Lighthouse Counseling
& Sand Play Training Center, LLC

Welcome to our Practice

Thank you for selecting our wellness team! We will strive to provide you with the best possible care.
If you have any questions or need assistance, please ask us- we will be happy to help.

Dx_____ Therapist_____ Date_____

Client Information

Client Name_____

Date of Birth_____ Age_____ Sex: □Male □ Female

Is the client a minor? □Yes □ No Parent/Legal Guardian Name (If Applicable) _____

If the client is a minor, In the case of separation or divorce, which parent has legal custody? _____

Home Address _____

Home Phone_____ Cell Phone _____ Work Phone _____

Calls will be discreet. Any restrictions? _____

Email Address _____

Referral Source _____ May we thank them? □ Yes □ No

*Can we add your email to our constant contact email blast? □ Yes □ No

Responsible Party

Please complete the following information regarding the person who is financially responsible for this account.
(If the client is a minor, the parent bringing the child in for services is considered the responsible party)

Name of Responsible Party _____

Relationship to client _____

Date of Birth _____ SS# _____

Address _____

City _____ State _____ Zip_____

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Employer

_____

Occupation _____

Work Phone _____ Ext. _____

Home Phone _____ Cell Phone_____

Emergency Contact Information

In the event of an emergency, whom should we contact?

Name _____

Phone _____

Relationship to client or family _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Address of Insured _____

Phone # of Insured _____

Insured's Birth date _____

SS# _____

Employer _____

Occupation _____

Insurance Company _____

Policy # _____ Group # _____

Insurance Company Contact Phone # (on card) _____

Insurance address for claims (mandatory) _____

_____

_____

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Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian of minor. Date

A note about Insurance

As a courtesy, our office will complete and submit your insurance forms to achieve maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your policy and/or contact your insurance provider so that you are fully aware of coverage and any limitations of the benefits provided.

Cancellation Policy

Your time is reserved especially for you. As a courtesy to other clients and our staff, if you are unable to keep your appointment, we require a 24-hour notice of cancellation.

We charge the <u>full session</u> fee for any failed appointment or appointment cancelled with less than 24 hours notice. This fee will NOT be reimbursed by your insurance provider. Medical emergencies are exempt from this policy.

For the Initial Evaluation a 50% credit card deposit is required to schedule ($150) and will be billed for **any failed appointment or appointment cancelled with less than 24 hours notice.**

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Please Initial here x_____

Client Information Sheet

As a new client, please fill out the information on this form to the best of your ability.

Client Name _____ Age: _____

Marital Status: ☐ Child ☐ Single Adult ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

History of Present Problem

Briefly describe the difficulties which have led you to seek services at this time:

_____

_____

_____

_____

Severity: (How severe is the problem on a scale of 1-10) _____
Duration: (How long have you had this problem, or when did it start) _____

Medical History

Current Physician: _____ Phone: _____

Current Psychiatrist: _____ Phone: _____

Is the client receiving medical treatment for any condition now or within the past year?
☐ Yes ☐ No
If yes, please explain: _____

Please list any current medications you are taking:

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Medication	Dose	Reason Taking	Prescribed by

Has the identified client ever received any of the following psychiatric services?

		Details (e.g. Provider Name, Dates of Service)
Outpatient counseling	□ Yes □ No	
Psychiatric Emergency Screening Services	□ Yes □ No	
Inpatient Psychiatric Hospital Stay	□ Yes □ No	
Drug/Alcohol Rehabilitation	□ Yes □ No	
Therapeutic Residential Program	□ Yes □ No	
Child Study Team Evaluation	□ Yes □ No	

Social History

School Currently Attending: _____ Grade: _____

Employer: _____ Position: _____

History of Legal Charges or Arrests: □ Yes □ No Explain: _____

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily

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Use of Drugs (Including prescription pain medicine): ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Family Constellation

Mother or Wife	
Father or Husband	
Siblings or Children	
Step-Parent/Child/Siblings	
Others Living in Household	

Life Changes

Has the client or family experienced any major life changes lately?

☐ Move/Relocation ☐ Change of School ☐ Separation or Divorce
☐ Birth of Child ☐ Catastrophic Illness ☐ Unemployment/Financial Problems
☐ Trauma ☐ Victim of Crime ☐ Death
☐ Other _____

☐ DCPP (DYFS) Involvement If so, when & why? _____

DCPP Case Manager: _____

Current Functioning

In order to better understand the needs of the person seeking services, please respond to the following questions:

If you are the parent of a minor child seeking services, answer question on their behalf

How would you describe your mood most of the time?

☐ Cheerful/Happy ☐ Anxious/ Nervous
☐ Sad/Depressed ☐ Angry/Irritable
☐ Changes All the Time ☐ Bland/Unfeeling ☐ Other_____

Has the client ever…

Details:

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Attempted Suicide ☐No ☐ Yes _____

Currently have suicidal thoughts ☐No ☐ Yes_____

Engaged in self-injurious behavior ☐No ☐ Yes_____

Has the client ever…

Please explain any response:

☐ Been a Victim or Witnessed Sexual Abuse _____

☐ Been a Victim or Witnessed Domestic Violence _____

☐ Suffered a Traumatic Experience _____

Is there any additional information which you feel is important to share at this time?

_____

_____

_____

_____

If the child is a minor, are parent(s)/legal guardian(s) in agreement about the child's need for help? ☐No ☐ Yes

Thank you for your responses!

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Financial Agreement (effective November 1, 2023)

Counseling Services:

Initial Evaluation - 50% credit card deposit required to schedule	$350/60 min
	$400/75 min
Family/Parent Sessions (50-60 minutes)	$230
EMDR Eye Movement Desensitization Reprocessing	$230
Supervision (50 minutes)	$200
Marriage Counseling	$230
Supervised Visitation	Contact Sara for pricing
Individual Sessions	
16-37 Minutes (90832)	$150
38-52 Minutes (90834)	$200
53-60 Minutes (90837)	$230
Phone Sessions (Billed in 15-minute increments, not reimbursable by insurance)	
Every 15 minutes	$50
Group Therapy	
45 minutes	$75
60 Minutes	$85
75 Minutes	$95

Coaching

Initial Evaluation	$550
Ongoing sessions (phone, video, office)	$50/15 min

Miscellaneous Services: (Fees must be paid in advance)

Letter Preparation	$170 +
Brief Treatment Summary	No Charge
Full Day Court Fee	$4,000. + Travel

No Surprises Act

The No Surprises Act was designed to protect clients from receiving unexpected medical bills. As of January 1, 2022, state-licensed or certified health care providers need to give a Good Faith Estimate of healthcare charges to every new and continuing client who is either uninsured or is not planning to submit a claim to their insurance for the health services they seek.

The owners and affiliates of Lighthouse are using available resources to design No Surprises Act compliant paper- work. Therefore, please email your therapist regarding the Good Faith Estimate if you do NOT have insurances or do NOT intend to use your insurance to cover your services.

Effective November 1, 2023, we have updated all current financial rates on our website (under New Client Forms). You may request a paper copy of all financial rates at any time, and, if necessary, this paperwork can also be read to you either in person or over the phone.

Gretchen Morgan, MSW, LCSW 11/1/2023

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Financial Agreement (page2)

Phone Rates:

Phone calls will be charged for anything longer than 5 minutes. Each phone call will be billed $50. for each 15-minute increment. Although scheduled "phone sessions" can be submitted and reimbursed by the insurance company, your Insurance Company may not pay for unscheduled sessions. You are responsible for all phone call charges.

Cancellation Policy:

Your appointment time is reserved especially for you. As a courtesy to other clients and our staff, if you are unable to keep your appointment, **we require a 24-hour notice of cancellation. Failure to attend the appointment and notify your Treatment Provider will result in a charge of the FULL scheduled session fee.** This charge is billed directly to the client. For the Initial Evaluation a 50% credit card deposit is required to schedule ($150) and will be billed for **any failed appointment or appointment cancelled with less than 24 hours notice.**

Returned Checks:

There will be a $50 Service Charge for all returned checks.

Discount for Cash, Check, Venmo of $5 per session.

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Terms &Conditions

- All payments are due at the time of each session unless other arrangements are made in advance
- I understand that my "Out of Network" insurance is accepted as a courtesy, and that if my insurance provider should fail to reimburse for any of the services rendered, then I will be financially responsible for any unpaid balance.
- I understand tat it is my own responsibility to be aware of my insurance benefits (e.g., max benefits per year).
- I understand ad agree that fees for services will be billed directly to my insurance company by Lighthouse Counseling & Sand Play Training Center, LLC.
- **Account balances must be paid in full on a monthly basis**
- Any account balance not paid in full within 45 Days of statement due date will be assessed a $30 Service Fee and assigned for legal recovery with *I.C.Systems*, a professional collection agency.
- Should my unpaid account be assigned for legal collection, I understand that I will be responsible for all collections costs, which included the original debt owed, a collections charge of 30% of balance, Penalty Interest accrual rate of 16% (per applicable NJ Law) and any other legal and debt fees incurred in relation to recovery of outstanding amount balances.

I have read & understand the payment policy and agree to abide by its guidelines.

_____ _____ _____

Signature of Client or Parent/Guardian Date Witness Signature

Client/Parent/Guardian _____ accepted _____declined a copy of this document

Lighthouse Counseling
& Sand Play Training Center, LLC

Consent to Treatment

Name of client: _____

If the client is a minor, Name of parent/guardian giving consent to treatment: _____

This form is to document that you willfully give permission to a Treatment Provider of Lighthouse Counseling & Sand Play Training Center, LLC. to provide psychotherapeutic treatment to yourself and/or minor child.

Terms & Conditions

- A typical session lasts 50 minutes, unless planned otherwise.
- Parents/Guardians are expected to be onsite while children are within the counseling session and to appropriately supervise any children within the waiting area, to prevent disturbing others.
- Conversations within the counseling session will almost always be confidential.
- If the client is a minor, I understand that I have the right to general information on issues and progress, however some information shared in this professional relationship will be held in confidence by the Treatment Provider and the minor child.
- As Healthcare Providers, the Staff at LCSPTC, LLC., must by law report actual or suspected child or elder abuse to the appropriate authorities. Childhood abuse reporting is mandatory in all 50 states.
- As Healthcare Providers, the Staff at LCSPTC, LLC., have a legal responsibility to protect anyone that may threaten harmful or dangerous actions against self and/or another person(s) and may break confidentiality of our communications if such a situation arises. However, the Staff will make reasonable efforts to resolve these situations before breaking confidentiality.
- Regarding consultation procedures, there may be occasion when treatment providers may need to consult with clinical supervisors and/or in the interest of protecting the safety of the client or another whom may be at risk. In these situations, we will make every effort to maintain confidentiality, however in a situation of mandatory reporting, we will be required by law to disclose certain identifying and situational information.
- To safeguard confidentiality and preserve the integrity of the therapeutic relationship, the staff at LCSPTC, Inc., do NOT voluntarily become involved in client legal matters (e.g., custody, visitation, litigation against another, etc.).
- If at any time, I am dissatisfied with this therapy, I agree to fully discuss my views, reasons, and plans with my Treatment Provider.

Disclaimer: While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

_____ _____ _____

Signature of Client/Parent/Guardian Date Witness Signature

Client/Parent/Guardian _____ accepted _____declined a copy of this document

Lighthouse Counseling
& Sand Play Training Center, LLC

Authorization for Credit Card Use
Lighthouse Counseling and Sand Play Training Center, LLC.

I, _____, authorize Lighthouse Counseling & Sand Play Training Center, LLC. To charge my (or my child's) psychotherapy sessions to the credit card I have provided. I understand that this credit card will also be used to charge phone contacts, court documents, letters, and any other bills associated with treatment at the Center (unless other arrangements are made).

You may request an itemized bill in association with your account at any time. Itemized bills are sent out once per month.

You received a fee schedule with your intake packet. Please review this form and contact your treating therapist or the billing manager, Jennifer Morris, if you have any questions.

Please advise your treating therapist if your credit card number changes so that there is no interruption in services.

This authorization will remain in effect until revoked verbally or in writing.

_____ _____
Client/Responsible Party Date

_____ _____
Witness Date

Lighthouse Counseling
& Sand Play Training Center, LLC

Authorization to Use Clinical Work

The staff at Lighthouse Counseling & Sand Play Training Center, LLC., are committed to providing excellence in healthcare to our clients and their families as well as to other professionals. All the LCSPTC partners and many of our affiliates have taught Graduate or Undergraduate students at local universities and currently provide clinical instruction to other professionals in the field. Through the course of our instruction, we have recognized that it is most beneficial to utilize examples of our client's work to demonstrate various forms of intervention and treatment process. **You are under no obligation to grant us authorization to use the requested information,** however we believe that with these resources, we are better able to train competent and skilled professionals.

I hereby give my permission/authorization for the Staff at Lighthouse Counseling & Sand Play Training Center, LLC. To use copies of my and/or my child's:

- ☐ Artwork (drawings, paintings, etc.)
- ☐ Sand Play photos
- ☐ Clinical Narrative (presenting problem, interventions used, etc.)

I understand that this information will be used for educational, informational and training purposes.

The staff at Lighthouse Counseling & Sand Play Training Center, LLC., value and respect your confidentiality.

At <u>NO</u> time will any personally identifying information (such as name, address, etc.) be shared with others who might view any of the authorized work.

This authorization may be revoked at any time in writing by contacting my Treatment Provider.

Client Name: _____

Client/Parent/Guardian Signature _____

Date: _____

Lighthouse Counseling & Sand Play Training Center, LLC.
615 Hope Road, Bldg 3A
Eatontown, NJ 07724
Ph. (732) 380-1575 Fax (732) 380-1578

Lighthouse Counseling
& Sand Play Training Center, LLC

Notice of Disclosures and Practices

I. Disclosure of Financial Interest

Public law of the State of New Jersey mandates that providers of healthcare services inform clients/patients of any significant financial interest which may be held in a health care service.

II. Disclosure of Relationship

Accordingly, we wish to inform you that the partners of LCSPTC, LLC. do have a financial interest in the healthcare services provided under the auspices of the center to which we may refer to, including counseling, clinical trainings, and clinical supervision.

While we strongly believe in the clinical training and expertise of our staff, you may of course seek treatment at a health care service or provider of your own choice at any time.

Upon request, we will gladly provide a listing of alternative healthcare service providers. You may also consult the classified section of your telephone directory under the appropriate provider heading or contact your insurance carrier for a listing of providers.

Additionally, LCSPTC, LLC. Owner, Gretchen Morgan, and Affiliate, Heather Koenigsfest, are sales representatives for dōTERRA® and receive commissions on the sale of their products. Charlotte Stant, Gretchen Morgan's daughter is a sales representative for Rodan + Fields® and receives commissions on the sale of their products.

III. Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, it is required that all providers of medical and health services provide written notice of their Privacy Practices. Attached is a notice of our Official Privacy Policy Statement; it will remain in effect each year unless you are notified in writing of changes.

Please sign this form, which will acknowledge that you have been informed of the above disclosures and received the official Notice of Privacy Practices.

Signed: _____ Date: _____

LIGHTHOUSE COUNSELING & SANDPLAY TRAING CENTER, LLC.

INSURANCE COMPANY INFORMATION

The following information sheet is to inform clients about their responsibilities as well as help manage client expectations about the billing process at our office.

1) Clients are 100% responsible for their full session fess. There are no exceptions to this rule. A fee schedule is provided to all new clients in their welcome packet and is posted in the reception area.
2) Clients must pay their full session fee at the time of each session.
3) Medicaid, Medicare and all HMOs do NOT reimburse for any of our fees.
4) LCWC does not participate in any insurance companies. We are all "out-of-network" providers.
5) **Clients are solely responsible for obtaining "pre-authorization" for their treatment. Clients must contact their insurance company before starting treatment to see if they need "pre-authorization" for mental health services.**
6) Our Billing Manager submits claims every two weeks.
7) Although claims are submitted electronically, it will take **minimum** of 45 days for each claim to be processed. It is our experience that Insurance Companies will report that claims are "missing" or "can not be located in the system" when the claims have, in fact, been filed correctly and in a timely manner. Please do not contact the office about a missing claim unless it has been 60 days since the session date.
8) Our Billing Manager's primary responsibility is to submit HCFA's to the insurance companies. The Billing Manager can also provide billing statements to clients. Our Billing Manager is not responsible for tracking clients down to pay their bill. If you have a question for our Billing Manager, please leave it on her confidential voicemail (ext.310) or email (jennifermorris@yahoo.com) and she will send you the information you need. The Billing Manager is responsible for several hundred accounts and will not call any client back, as their request can be taken care of without a phone call.
9) **As a courtesy, clients will receive one bill stating that their account is past due. It is the client's responsibility to pay the bill immediately. All accounts that are 30 days past due will be sent to our collections agency, I.C. Systems. Once an account is in collections, the Billing Manager can not remove the account from collections unless a full payment (plus a 35% fee) is received at the office.**

NOTICE OF PRIVACY PRACTICES CONTINUED

II. Your Privacy Rights As Our Client

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. Psychotherapy notes are excluded from the legal provision that gives clients/patients the right to see and copy their health information. If you wish to examine your health information, you will need to submit your request n writing to the address listed at the bottom of this notice. Once approved, an appointment can be made to review your records.

Amendment: You have the right to amend your PHI if you feel it is inaccurate or incomplete. You request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to request an accounting of my disclosure of you PHI made for purposed other than treatment, payment o healthcare operations as described in this notice. The practice is not required to account for disclosures (1) which you requested, (2) which you authorized by signing an authorization to release medical information form, (3) to friends or family members authorized to be involved in your care, and (4) certain other disclosures my practice is permitted to make without your authorization. The request for an accounting must be made in writing to the address below and should include the time period for which you wish the accounting to include up to a six-year period.

Revocation: You have the right to revoke a prior authorization to release your PHI. All requests to revoke authorization of PHI, must be done so in writing by completing the Revocation of Authorization for Disclosure of Health Information Form. Contact the Privacy Officer to obtain a copy of this form.

Questions and Complaints:
If you think that we may have violated your privacy right, or you disagree with a decision made abut the access to you PHI, you may file a written complaint with Gretchen Morgan, LCSW at the address listed below. You may also send a written complaint to the Secretary of the department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

How to Contact Us:
Direct correspondence and concerns to the Privacy Officer at: Privacy Officer: Gretchen Morgan

Practice Name: Lighthouse Counseling and Sand Play Training Center, LLC.
Victoria Plaza
615 Hope Road, Bldg. 3A
Eatontown, NJ 07724
Phone: (732) 380-1575 Fax: (732) 380-1578

Lighthouse Counseling
& Sand Play Training Center, LLC

Social Workers and Licensed Counselors are licensed or certified by the State of New Jersey within the Division of Consumer Affairs. You may notify the board of any complaint relative to the practice conducted by a Social Worker or Professional Counselor.

The Social Work Board's address is:
Division of Consumer Affairs
Board of Social Work Examiners
Examiners
P.O. Box 45033
124 Halsey Street
Newark, New Jersey, 07101.

The Professional Counselor Examiners address is:
Division of Consumer Affairs
State Board of Marriage & Family Therapy
P.O. Box 45007
Newark, New Jersey 07101

By signing below, I acknowledge that I have received the HIPPA Policy form as well as the Notice of Privacy Practices. I understand that I have the option to receive copies of all forms in this Intake Packet.

_____ _____

Signature Date

Lighthouse Counseling
& Sand Play Training Center, LLC

Electronic Communication

Recognizing the profound impact that technology is having on society, and in accordance with the updated NASW Code of Ethics, which goes into effect 1/1/18, the owners and affiliates of Lighthouse Counseling & Sand Play Training Center, LLC, would like to clarify our policies about electronic communications. We want to be transparent, and for our clients to have a clear understanding of how we use technology to deliver services, communicate with our clients, search for information about our clients online, and store sensitive information.

Informed Consent

- We ask our clients or parents/guardians to provide written consent to the use of and ability to access technology and when appropriate, offer reasonable alternatives. When utilizing technology to communicate, we verify the identity and location of our clients.

- We obtain client consent before conducting an electronic search, gathering information, assessing, and intervening with our clients. With exceptions for compelling professional reasons, such as the need to prevent serious, foreseeable, and imminent harm.

Conflict of Interest

- We do not communicate with clients using technology for personal or non-work-related purposes.

- We do not accept requests from, or engage in, personal relationships with clients on social networks or other electronic media.

Privacy and Confidentiality

- We do not solicit information from or about our clients except for *compelling professional reasons, when disclosure of confidential information is necessary to prevent serious, foreseeable, and imminent harm to a client or others,* and as noted above.

- Our agreement includes specific considerations or restrictions for sharing confidential information in person or electronically, (e.g., through email, social media, online video and audio conferencing, text messaging, etc.), among clients,

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with others, family or group members.

- As always, we will not discuss confidential information "electronically or in person," unless confidentiality can be ensured.

- Although highly unlikely, we will notify clients of any breach of confidential information in a timely manner.

- While "online" client sessions have proven to be very helpful, and we consistently receive positive feedback about this modality of treatment, confidentiality cannot be guaranteed unless encrypted software is used. At this time, and in order to comply with the 2018 NASW Code of Ethics mandates, our recommendation is that texts and face-to-face communication online be done through servers such as Signal or Viber, which we have researched and found to offer state of the art encryption services.

- By signing and dating below, I am acknowledging that I have received this Electronic Policy Statement, that I understand both the benefits and limitations of electronic communication and that I have discussed any questions or concerns about this document with my treating therapist.

_____ _____

Signature Date

Lighthouse Counseling & Sand Play
Training Center, LLC.
615 Hope Road, Bldg 3A
Eatontown, NJ 07724
Ph. (732) 380-1575 Fax (732) 380-1578

Lighthouse Counseling
& Sand Play Training Center, LLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

Address: _____ Telephone #: _____

I hereby authorize my Treatment Provider to disclose or obtain my health information to/from:

_____

_____

Phone: _____ Fax: _____

The information to be disclosed to and used by the above is for the following purpose:

Continuing Care ____ Attorney/legal ____ Insurance ____ Other_____

Information to be faxed to the receiver: Yes: ___ Fax #: _____ No: ___

Complete Record ___	Psychiatric Evaluation ___	Current Treatment Plan ___	Medication Management ___
Admission Assessment ___	Treatment Plan ___	Progress Notes ___	Child Study Team Information ___
Diagnosis ___	Treatment Summary ___	Medical Information ___	Educational Information ___
Psychosocial Evaluation ___	Discharge Summary ___	Legal Records/Information ___	Other: _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS,

BEHAVIORAL OR MENTAL HEALTH SERVICES AND INFECTIOUS DISEASE information as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. Furthermore, I understand the revocation will not apply to the extent that my Treatment Provider has already taken actions in reliance on the authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition.

I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign this authorization. I need not sign this for in order to assure treatment, payment or enrollment or eligibility of benefits. I understand that I* may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF164.524. *I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules.* If I have questions about disclosure of my health information, I can contact my Treatment Provider at (732)380-1575.

Date: _____ Patient Signature: _____ Patient is age 14yrs or older: Yes __ or No __

Parent/Guardian: _____ Legal Representative: _____

Witness: _____

Office use only LCWC
Treatment Provider Name: _____ Date Information Released: _____ Signature: _____