PARSONS COUNSELING & PLAY THERAPY CENTER

ADULT INTAKE PACKET

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT

Welcome *to Parsons Counseling, LLC (PC, LLC.).*

This document contains important information about our services and business policies.

Client Name: _____ **Date:** _____

Social Security #: _____ **Birthdate:** _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I hereby authorize staff of Parsons Counseling, LLC. to render treatment and/or service to the client listed above. I understand that information or opinions will be given to others only with my written consent.

Relationship: ☐ self, ☐ child, ☐ other (specify).

_____

Signature of Client or Legal Guardian **Print Name** **Date**

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law including, specifically:

1. You consent in writing by signing a release of information, or
2. The disclosure is allowed by a court order and/or issued by a judge, or
3. The disclosure is made to medical personnel in a medical emergency, or
4. If you pose a threat of harm to yourself or an identified person, or
5. If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect.

State Law and Regulation do not protect any information about suspected child abuse or neglect, including spousal abuse which must be reported in situations involving a vulnerable adult. Kentucky law requires that child abuse and neglect be reported. In Kentucky, no one under the age of 16 can legally consent to sexual contact.

Initial here: _____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by *PC, LLC.* In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. *PC, LLC.* counselors will use their clinical judgment when revealing such information. *PC, LLC.* will not release records to any outside party unless authorized by a signed release by a legal guardian.

Initial here: _____

THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that PC, LLC. carry out counseling treatment and diagnosis of a mental health or behavior issue. Participation in therapy can result in a number of benefits through working together openly and honestly with your counselor and working on interventions to make a change. However, during sessions topics, your past history may become uncomfortable and result in negative side effects, such as strong negative emotions, heightened anxiety, insomnia, and depression to name a few. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended.

- ❖ I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- ❖ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

- I understand that there are some occasions when confidentiality can/must be breached. These are:
  a) I sign a *Release of Information Form* or I verbally direct my counselor to tell someone else,
  b) My counselor determines that his/her client poses a threat to self or others,
  c) My counselor is ordered by a court to disclose information,
  d) My counselor knows or has reasonable cause to be believe that a child is dependent, neglected or abused and will report such information to Child Protective Services or law enforcement as required by Kentucky law, or
  e) Forensic consultation or treatment ordered by the courts.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that PC, LLC. counselors' are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: _____

Rights and Risks:

- Please feel free to ask questions about any aspect of the counseling process. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the PC, LLC counselor's expertise in employing them, or about the treatment plan, please ask and you with be answered fully.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that PC, LLC does not provide, the therapist has an ethical obligation to assist you in obtaining those treatments.

Initial here: _____

TELEPHONE & EMERGENCY PROCEDURES:

- The ***best phone number*** for calling the center is **(859) 985-7862,** our Main Berea Center location. You may also use **(859) 428-7862 to text or call in Berea OR (859) 428-8696 to text or call Richmond**. If you receive the voicemail, please leave a message for our administrators. Your counselor may be on the phone, in therapy with someone else, or out of the office. Our administrators will be sure to contact you and/or relay any necessary information to your counselor in a timely manner.
- ***In a crisis,*** if your therapist cannot be reached and ***you are in imminent danger, call the police (911), or go immediately to Baptist Health Richmond Emergency Room or to your local emergency hospital.*** If you are suicidal, extremely depressed, have thoughts of hurting yourself or others, or have another mental health crisis please go directly to the closest emergency hospital. ***Parsons Counseling, LLC. DOES NOT TAKE after-hour CRISIS CALLS*** due to limited staff and availability to return your crisis phone call. Parsons Counseling does not take after-hour calls.
- If you need to contact PC, LLC. between sessions, for an emergency, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and therefore, we cannot guarantee immediate returned calls. PC, LLC. counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call, consultation, or session.

Initial here: _____

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, PHOTOGRAPHS, AND MAIL CONTACT:

Privacy precautions have been made to ensure your privacy. PC, LLC. uses a secure program, TherapyNotes, for storing all documents, along with storing some in house documents in a locked filing cabinet. All precautions are attempted to keep your information confidential. If you choose to communicate over the internet or via phone through texting you understand you are waiving your right for confidentiality since there is no 100% guarantee of privacy through email or texts.

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Permission for PC, LLC. to initiate emails to you: Initial below if you give your permission for PC, LLC. to initiate sending emails to you and reminder appointments. Email is not to be used for emergencies or in a crisis.

Print your email clearly: _____ **Initial here: _____**

Photographs and artwork: I give permission for my therapeutic work, such as clients' miniatures, sandworlds and therapeutic artwork, to be shown for educational and training purposes without disclosing confidential identifying information.

Initial here: _____

INTERNS: PC, LLC is working with qualified students to train them for the human services profession. They will maintain client confidentiality and maintain professionalism in the workplace. Interns will schedule appointments, work with clients, assist with intakes, and other office tasks.

Initial here: _____

APPOINTMENTS: All office appointments are scheduled for 53 minute sessions. Consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. No more than 2 future appointments can be scheduled at a time in order to fairly accommodate all of our clients. Please arrive on time to all scheduled appointments. If you are unable to keep a scheduled appointment, you must notify PC, LLC. **at least 24 hours in advance** to avoid the *canceled or missed appointment fee of $30.00.* To cancel an appointment, you may choose to leave a message on voicemail, leave a text message at 859-428-7862, or email appt@parsonscounseling.com. ***Your compliance in keeping appointments and active participation in treatment is vital.*** (*only instances *not prohibited by law are subject to the missed/cancelation fee**)

I understand that I will be charged $30 for each missed appointment canceled inside a 24 hour period from my scheduled appointment. I understand that I cannot have another appointment until the missed appointment fee is paid. A doctor's note will waive fee.

Initial here: _____

TERMINATION:

- An orderly end of therapy has positive effects for clients. It is suggested that you discuss openly with your counselor your wish to end therapy at least three (3) sessions before your last session.
- If at any point during psychotherapy, a PC, LLC. counselor assesses that she/he is not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, terminate treatment. In such a case, the counselor would give you a number of referrals that may be of help to you.
- Frequent missed or rescheduled appointments will result in termination of services deemed by PC, LLC. A letter will be sent to you acknowledging the termination, reasons why, and a closing bill for any unpaid balance.
- If you have not had an appointment for at least 60 days a letter will be sent to the address on file inviting you to schedule an appointment within 10 days before terminating your chart. ***If you choose to schedule an appointment and do not show your chart will be terminated.***
- **If you cancel or miss three visits within a 90 day period PC, LLC. reserves the right to terminate your chart immediately & refer you elsewhere.**

Initial here: _____

Notification of Follow-Up Consent: I give permission to be contacted during the course of treatment and/or following termination from treatment to determine my satisfaction with the services received at PC, LLC **____Yes ____No**

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Appeals and Grievances: If you have a complaint about quality of care please contact the Practice Administrator by email at info@parsonscounseling.com within 30 days of the incident.

Initial here: _____

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a ***cash basis*** are expected to ***pay in full at time of service*** unless other arrangements have been made.
- ***Additional fees*** of $100 an hour will be charged for lengthy telephone communications, court attendance, and report/letter writing. Insurance does not cover this.
- If your case requires us to hire an attorney to assist or protect our office involving your case you will be responsible for ***all attorneys' fees***
- There is a ***$30.00 service fee*** **for checks returned** for Insufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay ***in cash*** the service charge ***PLUS*** the value of the check.
- I authorize my insurance to be billed for counseling services in attempt to assist in paying for my services.
- At any time during treatment ***should the client become ineligible for insurance coverage****, the client and/or responsible party agrees to notify the counselor and* ***will be responsible for 100% of the bill.***

Initial here: _____

CONSENT TO TREATMENT AND FEE:

By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Parsons Counseling, LLC. and all insurance benefits due to me to the full extent of my financial obligation to Parsons Counseling, LLC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Kentucky State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Initial here: _____

. . . . . .

HIPPA Notice of Privacy Practices

Please mark one of the following:

_____ I have received a copy of the HIPAA Notice of Privacy Practice (available at the Center or on www.parsonscounseling.com)

_____ I decline to receive a copy of the HIPAA Notice of Privacy Practice

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them; I have been given an opportunity to discuss these policies with a Parsons Counseling, LLC staff person and all questions I raised were answered to my satisfaction.

_____ _____ _____

Signature of Client or Legal Guardian **Print Name** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

ADULT'S CONTACT INFORMATION & PSYCHOSOCIAL

*Client Name: _____ *Date: _____

*Social Security #: _____ *Birthdate: _____ *Height: _____ *Weight: _____

*Gender at Birth: M or F (If applicable) Gender Identity: _____ Sexual Orientation: _____

*Address:_____

*City, State, Zip:_____

*Home Phone: _____ *May we leave a message at home? Yes No

*Cell Phone: _____ *May we leave a message or text the cell? Yes No

*Work Phone: _____ *May we leave a message at work? Yes No

*Email: _____ *May we email you or put you on our mailing list? Yes No

INSURANCE INFORMATION

****If you have Medicaid & other insurance in addition to Medicaid please list the OTHER insurance as the Primary Health Insurance. Medicaid will NOT pay if we do not bill the other insurance first. Ms. Lisa Parsons, Ms. Brittany Wills & Ms Jeanne Nakazawa are currently the only participating therapists with other private insurances outside of Medicaid. If you have other insurance & see another therapist you will be responsible for the full intake fee of $80.00. ****** For Medicaid, the client is the subscriber; all other insurances an adult parent is the subscriber.

*Primary Health Insurance: _____ *ID #: _____ *Group #: _____

*Subscriber Name: _____*Client's Relationship to Subscriber:_____ *Subscriber DOB: _____

*Subscriber Address: _____

Secondary Health Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____Client's Relationship to Subscriber:_____ Subscriber DOB:_____

Subscriber Address: _____

PERSONAL HISTORY

Primary Language: _____ Ethnicity: _____ Education: Are you a student? +Yes or No

If +yes, full-time or part-time? Name of School/College: _____

Highest grade completed: Middle School _____ High School: 9 10 11 12 Diploma GED

College: _____ Degree in: _____

Client Occupation: _____ Employer: _____

Check One: ___Employed Full-Time ___Employed Part-Time ___Unemployed ___ Homemaker ___ Disabled

Marital Status: ___Never Married ___Married ___Separated ___ Divorced ___Widowed ___Engaged ___ Partner

Spouse/Partner's Name: _____ Occupation _____

Gender: M F Age: _____ Birth date: _____ Length of Relationship: _____

Check One: ___Employed Full-Time ___Employed Part-Time ___Unemployed ___ Military ___ Homemaker ___Disability

ADULT'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Please list the names of your children or dependents.

Names of Children	**Date of Birth**	**Age**	**Lives With You?**
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Problem Analysis - History of Present Problem

PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish help with right now: _____

_____

PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle):

1 2 3 4 5 6

Not intense Moderately Intense Extremely Intense

PROBLEM DURATION: Approximately **how long** have you had the current problem? _____

COPING ATTEMPTS: In what ways have you **attempted to cope** with this problem? _____

_____

DEPRESSION: On a scale from 1-10 with ten being extremely depressed/suicidal, how depressed are you? _____

ANXIOUS: On a scale from 1-10 with ten being extremely anxious, how anxious are you? _____

HOSPITALIZED: Have you **ever been hospitalized** for psychological/emotional difficulties? _____Yes _____No

If yes, explain difficulty and dates hospitalized _____

_____

SUICIDAL: Have you had **suicidal thoughts** recently? ___frequently ___sometimes ___rarely ___never

Have you had suicidal thoughts in the past? ___frequently ___sometimes ___rarely ___never

Have you attempted suicide? ___Yes ___No ___Unsure

CUTTING/OTHER: Have you ever intentionally inflicted any harm upon self? ___Yes ___No ___Unsure

Trauma History

Nature of trauma (mark all that apply as a child or adult):

__Domestic Violence __ Sexual Abuse __ Divorce __ Post-Traumatic Stress Disorder __ Foster Care

__Physical Abuse __ Unwanted sex / rape __ Death __ Being controlled __ Neglect

ADULT'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Family Background & Psychiatric History - Please list your family members of origin.

Relatives	Name	Age	Grade/ Occupation	Substance Abuse or Mental Illness with Diagnosis
Father				
Mother				
Brother(s)				
Sister(s)				

1. Please check any past, present, or impending **special problems in your family**:

_____ serious illness _____ frequent relocations _____ deaths

_____ alcohol abuse _____ drug abuse _____ debilitating injuries / disabilities

_____ psychiatric disorder _____ physical / sexual abuse _____ financial crisis / unemployment

_____ eating disorders _____ legal problems _____ attempted / completed suicide

_____ divorce

2. Who in your family do you currently **feel closest** to? _____

Most **distant** from? _____ In most **conflict** with? _____

3. When was the last time you viewed **pornography**, where you viewed it, and for how long? _____

_____

Medical Conditions & History

1. How is your **physical health** at present? _____ poor _____ unsatisfactory _____ satisfactory _____ good _____ very good
2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, diabetes, headaches, surgeries etc.)

_____

3. 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

4. How many times per week do you **exercise**? _____ For about how long each time? _____
5. Are you having any difficulty with **appetite or eating habits**? ___Yes ___No

If yes, check where applicable: ___eating less ___eating more ___binging ___poor appetite

___making myself vomit ___significant weight change (last two months)

ADULT'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Substance Use

Do you use tobacco or nicotine? ____ cigarettes ____ dip ____ cigar/pipe ___ vapor

How many cigarettes or packs daily? _____ 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? _____

Do you consider your alcohol consumption a problem? ___Yes ___No ___Unsure

How often DO you engage in **recreational drug use**? ___daily ___weekly ___monthly ___rarely ___never

How often DID you engage in **recreational drug use**? ___daily ___weekly ___monthly ___rarely ___never

Current (C) or Past (P) : ___ Amphetamines ___ Marijuana ___ Opiate ___Cocaine ___Benzodiazepines

___Methamphetamine ___Heroin ___Inhalants ___ Hallucinogens

Do you consider your drug use a problem? ___Yes ___No ___Unsure

Social Issues

1. Rate the quality of your **peer relationships**? ___very poor ___unsatisfactory___about average ___good ___excellent
2. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? ____
3. **Support System:** who can you count on for friendship or **emotional support**? Mark all that apply:

__ Husband/wife __ Boyfriend/girlfriend __ Mom / Dad __ Brother __ Sister __ Aunt __ Uncle

__ Grandparents __ Church member __ Pastor __ Neighbor __ High school/college friends __ Co-workers

Legal Issues

Current (C) or Past (P) : ___ Arrest ___ DUI ___ Custody ___ DVO ___ EPO ___ Public Intoxication

___ Parole ___ Probation ___ Previous jail ___ Has a guardian ___ Charges pending

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

Please check all that apply:

	Abortion		Gender identity		Overweight
	Abuse - emotional		Goals not being met		Panic or anxiety attacks
	Abuse - neglect		Grieving, mourning		Parenting
	Abuse - sexual		Guilt		Perfectionism
	Adoption		Headaches, pains		Pessimism
	Aggression		Health, illness		Phobias
	Alcohol Use		Hearing voices		Physical problems
	Ambition		Helplessness/hopeless		PMS
	Anger		Hostility		Poor self-care
	Anxiety		Hyperactivity		Pornography use
	Arguing		Impulsive spending		Procrastination
	Attention problems		Impulsiveness		Relationship problems
	Career concerns		Incest		Relaxation
	Childhood issues		Indecision		Re-marriage
	Children – care of		Inferiority feelings		Risk-taking
	Children - custody		Infertility		Sadness
	Children - management		Inhibitions		School problems
	Choices I've made		Interpersonal conflicts		Self-abuse - burning
	Chronic pain		Irresponsibility		Self-abuse - cutting
	Codependence		Irritability		Self-abuse - other
	Communication		Judgment problems		Self-abuse - scratching
	Compulsive spending		Laziness		Self-abuse – pulling hair out
	Confusion		Legal matters, charges, suits		Self-centeredness
	Constant conflicts		Loneliness		Self-control
	Crying		Loss of control		Self-esteem
	Deaths		Losses		Self-neglect, poor self-care
	Debt		Loss of interest in activities		Separation
	Decision making		Loss of interest in sex		Sexual addiction
	Dependence		Low energy		Sexual conflicts
	Depression		Low frustration tolerance		Sexual desire differences
	Distractibility		Low income		Shyness
	Divorce, separation		Low mood		Smoking
	Domestic violence		Marital conflict		Spirituality
	Drug abuse – over the counter		Marital distance		Step-parenting
	Drug abuse - prescription		Marital infidelity/affairs		Stress
	Drug abuse – street drugs		Medical concerns		Stress-management
	Drug abuse - alcohol		Memory problems		Suspiciousness
	Education		Menopause		Temper problems
	Employment – lack of		Menstrual problems		Tension / stress
	Employment - overdoing		Mixed feelings		Thought disorganization
	Employment problems		Mood swings		Threats of violence
	Employment - termination		Motivation		Tiredness
	Emptiness		Mourning		Tobacco use
	Exhaustion		Nail-biting		Unhappiness
	Failure		Nervousness		Violence
	Fatigue, low energy		Nightmares		Violence – victim of crime
	Fears, phobia		Obsessions, compulsions		Weight and diet issues
	Financial troubles		Outbursts		Withdrawal - isolating
	Friendship problems		Oversensitive to criticism		Work problems
	Gambling		Oversensitive to rejection		Worry all the time

Please sign below to indicate that the information provided is true and correct:

Client/Legal Guardian: _____ **Date:** _____

Parsons Counseling, LLC Representative: _____ **Date:** _____

MEDICATION RECONCILIATION RECORD for ALL MEDICATIONS

Client Name: _____ **Birthdate:** _____

Date: _____

❑ **No Known Allergies OR List Allergies:**

Current Medications: *Prescribed medications, herbal supplements, vitamins, over-the-counter drugs, everything that you are taking on a regular basis for any reason.*

Medication Name	Dose and Frequency	Date Started	Date Discontinued	Reason for Taking It	Prescriber (first and last name with specialty)

Initials of Parsons Counseling, LLC. Representative: _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Adult

Client Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Parsons Counseling, LLC. to use or disclose protected health information from the mental health records of the client listed above, which may include psychiatric diagnosis, treatment plans, and progress (written, verbally or electronically) to the following and initial for my consent:

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Inform physician of therapeutic services and any medical or mental concerns.

***Psychiatrist or Prescribing Doctor of Psychotropic Drugs (if applicable):**

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate and obtain medical information from the physician to assist in meeting any medical, medication, or mental concerns.

Emergency Contact:

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: In case of a medical emergency and scheduling appointments.

Support person involved in treatment (if desired):

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Appointments, progress of treatment goals, concerns, and areas where support person can make improvement to assist client.

DCBS or Agency who has custody of child (if applicable):

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate with DCBS/agency to report progresS & therapeutic goals regarding behavioral or mental health concern to assist in reaching DCBS or agency goals & obtain a copy of most recent Family Prevention Plans/case plans.

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Adult

Legal or other:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: _____

By signing below, I acknowledge that I have read and understand this Authorization

1. I understand that, unless withdrawn, this authorization will expire in one year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Parsons Counseling, LLC. at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that Parsons Counseling, LLC will NOT give copies of client notes without another release signed indicating such.
5. I understand that I may inspect or copy my mental health records.
6. I understand that I may refuse to sign this authorization and that Parsons Counseling, LLC. will not allow my refusal to interfere with receipt of payment for mental health and counseling services.
7. I understand that I am entitled to receive a copy of this authorization.

_____ _____ _____

Signature of Client/Legal Guardian/Authorized Person **Relationship to Client** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**