INFORMATION FORM

Date _____

Patient Name _____ **Date of Birth** _____

Address _____

City/State _____ **Zip Code** _____

Phone (Home) _____ **Phone (Work)** _____

Policy holder name _____

SS#(of policy holder) _____ **Date of Birth** _____

Employer _____

School (if patient is a student) _____

Insurance Co. _____

Referral Source _____

Marital Status:
__ Never Married __ Married __ Divorced __ Separated __ Widowed __ Other

Family Members:

Name	Date of Birth	Relationship

What concern brings you to counseling?

What changes do you want to see as a result of counseling?

Client Information and Acknowledgment of Informed Consent to Treatment

Therapist: Neila Senter, LPCC, is a licensed independent counselor engaged in the private practice of providing mental health care services through Senter Counseling Services.

Definitions: and Senter Counseling Services are hereinafter referred to as "the Provider."

Nature and Purpose of Services: The purpose of receiving mental health or substance abuse care services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using the Provider's knowledge of human development and behavior, the Provider will make observations about situations as well as suggestions for new ways to approach them. It is important for you to examine your own feelings, thoughts, and behavior, and to try new approaches in order for change to occur.

The services the Provider offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse care services have also been shown to have benefits. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Extent and Timeframe of Services; Appointments: Appointments are made by calling 513-454-5437. Appointments are typically 50 minutes in length, but may vary. We will discuss the number of appointments you may need.

Fees: The standard fee is $80.00 for a 50 minute session, however, certain managed care and insurance company contracts may have pre-set fees. If your health insurance policy does not provide coverage for the Provider's services or denies coverage, then you are responsible for payment of fees. Please see the document entitled, “Notice of and Agreement to Pay Fees” for additional information.

Missed Appointments: There is also a cancellation fee for failing to attend a scheduled appointment without giving 24 hours notice of cancellation. Insurance will not cover or reimburse for missed appointments and you are responsible for payment of the cancellation fee.

Relationship: As the Provider's client, we will have a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the Provider not have any other type of relationship with you. Personal and/or business relationships undermine our professional and therapeutic relationship. While the Provider cares about helping you, the Provider cannot have a social or personal relationship with you.

Goals: There may be alternative ways to treat the problems you are experiencing. It is important for you and the Provider to discuss any questions you may have regarding your treatment and for you to have input into setting the goals for your therapy. As your therapy progresses, these goals may change. The Provider will work with you to address the changes in your goals.

Privacy: Please see the document entitled, “Notice of Privacy Practices”

Professional Records: The Provider is legally required to keep documentation about the services provided to you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways problem affects your life, your diagnosis, your treatment

goals, your progress toward those goals, your medical, social, and treatment history, results of clinical tests (including raw test data), any past treatment records that the Provider receives from others, reports of any professional consultations, payment records, copies of any reports that the Provider has sent to anyone, and either annotations or copies of emails we exchange.

The Provider may also keep psychotherapy notes which are for the Provider's own use and designed to assist the Provider in providing you treatment. These notes are kept separate from your Clinical Record. They are not considered part of your Clinical Record and are not released, except in rare legal circumstances.

Minors: If you are under 18 years of age, the law may give your parent or guardian the legal right to review your Clinical Record. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

Third Parties: You may bring other individuals (such as a family member) to your therapy sessions if you feel this would be helpful or if the Provider recommends it. A third party is not a client and there is no confidentiality between the Provider and the third party. The third party shall not have any rights to access any part of your file, including but not limited to any session in which the third party participated, unless you sign a release. If a decision is made to include a third party, you are required to complete and sign the document entitled, “Consent to Include Third Party”.

Involuntary Services: If you are involuntarily required to receive services, for example pursuant to Court Order or other valid governmental requirement (“Involuntary Services”), please review this document for a description of the nature, purpose, and extent of our services and other relevant information. Although you may refuse Involuntary Services, you may face penalties for failure to comply including but not limited to Contempt of Court.

After-Hours Emergencies: In the event of an emergency, go to a hospital Emergency Room or call 911.

No Discrimination: The Provider shall not practice, condone, facilitate, collaborate or otherwise participate in any form of discrimination prohibited by applicable law.

Email: If you are going to communicate with the Provider via email, you are required to complete the document entitled, “Information Concerning and Acknowledgment of Informed Consent to Communicate Via Email”.

Electronic Service Delivery: If you are going to receive therapy primarily by electronic or technology-assisted approach when the Provider and you are not located in the same place during delivery of services, including but not limited to internet, email, and teleconference, you are required to complete the document entitled, “Information Concerning and Acknowledgment of Informed Consent to Communicate Via Electronic Service Delivery”.

Consent: By my signature below:

a. I hereby give my informed consent to receive mental health or substance abuse assessment, care, treatment from the Provider;

b. I understand that I have the right to refuse or withdraw the informed consent given above;

c. I understand and agree that I will participate in the planning of my care, treatment, and services and that I may stop such care, treatment and services at any time;

d. I understand that there are no guarantees that treatment will be successful;

e. I agree that, in the event of the disability, death, or retirement of the Provider, I will instruct the Provider where to send my Clinical File and records;

f. I acknowledge that I have read and understood all information contained herein and that I have been given an opportunity to ask questions concerning this document;

g. I acknowledge that I have been given a signed copy of this document.

Signature of Client _____

Date _____

Signature of Parent, Guardian or Responsible Party of a Client who is a Minor _____

Date _____

Client Information

Name of Client _____
Last **First** **Middle**

Other Possible Names _____

Date of Birth _____ **Phone** _____

Address _____

City/State _____ **Zip Code** _____

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

To What Health Information Does This Notice Apply? Protected Health Information is information that you provide to the Provider or that the Provider creates or receives about you and your health care and treatment, including but not limited to your name, age, race, sex, and other personal identifying information, information related to your physical or mental health in the past, present, or future, information related to your care, treatment, services, and information related to payment for your care, treatment, and services (herein, “Protected Health Information” or “PHI”).

Who Must Follow This Notice? The Provider is required to comply with the privacy practices described in this Notice. The Provider reserves the right to change this Notice and to make any new practices effective for PHI the Provider already has and for PHI that the Provider receives in the future. Any changes made to this Notice will be posted at The Provider’s website (www.sentercounselingservices.com) and made available to you at your next appointment.

Ways We Can Share Your PHI Without Your Written Permission:

In certain situations, described below, the Provider requires your written permission to share your PHI, however, the Provider does not need any type of permission from you to share your PHI in the following circumstances:

A. The Provider must share your PHI to provide that information to you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this Notice.

B. Sharing Your PHI for Treatment, Payment and Health Care Operations. The Provider may share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and/or perform our "Health Care Operations.” This is what these terms mean:

i. Treatment: The Provider may share your PHI to provide care and other services to you, for example, to provide a mental health evaluation. In addition, the Provider may contact you to provide appointment reminders or information about treatment options.
ii. Payment: The Provider may disclose your PHI to receive payment for services that the Provider provides to you. For example, the Provider may share your PHI to request payment and receive payment from your health insurance company (“Payor”) and to confirm that your Payor will pay for services that the Provider provides to you. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.
iii. Health Care Operations: The Provider may share your PHI for our health care operations, which include management, care coordination, planning, and activities that are intended to improve the quality and lower the cost of our services.

C. The Provider may share your PHI to Business Associates that perform functions on our behalf or provide the Provider with services if the information is necessary for such functions or services. Our Business Associates are required both by law and under contract with the Provider to protect the privacy of your PHI and are not allowed to share any information other than as required by law or specified in our contract.

D. Data Breach Notification Purposes. The Provider may share your PHI to provide you with notice about the unauthorized acquisition, access, or disclosure of your PHI.

E. Public Health Activities. The Provider is required or is permitted by law to report your PHI to certain government agencies and others. For example, the Provider may share your PHI for the following:

i. to report to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
ii. as required in investigations by governmental bodies, including but not limited to licensing boards, health departments, and police;
iii. to report known or suspected abuse or neglect to the appropriate public child protective services agency;
iv. to report to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
v. to attempt to prevent or lessen a serious and imminent threat to a person for the public's health or safety or to certain government agencies with special functions such as the United States Department of State.

F. Health Oversight Activities. The Provider may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicaid, are being followed.

G. Judicial and Administrative Proceedings. The Provider may share your PHI in the course of a judicial or administrative proceeding, including but not limited to in response to a Court Order or other lawful process.

H. Law Enforcement Purposes. The Provider may share your PHI with the police or other law enforcement officials as required or permitted by law, or in compliance with a Court Order or Warrant.

I. Decedents. The Provider may share your PHI with a Coroner, funeral director, or Medical Examiner, as authorized by law.

J. Workers' Compensation. The Provider may share your PHI as permitted by or required by State law relating to workers' compensation or other similar programs.

K. As Otherwise Required By Law. The Provider may share your PHI when required to do so by law, rule, or regulation not otherwise referred to above.

Uses and Disclosures of Your PHI Requiring Your Written Permission:

For any purpose other than the ones described above, the Provider may only share your PHI when you grant the Provider your written permission (“Authorization”). For example, you will need to give the Provider your Authorization to share your PHI with other people you identify, such as family members or friends.

Sharing Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you, which includes any portion of your health information that is: (1) kept in psychotherapy notes, (2) about mental health and developmental disabilities services, (3) about alcohol and drug abuse prevention, Treatment and referral, (4) about HIV/AIDS testing, diagnosis or Treatment, (5) about sexually transmitted disease(s), (6) about genetic testing, (7) about child abuse and neglect, (8) about sexual assault, or (9) about In Vitro Fertilization (IVF) (collectively, "Highly Confidential Information"). Before the Provider shares any of your Highly

Confidential Information for a purpose other than those permitted or required by law, the Provider must obtain your Authorization.

Your Rights Regarding Your PHI: Although your record is the physical property of the Provider, you have the following rights:

You have the right to be informed of our privacy practices.

Our practices related to protecting the privacy of your PHI are described in this Notice. You have the right to a paper copy of this Notice. When you first become our client, the Provider will ask you to sign an Acknowledgment of Receipt of this Notice indicating that you have received a paper copy of this Notice. You may also obtain a paper copy of this Notice anytime you visit.

A current version of this Notice can also be viewed on our website at www.sentercounselingservices.com. Even if you have access to this Notice electronically, you are still entitled to a paper copy.

Submit your written request for a paper copy of this Notice to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150.

You have the right to request access to your PHI.

You have the right to inspect and/or obtain your PHI that may be used to make decisions about your care. Usually, this includes medical and billing records. In some cases, you may receive a summary.

To inspect and/or obtain a copy of your PHI, you must submit a written request to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150. The Provider may charge a reasonable fee for any copies.

In certain circumstances, the Provider may deny your request to inspect and/or copy. For example, you may not inspect and/or receive a copy of (i) psychotherapy notes, (ii) information collected for use in a civil, criminal, or administrative action, and/or (iii) certain PHI that is otherwise protected by law. If you are denied access to your PHI, you may request that the denial be reviewed. Please call the Provider at 513-454-5437 if you have further questions.

You have the right to request that the Provider disclose your PHI to others.

If you would like specific items of your PHI to be sent to someone else (for example to an attorney or to your employer), you must complete and sign our Authorization to Disclose Information form. The Provider may charge a reasonable fee for any copies.

The Authorization to Disclose Information form is available at 228 Mill St. , Suite 103, Milford, Ohio 45150.

When the Provider receives your completed Authorization to Disclose Information form, the Provider cannot and does not guarantee that the person to whom the information is provided will not disclose the information.

You may revoke your Authorization to Disclose Information form at any time, in writing, by mailing your revocation request to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150. Your revocation is effective upon our receipt, except if the Provider has already acted based on

your Authorization to Disclose Information form.

You have the right to request that the Provider correct your PHI.

You have the right to ask the Provider to correct PHI the Provider maintains about you if you believe the PHI is inaccurate or incomplete. Your request must be in writing and provide the reasons for the requested correction. The Provider will review your request and either make the correction or let you know why the Provider thinks our information is accurate and/or complete. If the Provider denies your request, you may give the Provider a written statement disagreeing with our decision that the Provider will keep with your PHI.

To request a correction to your PHI, mail your request to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150.

You have the right to request that the Provider communicate with you in a certain way or at other locations.

You have the right to request that the Provider communicates with you about your health in a certain way or at a certain location. For example, you may ask that the Provider contact you at work or by U.S. Mail. The Provider will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150.

You have the right to request restrictions or limitations on the sharing of your PHI.

You have the right to request restrictions or limitations on the sharing of your PHI. The Provider is not required to agree with your request, except that the Provider must agree to any request you make to restrict disclosure of specific information to your Payor, if you completely pay for the health services you request not be disclosed out of your own pocket.

You have the right to request that the Provider restricts disclosures of PHI to your family members or to others who are involved in your health care or payment for your health care. While the Provider will try to honor your request, the Provider is not required to agree to any such request.

Requests for restriction or limitation on the sharing of your PHI must be in writing and sent to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150. If the Provider does not agree, the Provider will notify you. If the Provider does agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

You have the right to request an accounting of disclosures.

You have the right to request an accounting of disclosures made during the 6 years prior to your request.

An accounting of disclosures shall not include any disclosures made (i) prior to April 14, 2003, (ii) for Treatment, Payment, and/or Health Care Operations, (iii) to you or pursuant to any authorization given by you, (iv) to correctional institutions or law enforcement officials, and (v) other disclosures for which federal law does not require the Provider to provide an accounting.

A request for an accounting of disclosures must be in writing and sent to the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150.

You have the right to file a complaint.

If you believe your privacy rights have been violated, you may file a complaint with the Provider at 228 Mill St. , Suite 103, Milford, Ohio 45150. You may also notify the Secretary of the U.S. Department of Health and Human Services at the following address:

Celeste Davis, Regional Manager
Office for Civil Rights U.S. Department of Health and Human Services
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
Voice Phone (800) 368-1019
FAX (312) 886-1807
TDD (800) 537-7697

The Provider will not retaliate against you for filing a complaint.

You have the right to express concerns or to ask questions.

If you have any concerns about the privacy of your PHI or if you have questions about this Notice, please contact the Privacy Officer at the Provider's address at 228 Mill St. , Suite 103, Milford, Ohio 45150.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices of the Provider.

I understand that such Notice describes how my Protected Health Information, as defined in the Notice, may be shared, and that the Notice informs me of my rights with respect to my PHI.

Name of Client:_____

Date of Birth:_____

Signature of Client or Personal Representative:_____

Printed Name of Client or Personal Representative:_____

If Personal Representative, indicate relationship:_____

Date:_____

Refusals

_____ The Individual refused to accept a copy of the Notice of Privacy Practices.

_____ The Individual received a copy of the Notice of Privacy Practices but refused to sign an Acknowledgement of Receipt.

Signature of the Provider Representative:_____

Printed Name of the Provider Representative:_____

NOTICE OF AND AGREEMENT TO PAY FEES

Client Name:_____ Date of Birth:_____

NOTICE OF FEES: The Provider charges a fee for providing services. The standard fee is $80.00 for a 50 minute session, however, certain managed care and insurance company contracts may have pre-set fees. If your health insurance policy does not provide coverage for the Provider's services or denies coverage, then you are responsible for payment of fees. There is also a cancellation fee for failing to attend a scheduled appointment without giving 24 hours notice of cancellation, which is not covered by insurance.

In order to set realistic treatment goals and priorities, it is important for you to understand what resources you have to pay for your treatment. If you have a health insurance policy, it may provide coverage for mental health or substance abuse treatment. It is very important that you find out what your health insurance policy covers. As a convenience to you only, the Provider will assist you apply for health insurance benefits for which you have coverage.

In connection with the submission of a claim, most insurance companies require you to authorize the Provider to provide them with a clinical diagnosis. Sometimes the Provider has to provide additional clinical information, such as treatment plans or summaries or copies of the entire record in rare cases. This information will become part of the insurance company files and will likely be stored in a computer. We have no control over the use of this information after it is provided to them.

CLIENT ACKNOWLEDGMENT: I acknowledge and agree that:

a. I am responsible for and will pay the fees for services rendered in the event that I am a cash-pay client or in the event my health care insurance company denies a claim for payment;

b. I am responsible for and will pay the cancellation fee for failing to attend a scheduled appointment without giving 24 hours notice of cancellation;

c. I am responsible to determine what treatment my health insurance policy covers and that any assistance provided to me applying for any health insurance benefits to which I am entitled is provided to me only as a convenience and does not guarantee coverage or otherwise obligate the Provider in any way;

d. That the Provider is authorized to use and disclose information required or requested by my health care insurance company, including but not limited to the information described above and that this information will become part of the insurance company files and will likely be stored in a computer and that the Provider has no control over the use of this information after it is provided to them; and

e. I have been given a signed copy of this document.

Signature of Client:_____
Date:_____

Signature of Parent, Guardian or
Responsible Party of a Client who is a Minor:_____
Date:_____

INITIAL EVALUATION/ASSESSMENT

Client Name _____ **Date** _____

Presenting Problem/Precipitating Event (onset, duration, intensity, and why now)

_____

_____

_____

_____

_____

Target Symptoms: **Symptom** **Frequency/Duration** **Degree of Impairment**

Symptom #1 _____

Symptom #2 _____

Symptom #3 _____

Mental Status (circle appropriate items):

Appearance:	Appropriate	Inappropriate	Disheveled	Unclean Bizarre	
Affect:	Appropriate	Inappropriate (describe)_____ (sad, angry, anxious, superficial, restricted, labile, flat)			
Orientation:	Oriented	Disoriented (to person, place, time, date, day, situation)			
Mood:	Normal	Other_____ (sad, depressed, irritable, angry)			
Thought Content:	Appropriate	Inappropriate			
Thought Process:	Logical	Tangential	Illogical		
Speech:	Normal	Slurred	Slow	Pressured	Loud
Motor:	Normal	Excessive	Slow	Other_____	
Intellect:	Average	Above	Below		
Insight:	Present	Partially Present	Absent		
Judgment:	Normal	Impaired			
Impulse Control:	Normal	Impaired			
Memory:	Normal	Impaired: Immediate, Recent, Remote			
Concentration:	Normal	Impaired			
Attention:	Normal	Impaired			
Behavior:	Appropriate	Inappropriate (anxious, agitated, guarded, hostile, uncooperative, drowsy, hyperactive, psychomotor retarded)			
Thought Disorder:	No Problem Delusions, grandiosity, paranoia, ideas of reference, tangential, Loose associations, perseveration, confusion, thought blocking, Obsessions, flight of ideas				

PSYCHOSOCIAL INFORMATION

Support Systems _____

School / Work Life _____

Marital History _____

Legal History _____

Military History _____

Spiritual Beliefs _____

RISK ASSESSMENT

	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation							
Homicidal Ideation							

Family Mental Health or Chmical Dependency History _____

_____

_____

_____

SUBSTANCE ABUSE HISTORY (complete for all patients of age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opiods/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Risk Factors noted to include:

_____ Non-compliance with treatment
_____ AMA/elopement potential
_____ Prior behavioral health inpatient admissions
_____ History of multiple behavioral diagnoses
_____ Suicidal/homicidal ideation
_____ Domestic Violence
_____ Child Abuse
_____ Sexual Abuse
_____ Eating Disorder
_____ Other (describe)

FOR CHILDREN AND ADOLESCENTS

Developmental History (developmental milestones met early, late, normal):

Peri-natal History (details of labor/delivery):

Pre-natal History (medical problems during pregnancy, mother's use of medications):

DIAGNOSTIC IMPRESSION

Primary Diagnosis (Clinical Disorder): _____

Specifier(s): _____

Primary Diagnosis (Personality Disorder): _____

General Medical Condition: _____

Stressors: **Family** _____ **School** _____ **Work** _____ **Health** _____

Legal _____ **Financial** _____ **Other** _____

Additional Comments/Information:

TREATMENT PLAN

**** All treatment goals must be objective and measurable, with estimated time frames for completion. The treatment plan should be developed with the patient, and the patient's level of understanding/acceptance of the goals developed should be documented.**

Treatment Goals [after each item selected, indicate outcome measures (i.e. "as evidenced by")]

___ Reduce Risk Factors of: _____

___ Reduce Major Symptoms of: _____

___ Improve Functional Impairment of: _____

___ Develop Coping Strategies to Deal with Stress of: _____

___ Stabilize (short term) Crisis of: _____

___ Maintain (long term) Stabilization of Symptoms of: _____

___ Medication referral to: _____

Planned Interventions-Patient Participation (must be consistent with treatment goals):

___ Assertiveness Training

___ Anger Management

___ Affect Identification and Expression

___ Cognitive Restructuring

___ Communication Training

___ Grief Work

___ Imagery/Relaxation Training

___ Parent Training

___ Problem Solving Skills Training

___ Solution Focused Techniques

___ Stress Management

___ Supportive Therapy

___ Self/Other Boundaries Training

___ Decision Option Exploration

___ Pattern Identification and Interruption

___ Engage Significant Others in Treatment: _____

___ Facilitate Decision Making Regarding: _____

___ Explore/Monitor: _____

___ Teach Skills of: _____

___ Educate Regarding: _____

___ Assign Readings: _____

___ Assign Tasks of: _____

___ Referrals Planned: _____

___ Use of resources/strengths: _____

___ Preventive Strategies: _____

___ Obstacles to change: _____

The provider and I have developed this plan together, and I am in agreement to working on these issues and goals. I give my permission to disclose the above assessment and treatment plan to my primary care physician for the purpose of medical supervision and ongoing care.

Client Signature _____ **Date** _____

Therapist Signature _____

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Name of Client _____
Last First Middle
Other Possible Names _____

Date of Birth _____ **Phone** _____

Address _____

City/State _____ **Zip Code** _____

I hereby authorize the Provider to use and disclose the information indicated below to:

Name _____

Address _____

Phone _____ **Fax** _____

Information may be: ☐ **Mailed** ☐ **Reviewed Only** ☐ **Picked up by:** _____

Information to be used and disclosed (check all that apply):
From and to dates: _____
☐ Personal Identifying Information ☐ Assessment ☐ Diagnosis ☐ Psychosocial Evaluation ☐ Treatment Plan ☐ Current Treatment Update ☐ Presence/Participation in Treatment ☐ Discharge/Transfer Summary ☐ Continuing Care Plan ☐ Progress in Treatment ☐ Demographic Information ☐ Billing and Payment Information ☐ Other _____

I understand that information to be used and disclosed may include protected health information, HIV-related information, and/or information relating to diagnosis or treatment of mental illness and/or substance abuse and that by signing this Authorization, I am authorizing the use and disclosure of information relating to (check all that apply):
☐ **Substance Abuse (including alcohol/drug abuse)**
☐ **Mental Health Treatment**
☐ **HIV related information (including AIDS related testing)**

Purpose for the use and disclosure (check all that apply):
☐ Changing provider ☐ Second opinion ☐ Continuing care ☐ Legal ☐ Personal
☐ Insurance ☐ Workers' Compensation ☐ School ☐ Payment ☐ Other_____

I understand and agree as follows:

a. This Authorization will expire 6 months from my last date of service provided by the Provider. I may shorten, extend, or revoke this Authorization at any time by notifying the Provider in writing at 228 Mill St. , Suite 103, Milford, Ohio 45150, which will be effective on the date the notice is received except to the extent action has been taken in reliance upon this Authorization;

b. If I am receiving treatment related to mental health or substance abuse, I authorize the Provider (i) to use information maintained by Neila Senter, to obtain payment for services rendered and (ii) to use and disclose my information, including but not limited to my protected health information, to obtain payment from such entitles for services rendered; and

c. I have received a copy of this Authorization after I sign it or refuse to sign it. A photocopy of this Authorization will be considered as valid as the original.

Signature of Client:_____
Date:_____

Signature of Parent, Guardian or
Responsible Party of a Client who is a Minor:_____
Date:_____

_____**: Check here if Authorization not given**

The Provider will not condition treatment or payment on this Authorization. Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by applicable law, rule, or regulation.

Prohibition on Redisclosure:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.