



Journey Health Child Intake

836 S Suburban Ave Springfield, Missouri
Phone:417-612-5418 Fax:417-356-8796

Today's Date: _____

Name of Child: _____ DOB: _____

Address: _____ Social Security No: _____

Medicaid No: _____ Mother's Name: _____

Father's Name: _____ Cell Phone: _____

Who referred you to Journey Health? _____

Name of Person Completing Form: _____

Relationship to Client: _____ Phone Number _____

Legal Guardian (If different than above): _____

Phone Number _____ Client's School/Daycare _____

Emergency Contact Name: _____ Relationship: _____

Cell Phone: _____ Permission to Call: Yes No

Party Responsible for Payment: Self Other Relationship _____

Primary Insurance: _____ Insured Name: _____

DOB: _____ Social Security No: _____

ID No.: _____ Group No.: _____

Employer: _____

Secondary Insurance: _____ Insured Name: _____

DOB: _____ ID No.: _____ Group: _____



Employer: _____

Primary Reasons for Seeking Treatment:

Please indicate the primary reason(s) you are seeking services for your child:

- | | |
|---|--|
| <input type="checkbox"/> Abuse/Neglect Victim | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Addictive Behaviors | <input type="checkbox"/> Fear/Phobias |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sleeping Issues |
| <input type="checkbox"/> Behavioral Concerns | <input type="checkbox"/> Traumatic Events |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Violent Outbursts |

How long have the behaviors been present?

- 0-3 months 3-6 months 6-12 months More than 12 months

Please list any other stressors or challenges that are influencing your child's behavior:

Please describe the onset of your child's symptoms:

Has your child seen a mental health professional before? Yes No

If so, please specify dates, providers, previous treatments, as well as interventions and responses:

Has your child been hospitalized for mental health reasons? Yes No

If so, please provide approximate dates and reasons for hospitalization:

Has your child used drugs or alcohol? Yes No



If so, please list all drugs and approximate dates of use:

Psychosocial History

List all current members of the child's household and their relationship to the child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additional Members: _____

Does your child get along with all members of the household? Yes No

If no, please describe why: _____

Has your child experienced any significant separation from parents or other family members?

Yes No If no, for how long? _____

Has your child ever been placed in foster care? Yes No If so, for how long? _____

Is there any significant history of mental illness in your child's family? Yes No

If so, please describe any formally or informally diagnosis and the person who had them:

Is there any current legal involvement? Yes No If so, please described:

Is spirituality important to your child? Yes No If so, please describe faith community involvement and how spirituality may impact treatment:

Are there any cultural practices that may impact treatment? Yes No If so, please explain:



School History

In what grade is your currently? _____ Does your child maintain good grades? Yes No

If no, please described: _____

Does your child have an IEP of Special Education Services? Yes No

Does your child have a 504 Educational Plan? Yes No

Describe your child's strengths and challenges as they relate to school:

Strengths: _____

Challenges: _____

Describe your child's relationship with his peers: _____

Teachers: _____

Childcare providers: _____

Does your child have issues with school attendance? Yes No NA

If so, please describe: _____

Has your child had any problems with making friends or maintaining friends in the past?

Yes No

Has your child been a victim of bullying? Yes No

Social and Behavioral History and Current Status of Child:

Describe your child's current temperament: _____

Does your child react well to frustrating or difficult tasks? Yes No If no, please describe:



Has your child experienced significant losses (i.e. separation from parents, illness, or death)?

Yes No If so, please describe: _____

Has your child ever been exposed to the following types of abuse?

- Physical Abuse Sexual Abuse
 Emotional Abuse Exposure to Violence

If so, please describe: _____

Has your child ever experienced any of the following events?

Accidents? Yes No

Family member/loss of pet? Yes No

Witness to domestic violence? Yes No

Police/CPS/DFS Involvement? Yes No

If yes, please describe: _____

Does your child regularly use social media? Yes No

Medical History and Current Medical Status:

Is there any family history of physical illness? Yes No

Does the child have any known medical condition(s)? Yes No

If yes, please list diagnoses: _____

Is your child currently taking any medications? Yes No

Please list all medications and conditions the medications are used for:



Describe your child's general health: Excellent Good Average Poor

When was the approximate date of your child's last checkup? _____

Primary Care Physician Name and Phone: _____

Can Journey Health reach out to the Physician to coordinate care, if needed? Yes No

Does your child have any acute or chronic health problems? Yes No

If so, please describe: _____

Has your child ever been hospitalized for medical reasons? Yes No

If yes, how long? _____ What was the reason for the hospitalization? _____

Does your child maintain a healthy appetite? Yes No If no, describe: _____

Does your child maintain a healthy sleeping pattern? Yes No If no, describe: _____

Other relevant information: _____

I _____ (parent/legal guardian) do hereby seek and to consent to _____

(client) taking part in services provided by Journey Health Systems LLC (dba Journey Health). I understand that no promises have been made as to the results of treatment or of services provided by Journey Health Systems LLC (dba Journey Health).

Signature of Legal Guardian

Date



CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.



BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name

Client/Legal Guardian Signature

Date



In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call the Burrell Crisis Hotline (800) 494-7355
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name

Phone



**You agree to inform me of the address where you are at the beginning of every session.
You agree to inform me of the nearest mental health hospital to your primary location that
you prefer to go to in the event of a mental health emergency.**

Please list this hospital and contact number here:

Hospital

Phone

**You agree to inform me of the nearest police department to your primary location that you
prefer to go to in the event of an emergency.**

**Please list this police department and contact number
here:**

Police Department

Phone

**BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE
TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

Client/Legal Guardian Name

Signature

Date



EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on [May 25th, 2023]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full



and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.



8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws. 10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right



to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client/Legal Guardian Name

Legal Guardian Signature

Date



PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS Please remember to cancel or reschedule 24 hours in advance. You may be responsible for a \$15 fee if cancellation is less than 2 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A \$10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if **NOT RECEIVED AT LEAST 2 HOURS IN ADVANCE**. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for



a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5)

There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. In the course of treatment you have missed 2 appointments I will send or email a letter that will state the concern for the missed appointments. If continued absences persist, I will assume that you no longer need counseling if no communication is made within a month of the first absence and I will terminate services and care. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client/Legal Guardian Name

Legal Guardian Signature

Date



Release of Information Consent

Client's name:

I authorize Journey Health Systems LLC [DBA Journey Health] to:

Mark "x" in all applicable box(s)

Send

Receive

The following information:

Medical history and evaluation(s)

Mental health evaluations

Developmental and/or social history

Educational records

Progress notes, and treatment or closing summary

Other (please specify) _____

To/From:

Phone:

Your relationship to client:

Self

Parent/Legal Guardian



Personal Representative

Other (Specify) _____

The above information will be used for the following purposes:

Planning appropriate treatment or program

Continuing appropriate treatment or program

Determining eligibility for benefits or program

Case review

Updating files

Other (please specify) _____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client/Legal Guardian Name

Client/Legal Guardian Signature

Date



Release of Information Consent

Client's name:

I authorize Journey Health Systems LLC [DBA Journey Health], Joe De Vries (Isai Leal MS, PLPC Supervisor) to:

Mark "x" in all applicable box(s)

Send
Receive

The following information:

Medical history and evaluation(s)
Mental health evaluations
Developmental and/or social history
Educational records
Progress notes, and treatment or closing summary
Other (please specify) _____

To/From:

Phone:

Your relationship to client:

Self



- Parent/Legal Guardian
- Personal Representative
- Other (Specify) _____

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other (please specify) _____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

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If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client/Legal Guardian Name

Client/Legal Guardian Signature

Date



Informed Consent for Psychotherapy

General Information The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. Non-identifying assessment and/or treatment information may be used in future research. If you wish to not participate in any future research please advise your counselor in writing.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.



Gene Garcia, LPC, Journey Health Systems LLC Owner.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT

Client/Legal Guardian Name

Client/Legal Guardian Signature

Date