_\_\_\_\_\_

11. What significant life changes or stressful events have you experience recently:

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

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**FAMILY MENTAL HEALTH HISTORY:**

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

 **Please circle List Family Member**\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol/Substance Abuse yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity yes / no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obsessive Compulsive Behavior yes / no \_\_\_\_\_

Schizophrenia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ yes / no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ yes / no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDITIONAL INFORMATION:

1. Are you currently employed?  No  Yes

If yes, what is your current employment situation?

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

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

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

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1. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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

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1. What do you consider to be some of your weakness?

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

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 **Problem Inventory** **Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

**CURRENT PROBLEMS**

*I am currently experiencing the following problems (please check all that apply):*

* Marital relationship problems
* Physical abuse
* Problems on the job

Losing someone or something close to me

(person, job, pet, moving, etc.)

* Problems with my children
* Sexual abuse
* Current problems from past sexual abuse
* Alcohol abuse
* Drug abuse
* Feeling guilty about past misdeeds
* Feeling that I am no good
* Feeling the need to get more sleep
* Losing pleasure in my daily activities
* Often restless or irritable
* Thinking about dying or killing myself
* Trouble keeping my mind on a task
* Feeling sad or “down in the dumps”
* Preoccupied with sexual thoughts or urges
* Needing less sleep than usual
* Spending sprees
* Trouble making myself slow down or talk less
* Fear of crowds or public places
* Specific fear of a thing or place
* Attacks of fearfulness where I feel I need to run
* Heart palpitations
* Chest pains or discomfort
* Feeling dizzy or unsteady
* Feeling things that aren’t there
* Tingling in hands or feet
* Hot or cold flashes
* Trouble breathing
* Feeling trembly or shaking
* Fears of dying or going crazy
* Feeling the urge to avoid certain places or objects

 Feeling troubled by repetitive thoughts

* Feeling anxious and nervous
* Worrying about things over and over
* Feeling the urge to do something unnecessary
* Checking, hand washing, hair pulling

 People following me, out to hurt me, or talking about me

 People reading my thoughts

 Hearing voices

 Thoughts being put into my head, controlling me, making me do things

 Special messages to me from TV or radio

 Feeling emotionally “numb”

 Recurring nightmares

 Frequently feeling startled

 Being troubled by painful memories

 Parts of my body not functioning well

 Feeling aches and pains all over my body

 Often feeling sickly

 Fear of having or getting a disease

 Problems with my memory

 Knowing where or who I am

 Getting lost or confused

 Having trouble remembering my past

 Finding things I don’t remember my past

 Feeling anger or resentment

 Urges to do something harmful to myself or others

 Urges to set fires

 Difficulty controlling my temper

 Feeling anger or resentment

 Taking laxatives to control my weight

 Vomiting to control my calorie intake

 Exercising frequently and vigorously

 Fasting in order to control my weight

 Feeling helpless about my eating habits

 Extreme changes in my weight

 Any other problems not mentioned:

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## Patient Information & Consent for Treatment

*Welcome to our office. We want to help make your experience with us as pleasant as possible. Please feel free to ask questions about anything you do not understand.*

**ALL CLIENTS:**

* Our office initial fee is **$125**; follow up visits are **$95** per session (50 min.). Please note payment is due at the time of service.
* We currently accept cash, credit cards (MasterCard, VISA, Discover) and/or checks as a form of payment.
* In order to maintain standing appointments, your account must be kept current.

**CLIENT WHO ARE MINORS:**

* The adult accompanying a minor or the parent/guardian are responsible for full payment.
* Except in emergency situations, minors who are unaccompanied by an adult will be denied services, unless a payment has been pre- arranged.

**SOCIAL MEDIA SESSIONS:**

* Skype and phone sessions are available to military families during deployment; however, spouse must come into the office.
* Skype sessions for regular clients will have to have to be determined on a case by case basis and cannot be conducted on an initial session.

**FINANCIAL POLICY:**

You are fully responsible for all services rendered. Full payments for sessions, co- payments, co- insurance, deductibles or fees are expected at the time of service, unless other contractual arrangements apply. **Please make checks payable to Talking Solutions AMCC.** We also accept credit card payments (MasterCard, VISA, Discover).

There will be a **$35.00 fee** for **returned checks** as non- sufficient funds or non- payable. You will receive an invoice from our office letting you know the total amount.

**Cancellations must be made at least 24 hours prior to your scheduled appointment. A $75.00 fee (not covered by insurance) will be applied for late cancellations or missed appointments, due prior to next appointment.**

**Court services** are not a part of mental health treatment. If you require our services on any court proceeding, additional fees will apply. Please note that court- related fees are not covered by insurance. Court services are billed at **$125.00** per hour and will include preparation time, travel time and court time (even if never called to witness). A deposit of **$250.00** is required in advance of the court date.

If you require your therapist to complete forms or prepare documents regarding your participation and progress in treatment for a third party (other than insurance), a **$75.00 document fee** will apply.

It is your responsibility to know your **insurance benefits**. Please be aware that mental health benefits vary widely in coverage, and regular co-pay information often does not apply. In the event that your insurance carrier determines a service to be **“non- covered”**, or in not paid within **90 days of service**, you will be responsible for the charges. **Disputes** over coverage must be handled between you and your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and are not authorized to **reduce or waive co- payments** on your behalf.

If you have questions regarding your account, please contact our office manager at (678)833-1820.

**\*\*\*I have read and fully acknowledge the policies of this office including payments and insurance. I agree to comply and accept responsibility for any payment that becomes due as previously outlined. \*\*\***

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 Signature of Patient/ClientDate

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 Signature of Responsible Party (if different) Relationship Date

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## NOTICE OF PRIVACY PRACTICES

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minor/Guardianship**

Parents or legal guardians of non- emancipated minor clients have the right to access the clients’ records.

**Insurance Providers** (when applicable)

Insurance companies and other third party payers are given information that they request regarding services to clients. Information that may be requested includes, but it is not limited to; types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*If we receive a subpoena or similar legal process demanding release of any information about you we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.*

**I agree to the above limits of confidentiality and understand their meanings and ramifications.**

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

Talking Solutions

Anger Management & Counseling Center

2020 Avalon Parkway Suite #185 talkingsolutionsamcc@yahoo.com

McDonough, GA 30253 http://www.talkingsolutionsamcc.com

678.833.1820 **PH** 678.833.1821 **FAX**

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*Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Georgia State Law requires a signed patient consent to release medical information to your insurance company and any other practices cooperating in the delivery of your care.*

**ASSIGNMENT OF INSURANCE INFORMATION:**

I hereby authorize assignment of benefits and payment of my medical / mental health benefits to:

**Talking Solutions Anger Management and Counseling Center** for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due to charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize refunds to my insurance company for any overpaid benefits.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

**AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:**

I hereby authorize **Talking Solutions Anger Management and Counseling Center** to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.

**Name (Printed)**

**Signature** **Date**