Summit Wellness Centers, PLLC

PO Box:
211 Arden, NC 28704

Client Information Survey (Completed by Client)

In order to better serve you, please clearly print the following information.

Date: ____________

Client Name:________________________________ Sex:______ M ______ F

Home Address: ______________________________ Date of Birth:___________Age: _____

______________________________ Marital Status: ________ Years Married:____

E-mail Address: ___________________________________

Phone Number (H): ________________________(cell):___________________

May we leave you a message at any of these phone numbers? __________Yes______________No

If no, please specify how you would like us to contact you. _______________________________________

You can receive appointment reminders to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments. You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.schedule.care to schedule or reschedule your appointments, or send a message to your counselor. Appointment information is considered to be "Protected Health Information" under HIPAA. By providing the information above, I signify that I am choosing to **"opt-in"** to communications via the methods specified above. I understand that email and standard SMS messages are not confidential methods of communication, and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my mental/ behavioral health care may be intercepted and read by a third party. Accordingly, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. I understand that I can opt-out of receiving communications at any time by contacting the office or speaking with my counselor.

If the client is a child/adolescent, who has legal custody? (*If joint custody, a signed agreement must be completed by both guardians. Please speak with office for this agreement prior to first appointment) A parent or legal guardian must be present and able to meet with their child's counselor for the initial session.

School Information: School: _______________________ Grade Level:_______

Special Educational Placements: __________________________

List other family members/significant others living in the home:

Name	Age	Relationship to Client
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________

List other children not living in the home:

____________________	________	____________________
____________________	________	____________________
____________________	________	____________________

Work/School

Current Employer/School __________________ Location ________________

If in school or college, Current Grade/Year ___________ Highest grade ever completed ________

Please explain any problems/concerns with Work/School (change of jobs/schools, firing, suspensions, grades, etc…)_____

____

____

HEALTH

Client Physician/Pediatrician: ______________________ Phone Number: _______________

Date of last appointment with any doctor: ___________

Date of last complete physical exam: ________________

Current Health: _____ good _____ fair _____ poor

Explain:

Have you ever experienced/been diagnosed with any of the following and if so when?

Arthritis__________	Cancer__________	Diabetes__________	Hearing/Vision Pr.__________
Heart Disease__________	Brain Injury__________	High/Low Blood Pressure__________	Kidney Disease__________
Stroke __________	Seizures __________	Fainting Spells__________	Lung Problems__________
Cirrhosis__________	Infertility__________	Low Blood Sugar__________	STD's__________
Thyroid __________	Pancreatitis__________	Migraines __________	Eating Disorder__________
Weight gain/loss __________		Alcohol/Drug Use __________	Other__________

Do you have other medical concerns not mentioned? (Please list other health problems, surgeries, limitations, or disabilities): ____

____

Is client pregnant? ____**Y / N** Due date: _________

Please note any important medical or mental health problems in your *family*: ________________________

____

____

If client is a child/adolescent, please note any concerns/abnormalities with pregnancy, birth or childhood development: ____

____

Medications:

If you are presently taking any medications, please complete graph below:

Name	Dosage	Frequency	Start Date – End Date	Reason/Effectiveness	Prescribed By

Do you take your meds as prescribed? __Y __N If no, please explain: ________________________

____

____

Substance Abuse

Has anyone *in your family* had a history of alcohol/drug use? ____Yes ____ No

If yes, explain: ____

____

Please describe *your* history or current abuse of the following substances:

(include age of first use, current frequency, date of last use, and average monthly cost)

Alcohol: ____

____

____

Drugs: ____

____

Prescription Meds:

Has drinking and/or drug use ever caused you problems in the following areas (please circle):

Family School Employment Legal Emotional Relational Health

Legal

Please tell us about any previous or current legal or court involvement (ie. Arrests or pending charges):

Previous Treatment

Have you ever received any type of *outpatient* mental health counseling in the past?

If so, where, and what was the outcome?

Have you ever seen another clinician in our center?

Please list any previous *inpatient* mental health or substance abuse treatment:

Facility Name/Location	Date	Reason	Response to Treatment

Trauma History

Do you have a history of physical, emotional, or sexual abuse, domestic violence, or physical trauma?

If yes, please briefly explain (your counselor will discuss further):

Beliefs

What is your belief about God?

Do you currently attend a church? If so, where?

Family History:

What words would you use to describe the family you grew up in?

Relationships

What concerns do you have regarding current relationships?______________________________

____

____

____

Today's Appointment

Explain in your own words why you have made this appointment today (your counselor will discuss this with you in more detail):____

____

____

____

____

____

On a scale of 1-10, how do you estimate the current severity of this problem/concern? __________

(1=Mildly upsetting, but tolerable 10= Incapacitating, not tolerable)

What is your goal of treatment?____

____

____

____

______What action(s) have you already taken regarding this issue?____

____

____

____

What do you perceive to be your strengths/abilities that will assist you in the process of achieving your goal?

____

____

____

What personal weaknesses or vulnerabilities may hinder your success? ____________________

____

____

____

How did you hear about our counseling center or the specific counselor that you are seeing today?__________

____

____

______*Other information you feel is important that wasn't asked about:___________________

____

______

Summit Wellness Centers, PLLC
LPC Declaration of Practices and Procedures

Thomas Wilson, M.Ed., LPC/MHSP(T)

First Baptist Concord Church
11704 Kingston Pike, Knoxville, TN 37934
865-316-6383

Declaration of Practices and Procedures

This document is designed to provide you with information about my professional background and credentials, to inform you of the characteristics and expectations of the counseling relationship, and to be sure that you understand and agree to our professional relationship.

Education

I am a 2018 graduate of King University with my Bachelor of Science degree in Psychology and a 2021 graduate of Lincoln Memorial University with my Master of Education degree in Mental Health Counseling. I am a Licensed Professional Counselor with Mental Health Service Provider (Temporary) designation in Tennessee. My current TN license number is 6215.

Clients/Services/Philosophy

I work with individuals, families, children, and adolescents. I utilize Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), cognitive behavioral therapy (CBT). I also incorporate art therapy (e.g., painting, writing, drawing), and spirituality (when it is important to my client) into my sessions. I occasionally utilize activities outside the counseling room such as assignment of homework or additional reading of self-help materials. The applicability of these techniques will be explained to you in an understandable manner throughout the counseling process. I believe that change is possible and maintain a hopeful stance for each individual I work with. I believe that the counseling relationship can be a powerful tool to understand other relationships in life. As your counselor, I aim to create a space where you feel safe and heard. I ultimately want to work with you to understand what techniques or activities are best for you. I believe therapy must include your investment and involvement in order to work.

Client Confidentiality

Client information is confidential and protected with the following exceptions:

a. You (or your legal guardian) consent in writing to the release of information,
b. A court orders disclosure of information,
c. When I believe that you intend to physically harm yourself or another person,
d. When a child or elder is being neglected, abused, or is witness to domestic violence,
e. It is necessary to release information to insurance companies or reimbursement sources for payment of services.

Clinical Diagnosis

Diagnosis becomes a permanent part of one's medical record. It is intended for the purpose of matching the most effective treatment approach with each person's unique circumstances. You should be aware that your contract with your health insurance company requires that we provide them with information relevant to the services that we provide to you.

Litigation Limitation

Given that certain types of litigation (such as child custody suits) may lead to the court-ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you or any attorney, or anyone else acting on your behalf, will ask me to testify in a deposition or in court or any other proceeding, nor will a disclosure of the medical record and/or progress notes be requested. If you are seeking custody evaluations, we are happy to refer you to someone who specializes in that area.

Appointment and Fees

Individual and family sessions are generally 53 minutes in length. Group sessions are generally 90 minutes in length. All sessions are by appointment only. The initial evaluation appointment fee is $150. Your fee for 53-minute follow-up sessions is $140. The fee for sessions that run over 53 minutes is $140. Payment must be made at the conclusion of each session. If you have an insurance plan that provides coverage for this service, we will be happy to file a claim for you. You are responsible for payment of your deductible and co-pays. Cash and personal checks are acceptable methods of payment. If for any reason you must cancel an appointment, please call at least 24 hours prior to the appointment. Otherwise, you will be charged for the time that was reserved for you. Besides weekly appointments, I charge my standard hourly fee for other professional services you may request, including report writing, phone conversations, consultations with other professionals per your request, or preparation of treatment summaries. As stated earlier, your signature on this disclosure ensures that I will not be called to testify in legal related matters. If, despite this consent, I am required to participate in legal proceedings, you will be expected to pay for all of my professional time and transportation costs. Because of the difficulty of legal involvement, I charge $200 per hour for my professional time spent in consultation with attorneys, report writing, preparation, and attendance at legal proceedings.

Telehealth

If recommended, as a result of geographic or physical challenges, and you have already had an initial face-to-face intake, telehealth services may be provided through a HIPPA compliant, encrypted portal. Telehealth services utilize two-way, real-time interactive audio and video capabilities in providing services to clients. I am able to offer telehealth services for clients located in the state of Tennessee at the time of service. All confidentiality guidelines, laws, and treatment expectations for face-to-face treatment, as described elsewhere in the professional disclosure statement, also apply in the venue of telehealth. Fees will also be the same as that for face-to-face services. Clients who choose to utilize this venue will be

provided instruction for logging on to the portal. Signing this consent signifies your understanding of the inherent risks with telehealth services, including, but not limited to, the transmission of private health information being disrupted, distorted, or compromised. Recording or dissemination of any personally identifiable images or information from the telehealth interaction is prohibited.

Emergency Procedures

If you feel that you are imminent risk of harm to yourself or others, you should immediately seek help or hospitalization by calling 911 or going to the emergency room at your local hospital. If you feel your situation is urgent, but not emergent, you can contact me at (865)-680-4394 during offices hours. If at any time I assess that you are at imminent risk to self or others, I will encourage voluntary psychiatric hospitalization and assist you in the process. I am obligated to seek involuntary hospitalization on your behalf if you do not agree to voluntary hospitalization should the aforementioned situation arise.

Complaint Procedures

If you are unhappy with our professional relationship, please speak with me immediately. This will make our work together more efficient and effective. If a problem arises requiring a legal remedy to solve, the client agrees to solve all problems through the means above or independent mediation rather than pursuing formal litigation. If you think you have been treated unfairly or unethically and cannot resolve the problem with me, you can contact the TN Department of Health Office of Investigations at 615-741-8485 or 1-800-852-2187, 665 Mainstream Drive, Second Floor, Nashville, TN 37243, as applicable.

Counseling Agreement

I understand and agree to the preceding information regarding the counseling process, confidentiality privileges and limitations, and the fee requirements, and I understand that I have the right to terminate therapy at any time.

Client Signature Date

Client Signature Date

Counselor Signature Date

Summit Wellness Centers, PLLC
PO Box:
211 Arden, NC 28704

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying

with federal privacy law. Additionally, we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim. I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** - We use and disclose your health information internally in the course of

your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

- ***For Payment*** - We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** - We may use and disclose your health information within as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

- ***Right to Choose*** - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** - You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** - With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Disclosure to Health Information Exchanges: (For NC State Health Insurance Plans)

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex. which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthCOnnex not paid for with state funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC Health Connex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthCOnnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Privacy Office at (828)-692-6383. Again, even if you opt out of NC HealthConnex, we will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of North Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature Date

____ _______________

Printed Name

____

Client/Legal Guardian Signature Date

____ _______________

Printed Name

____

Donna Gibbs, LCMHCS, HIPAA Compliance Officer

Summit Wellness Centers, PLLC

Payment Policy:

It is the policy of Summit Wellness Centers, PLLC that **PAYMENT IS DUE AT THE TIME OF SERVICE.** In order to complete this process efficiently, Summit Wellness Centers, PLLC will maintain secure records of our clients' credit /debit card. **If you are self-pay, your card will automatically be billed at the time of the service. If you are using insurance, your card will automatically be billed at the time of service for the estimated deductible, copay and/or coinsurance payment. Your card will also automatically be charged fees for no-show/late-cancellation appointments (including initial intake appointments).** You are responsible for keeping an updated card on file, and are responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and inquire regarding your behavioral health benefits, and if there is an out-of-network carve-out for behavioral health services.

By paying via credit/debit card, you acknowledge that this credit/debit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: TSYS (CAYAN). Health Savings Account cards can be kept on file as the primary form of payment, but there must be a back-up credit/debit card on file in case HSA funds are depleted.

Cancellation/No-Show Policy:

If for any reason you need to cancel an appointment, including intake appointments, you must call at least 24 HOURS prior to the appointment to reschedule. Otherwise, you will be charged for the time that was reserved for you ($150 for a late-cancel/no-show intake or $140 for a late-cancel/no show follow-up session). If you repetitively cancel appointments, we reserve the right to discontinue services. Because of high demand for our services, we keep a waiting list of those who are waiting for an opening. This cancellation and no-show policy assures that we are being good stewards of the availability and time reserved for our counselors, thereby allowing us to best serve our clients. We appreciate your cooperation and partnership in this matter as we seek to serve our community. In an effort to prompt reminders and mitigate no-show/late cancellations and associated fees, we offer clients the option of automated appointment reminders 48 hours in advance.

Signed Agreement:

I (we), the undersigned, authorize and request Summit Wellness Centers, PLLC to charge the credit/debit card, which I provide, for any balances due for services rendered that my insurance company identifies as my financial responsibility. If uninsured, or in the event of no-show appointments, I authorize Summit Wellness Centers, PLLC to charge my credit/debit card for my balance due. This authorization will remain in effect until I(we) cancel this authorization. To cancel, I(we) must give a 60 day notification to Summit Wellness Centers, PLLC in writing and the billing account must be in good standing.

Client Name ______________________________ Date _______________

Client Signature ___________________________

Updated 1/1/2024

Summit Wellness Centers, PLLC

REGISTRATION AND INSURANCE INFORMATION

Today's Date: ___________
Client: _______________________________________ **DOB:** ____________ **Age:** _______

Client Social Security Number (for insurance purposes only): ____________________________
Social Security Number of the insured:__________________________ DOB of insured:___________
Spouse Name:____
Parent/Guardian Name:____
Address:____
____

Telephone: (H):_________________ (W):____________________ (C):____________________
Emergency Contact Person:_________________________ Phone: ________________________

Insurance Information

Are you covered by health insurance? (circle) Yes No

	Primary Insurance	Secondary Insurance
Name of Insurance:	________________________	________________________
Insured's Name:	________________________	________________________
Insured's Social Security #:	________________________	________________________
Insured's Date of Birth:	________________________	________________________
Policy # / Group #:	________________________	________________________
Relationship to Client:	________________________	________________________

Note: We will file insurance claims for you. However, you are responsible for any deductible, non-covered charges, or co-payments which may apply. This responsibility, due at the time of service, is a result of your contract with your insurance company. Refusal to pay your contractual obligation is fraudulent. As a courtesy, we will verify your insurance benefits. However, we recommend that you also personally verify your behavioral or mental health benefits with your insurance company. In the event that insurance payments differ from the information we receive from your insurance company, you will be billed for any remaining balance owed. Being referred to our clinic by another physician does not guarantee that your insurance will cover our services.

I authorize any holder of medical or other information about me to release Social Security Administration, any Health Care Financing Administration or its intermediaries or carrier of any other commercial insurance company, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Summit Wellness Centers.

Client Signature: ___________________________________ Date: ____________________

Summit Wellness Centers, PLLC

Authorization to Release/Exchange Confidential Records and Protected Health Information

Client: ______________________________ **Date:** ________________________________

I hereby authorize *Summit Wellness Centers* to disclose/obtain/exchange mental health treatment information and records obtained in the course of treatment of client, including, but not limited to, provider's diagnosis of client, to/from/with the person(s) below: (both parties have my permission to exchange information regarding my treatment).

(List individual/office/facility)

Name: _________________________________ **Relationship:** __________________________

Address: ____

Phone Number: ____

This authorization may include the following exchange of information: (please *circle* individual items below only if you are limiting areas you want to identify for release. Otherwise, all below areas are included in this release and it is not necessary to circle. Summit only releases the minimum amount necessary per request). Referral information, relevant history or diagnoses, treatment planning, evaluation results, continuity of care, insurance information, Inpatient and/or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse, treatment notes and summaries, treatment plans, social histories, assessments, recommendations, and similar documents, information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work, and billing records. When requested of information, Summit only releases minimum information necessary to complete requests; typically in the form of a brief letter with dates of treatment and summary of progress.

Circle if this release is for billing purposes only: Billing Only

Please explain below any additional limitations to this release (anything you do not want Summit to release):

____

____

Communicable diseases, HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated by your initial here: _______ Do not release.

I understand that no services will be denied to me/the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release information. I do sign this release because I believe that it is necessary to assist in the development of the best possible treatment plan for me/the client. The information disclosed may be used in connection with my/the client's treatment. The purpose of the release may include continuation of care, legal purposes, or insurance purposes.

In consideration of this consent, I hereby release Summit from any and all liability arising from the release. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire one year from the date below.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

______________________________ ________________

Client / Parent / Guardian Signature Date

______________________________ ________________

Witness Signature Date