STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

DATE**: _____** AGE: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

FULL ADDRESS: _____

_____

HOME PHONE: _____ CELL PHONE: _____WORK:_____

E-MAIL:_____

EMERGENCY CONTACT: _____PHONE: _____

CHECK HERE TO RECEIVE EMAIL AND CELL PHONE REMINDER APPOINTMENTS ( )

SOCIAL SECURITY NUMBER: _____

D.O.B.:_____

MARTIAL STATUS: S M W D SEP SEX: _____ RELIGION: _____

DOES RELIGION PLAY A ROLE IN YOUR LIFE: _____

Family Systems Information:

Where born_____How long there_____ Parents: Father

Alive_____Where residing_____Relationship_____ Mother

Alive_____Where residing_____Relationship_____ Marital

Status_____#of marriages_____Spouse's name_____ Living

with a partner_____How long_____Partner's Name_____

Children:#1 M F Age_____ #2 M F Age_____ #3 M F Age_____#4 M F Age_____#5 M F Age_____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age_____

Family Alcoholism or Domestic Violence?_____ Sexual Addictions or Abuse?_____

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

Parents divorced?_____If yes, what year_____Your age at the time_____

If deceased, what year? _____Your age at the time_____Cause of death_____

Any step-parents?_____If yes, describe when and your relationship with them_____

_____

If reared by someone other than your birth parents, describe the situation in some detail_____

_____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

INSURANCE INFORMATION:
PLEASE COMPLETE THIS SECTION: PLEASE PROVIDE INSURANCE CARD

Primary Insurance: _____

Claims Office Address: _____ Policy Name:

_____ Policy Holder Name:

_____ Social Security Number: _____

D.O.B.:_____ Effective Date: _____ Contract Number:

_____ Group Number: _____

INFORMATION: PLEASE COMPLETE THIS SECTION: PLEASE PROVIDE INSURANE CARD

Secondary Insurance Provider: _____ Claims Office

Address: _____ Policy Name:

_____ Policy Holder Name:

_____ Social Security Number: _____

D.O.B.:_____ Effective Date: _____ Contract Number:

_____ Group Number: _____

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

PROBLEM(S):

1. _____

_____

2. _____

_____

3. _____

_____

TREATMENT HISTORY:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

Was therapy previously beneficial for you? _____

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

HEALTH AND SOCIAL INFORMATION:

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no If yes,

please list: _____ When

was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____

_____

Are you currently on medication to manage a physical health concern? If yes, please list:

_____

_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) yes ( ) no

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) yes ( ) no

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

CLIENT INTAKE FORM

Do you regularly use alcohol? ( ) yes ( ) no

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently? ( )
frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you self-harm in the past or present? ( ) yes ( ) no

Are you currently in a romantic relationship? ( ) yes ( ) no

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? ____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:
_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

OCCUPATIONAL INFORMATION:

Are you currently employed? ( ) yes ( ) no

If yes, who is your current employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ( ) yes ( ) no

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) yes ( ) no

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

STRIVE Counseling Services,
L.L.C. CLIENT INTAKE FORM

STRIVE COUNSELING SERVICES L.L.C.
FEE AGREEMENT

The purpose of this form is to provide you an efficient way of payment, if you so choose. It is also set up for the purpose of payment toward missed appointments. I welcome any questions you may have before signing.

● By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments, or other fees.

● Your signature indicates you understand that if you do not attend a scheduled appointment, your credit card will be charged the **100% of the regular amount** of the session you reserved unless you canceled at least **24 hours** in advance, business days Monday through Friday; for cancellations with less than **24 hours** notice, the full service fee will be charged. For missed appointments with no notice given, the full fee will be charged.

● Your signature indicates you understand that you, not an insurance company or any other 3rd party payer, will be paying for any missed or late cancelled appointments.

● Payments or copayments are expected at the time of service or in advance of service, unless otherwise agreed upon. Your signature indicates you understand that if you do not pay with cash or check at the time of service, your credit card will be charged for your payment due.

● Please note that we welcome Visa or Master Card; when using credit or debit card payments, a **$2.00** surcharge will be added to each card transaction. Current Fees for Services:

Initial Assessment –60 Minutes $140.00

Individual Therapy -50 minutes (regular session) $125.00

Individual Therapy –90 minutes $175.00

Marital and Family Therapy – 50 minutes $140.00

Marital and Family Therapy – 90 minutes $180.00

Requested letters, records or subpoenaed paperwork $100.00/hr.

No show or late cancellations **(50% of the amount for the regular session you reserved according to my fee schedule.**

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

Client/Guardian:_____ Sign:_____Date:_____
Print Name Signature Client Name:_____ SS# (or Insurance ID#):_____ If Different Than Above Day Phone: _____ Evening Phone: _____ Cell Phone: _____ Please enter the following information exactly as it appears on your credit card statement: Please Circle: VISA / MASTERCARD Card Number:_____ Expiration:_____ Card Verification Number:_____ Billing Zip Code:_____
Address:_____
*Your credit card information will be held confidential and this information will be secured in your client file.

STRIVE COUNSELING SERVICES, L.L.C.

PAYMENT AGREEMENT

1. I agree to pay my co-payment, deductible or my fee-for-service charge for each 45-60 minute session before each appointment begins. In order to make it possible for you to pay on the day of service we have a sliding fee available.

2. I understand that if I incur an outstanding co-pay or fee-for-service balance of more than $200.00 and/or two (2) sessions go by without any payment that therapy may be temporarily suspended or terminated until sufficient payment is received to place my outstanding balance below this amount.

3. I agree to make arrangements in advance, if another person/business is guaranteeing. If we have to send a statement or insurance claim, it will be at the full rate.

4. I understand that a 5% past due fee will be assessed for accounts that are 60 days past due and will continue to be assessed each month that payment has not been received (unless other arrangements have been made with Strive Counseling Services). I understand that a collection agency may be employed after my account becomes 90 days past due with the express purpose of collecting any past-due debts that I might owe Strive Counseling Services, L.L.C.

5. I understand that payment for any mental health legal report prepared is due in full before it will be released to another party or me.

6. I understand that I am personally responsible to know my insurance limits, exclusions, deductibles, and co-payment structures, even though support staff does a preliminary check. I do not hold Strive Counseling Services responsible for insurance company errors or refusals for reimbursements for services rendered. I understand I am responsible for all services for which my insurance company will not pay.

7. I agree to reimburse Strive Counseling Services for any session that I cancel or reschedule without 24 hours notice or for which I fail to arrive based on the fees listed on the fee sheet. I understand that my insurance company will not pay for late cancellations or missed appointments. Exceptions are illness and inclement weather conditions.

8. I understand that if I miss two or more sessions without giving 24 hours notice, Strive Counseling Services, L.L.C. and my therapist reserves the right to terminate our therapy relationship by letter or phone call. I also understand that if I am 20 or more minutes late to my counseling sessions two (2) or more times, my therapist and/or Strive Counseling Services, L.L.C. reserves the right to terminate our therapy relationship by letter or phone call.

9. I agree that all communication regarding my treatment will take place during the therapeutic hour. I understand that communication via telephone is preferred. I agree not to email or mobile to mobile text my therapist or Strive Counseling Services, L.L.C. unless authorized in advance by my therapist, and to do so for therapeutic purposes only.

10. I understand that my case may be discussed in group supervision for assessment, diagnosis, and evaluation of treatment and progress.

11. As defined in “Client’s Rights and Responsibilities” Strive Counseling Services, L.L.C. has a duty to warn and protect any individuals who may be or have been harmed by you as a client, including yourself (threat of self-harm or suicide).

12. I agree that I will not attempt to subpoena or require any counselor to appear in any legal proceeding related to any matters discussed during counseling; nor will I attempt to subpoena any notes or records related to this counseling.

13. I have read the above and understand its contents. I agree to abide by the provisions set forth above. I have been given a copy of "Client's Rights and Responsibilities" information, and I agree to read this information before my next counseling session, if I have not already done so.

_____ _____ _____

Signature of Patient or Responsible Party Signature of Co-Responsible Party Date

Strive Counseling Services, L.L.C. Social Media Policy

Crystal Mullen-Johnson, LICSW, PIP, RPT

Owner

Friending:

In respect of your privacy and confidentiality I do not accept friend or contact requests from current or former clients on any of my PERSONAL pages on social networking sites (Facebook, Twitter, LinkedIn, etc.). It may also blur the boundaries of our therapeutic relationship. Please discuss your concerns about social media during our intake if you have questions.

Fanning/ Following:

If I decide to maintain a Facebook Page for my professional practice, I will not accept clients as Fans or Followers. As FB is a public forum, any articles of interest posted are for educational purposes only and not intended to diagnose or treat. Please do not share, @, repost, or like any post if you are an active or former client. Client confidentiality is considered paramount and is upheld at all times.

Interacting

To protect your privacy and confidentiality, please do not use private messaging on sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I will not exchange any information with client about appointments, sessions, or anything pertaining to your therapy, mental or emotional state. If you are ever in a crisis please contact the Crisis Center hotline, (205) 323-7782 or check yourself into the emergency room. Please do not reference Strive Counseling Services, L.L.C. when you are posting, @replies, or other means of engaging with us online. Engaging with me in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, please contact me during business hours at my office. ALL voicemails and emails will be returned during BUSINESS HOURS ONLY. I do not communicate with clients on a cell phone. Please read below for more information regarding email interactions.

Use of Search Engines

I will not search for clients on Google, social media or any other search Engine as it violates your privacy. It's NOT a regular part of my practice. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which I will contact the emergency contact person/number your listed on your intake form. These are unusual situations and if I ever resort to such means, I will fully document it

and discuss it with you when we next meet.

Strive Counseling Services, L.L.C. Social Media Policy

Crystal Mullen-Johnson, LICSW, PIP, RPT

Owner

Business Review Sites

You may find my mental health counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

I highly recommend you not to violate your privacy but of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that we may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like.

Confidentiality means that I cannot tell people that you are our client, but you are more than welcome to tell anyone you wish who your therapist is or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

Email

I prefer using email for the sole purpose of arranging or modifying appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be

read by the system administrator(s) of the Internet service provider. You should also

know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Office Phone: 205/721-9893
Email: cmullenj@strivebhm.com

STRIVE Counseling Services, L.L.C.

2024 3rd Avenue North, Suite 312
Birmingham, AL 35203
(205) 721-9893
cmullenj@strivebhm.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____, authorize the Counseling Center

to: _____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR

Date of Birth:_____

_____
Signature of Witness Date
(7/98)

STRIVE Counseling Services, L.L.C.

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Client Date Witness Date

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Client Date Witness Date

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Client Date Witness Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality "What you share with me is between you and I with legal exceptions. *****Refer to Limits of Confidentiality**.

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Alabama law to report the matter immediately to the Alabama Department of Human Resources.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Alabama law to immediately make a report and provide relevant information to the Alabama Department of Human Resources.

· Health Oversight: Alabama law requires that social workers report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Alabama Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Alabama civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Alabama has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation 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: Under Alabama law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. [This sentence is now required under the HIPAA "Final Rule."]

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· 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 me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

STRIVE Counseling Services, L.L.C.
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Acknowledgement of

Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of STRIVE Counseling Services, L.L.C. "Notice of Privacy Practices at Strive Counseling Services L.L.C."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature:
_____
_ Printed Name:
_____

_ Date: _____

Witness: _____