Summit Wellness Centers, PLLC

PO Box:
211 Arden, NC 28704

Client Information Survey (Completed by Client)

Date: _____

In order to better serve you, we would appreciate the following information. Please complete this questionnaire as fully and accurately as you can.

Please Print:

Client Name:_____ Sex:_____ M _____ F

Home Address: _____ Date of Birth:_____Age: _____

_____ Marital Status:_____

Years Married:_____

E-mail Address: _____

(Completing this is an "opt-in" and signifies your comfort with electronic communications from our office regarding appointments or newsletters).

Phone Number (H): _____ (cell): _____

(Cell phones are not as secure as land-lines, but often our clients prefer this method of contact. Completing this signifies your comfort with cell phone communications with our office).

May we leave you a message at any of these phone numbers? Yes No

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

If the client is a child/adolescent, who has legal custody? (*If joint custody, a signed agreement must be completed by both guardians. Please speak with office for this agreement prior to first appointment).

School Information: School: _____

Grade Level: _____

Special Educational Placements: _____

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

Name	Age	Relationship to Client

List other children not living in the home:

Work/School

Current Employer/School _____ Location _____

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

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

_____

_____

HEALTH

Client Physician/Pediatrician: _____ Phone Number:_____

Date of last appointment with any doctor: _____

Date of last complete physical exam: _____

Current Health:_____ good _____fair _____ poor

Explain:

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

Arthritis_____	Cancer_____	Diabetes_____	Hearing/Vision Pr._____
Heart Disease_____	Brain Injury_____	High/Low Blood Pressure_____	Kidney Disease_____
Stroke _____	Seizures _____	Fainting Spells_____	Lung Problems_____
Cirrhosis_____	Infertility_____	Low Blood Sugar_____	STD's_____
Thyroid _____	Pancreatitis_____	Migraines _____	Eating Disorder
Weight gain/loss _____		Alcohol/Drug Use _____	Other

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

Is client pregnant? ____Y / N Due date: _____

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

_____

_____

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

_____

Medications:

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

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

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

_____

Substance Abuse

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

If yes, explain:_____

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

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

Alcohol:_____

_____

_____

Drugs:_____

_____

_____

Prescription Meds:_____

_____

_____

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

Family School Employment Legal Emotional Relational Health

Legal

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

_____

_____

_____

Previous Treatment

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

If so, where, and what was the outcome?_____

Have you ever seen another clinician in our center?_____

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

Facility Name/Location Date Reason Response to Treatment

_____

_____

_____

Trauma History

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

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

_____

_____

_____

_____

_____

Beliefs

What is your belief about God? _____

_____

_____

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

Family History:

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

_____

_____

Relationships

What concerns do you have regarding current relationships?_____

_____

_____

Today's Appointment

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

_____

_____

_____

_____

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

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

What is your goal of treatment?_____

_____

_____

What action(s) have you already taken regarding this issue?_____

_____

_____

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

_____

_____

What personal weaknesses or vulnerabilities may hinder your success? _____

_____

_____

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

_____

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

_____

Summit Wellness Centers, PLLC

REGISTRATION AND INSURANCE INFORMATION

Today's Date: _____
Client: _____ **DOB:** _____ **Age:** _____

Client Social Security Number (for insurance purposes only):
Social Security Number of the insured:_____ DOB of insured:_____
Spouse Name:_____ Parent/Guardian Name:_____
Address:_____
_____
Telephone: (H):_____ (W):_____ (C):_____
Emergency Contact Person:_____ Phone: _____

Insurance Information

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

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

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

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

_____ _____
Client Signature Date

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

Payment Policy:

It is the policy of Summit Wellness Centers, PLLC that payment is due at the time of service unless other financial arrangements are made in advance. In order to complete this process efficiently, Summit Wellness Centers, PLLC will maintain secure records of our clients' credit /debit card. Your card will be billed for the deductible, copay and/or coinsurance payment. Your card will also be charged for no-show appointments on the date of service you were scheduled.

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

I (we), the undersigned, authorize and request Summit Wellness Centers, PLLC to charge my credit/debit card, which I provide, for any balances due for services rendered that my insurance company identifies as my financial responsibility. If uninsured, or in the event of no-show appointments, I authorize Summit Wellness Centers, PLLC to charge my credit/debit card for my balance due. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and check into your coverage for behavioral health services. This authorization will remain in effect until I(we) cancel this authorization. To cancel, I(we) must give a 60 day notification to Summit Wellness Centers, PLLC in writing and the account must be in good standing.

Cancellation/No-Show Policy:

If for any reason you need to cancel an appointment, you must call at least 24 hours prior to the appointment to reschedule. Otherwise, you will be charged for the time that was reserved for you. If you repetitively cancel appointments, we reserve the right to discontinue services. Because of high demand for our services, we keep a waiting list of those who desire to have appointments and are waiting for an opening. This cancellation and no-show policy assures that we are being good stewards of the number of sessions our counselors can provide and allows us to best serve our clients. We appreciate your cooperation and partnership in this matter as we seek to serve our community.

Signed Agreement:
I understand and agree to the preceding information regarding the cancellation/no-show policy and the financial requirements/payment policy for services rendered.

Client Name _____ Date _____

Client Signature _____

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

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

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

LIMITS ON CONFIDENTIALITY

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

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

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

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

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

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** - We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** - We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** - We may use and disclose your health information within as part of our

internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** - You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** - With your written consent, any

part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

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

COMPLAINTS

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

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

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Kevin Wimbish, LMFT, HIPAA Compliance Officer

James Boone Leigh, MDiv MA, LCMHC
Summit Wellness Centers, PLLC
PO Box 211
Arden, NC 28704-0211
(828)692-6383

Professional Disclosure Statement

About the Counselor

I am the Rev. James Boone Leigh and am an ordained minister as well as a Licensed Clinical Mental Health Counselor. I received my Masters of Divinity from Reformed Theological Seminary in 2001 and a Masters of Arts in Professional Counseling from Liberty University in 2012. I have been doing pastoral counseling in church settings for the past eighteen plus years and Professional Counseling for the past eleven years. I work with children, adolescents, teens, adult singles, and married couples. I am currently a Licensed Clinical Mental Health Counselor (LCMHC) in both NC (#9860) and SC (LPC# 6435).

Clients/Services/Counseling Philosophy:

I work with individuals, couples and families, children and adolescents. I provide a wide range of services primarily utilizing supportive Christian counseling, cognitive behavioral therapy, reality therapy, problem-solving and decision making therapy. I believe that what we think and believe affects how we feel and what we do.

Appointment and Fees:

Individual and family sessions are generally 55 minutes in length. All sessions are by appointment only. The initial evaluation appointment fee is $130. Your fee for 55 minute follow-up sessions is $120.00, $100 for sessions less than 50 minutes. Payment must be made at the conclusion of each session. If you have an insurance plan that provides coverage for this service, we will be happy to file a claim for you. You are responsible for payment of your deductible and co-pays. Cash, credit card, and personal checks are acceptable methods of payment. **If for any reason you must cancel an appointment, please call at least 24 hours prior to the appointment. Otherwise, you will be charged for your session.** Besides weekly appointments, I charge my standard hourly fee for other professional services you may request, including report writing, phone conversations, consultations with other professionals per your request, or preparation of treatment summaries. As stated earlier, your signature on this disclosure ensures that I will not be called to testify in legal related matters. If, despite this consent, I am required to participate in legal proceedings, you will be expected to pay for all of my professional time and transportation costs. Because of the difficulty of legal involvement, I charge $200 per hour for my professional time spent in consultation with attorneys, report writing, preparation, and attendance at legal proceedings.

Telehealth:

If recommended, as a result of geographic or physical challenges, and you have already had an initial face-to-face intake, telehealth services may be provided through a HIPPA compliant, encrypted portal. Telehealth services utilize two-way, real-time interactive audio and video capabilities in providing services to clients. All confidentiality guidelines, laws, and treatment expectations for face-to-face treatment, as described elsewhere in the professional disclosure statement, also apply in the venue of telehealth. Fees will also be the same as that for face-to-face services. Clients who choose to utilize this venue will be provided instruction for logging on to the portal. Signing this consent signifies your understanding of the inherent risks with telehealth services, including, but not limited to, the transmission of private health information being disrupted, distorted, or compromised. Recording or
dissemination of any personally identifiable images or information from the telehealth interaction is prohibited.

Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Emergency Procedures

If you feel that you are at imminent risk of harm to yourself or others, you should immediately seek help or hospitalization by calling 911 or going to the emergency room of a local hospital. If at any time I assess that you are at imminent risk to self or others, I will encourage voluntary psychiatric hospitalization and assist you in the process. I am obligated to seek involuntary hospitalization on your behalf if you do not agree to voluntary hospitalization should the aforementioned situation arise.

Client Confidentiality:

The time spent in private counseling sessions will be kept confidential for both legal and ethical reasons. Client information is confidentially protected with the following exceptions: -You (or your legal guardian) consent in writing to the release of information;
-A court orders disclosure of information;
-When I believe that you intend to harm yourself or another person or when I believe a child or elderly person has been or will be abused or neglected;
-It is necessary to release information to insurance companies/reimbursement sources for payment of services.

Complaint Procedures:

If you are unhappy with our professional relationship, please speak with me immediately. This will make our work together more efficient and effective. If you think you have been treated unfairly or unethically and cannot resolve the problem with me, you can contact The North Carolina Board of Licensed Clinical Mental Health Counselors P.O. Box 77819 Greensboro, NC 27417. Phone # 844-622-3572. Fax # 336-217-9450. Email: Complaints@ncblcmhc.org

Counseling Agreement

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

Clients Signature_____ Date_____

Counselors Signature_____ Date_____

Revised 01/13/21

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

Services and Policy Consent Form

Location – Based Tracking

If you have location tracking enabled on your mobile phone, it is possible that others may identify your location at our office. Please be aware of your risks of exposing your privacy should you continue utilizing this service on your personal technology.

Social Media Policy

Our Summit Facebook page is a passive page. Comments are intentionally disabled to protect privacy, and to ensure that a non-multiple relationship is maintained. (If you choose to comment, you will see the comment, but others will not). If you desire to follow the blog, or learn of upcoming events, we encourage you to follow the social media link without actually creating a visible public link to the page, as "fanning" could potentially compromise your privacy. You may use your own discretion in choosing whether to follow a professional page, or the Summit page, on these sites.

Though you may follow the *professional* author page of Donna Gibbs, or any other Summit contractor, or the Summit Wellness Centers page, Summit counselors will not accept requests from current or previous clients to friend on any *personal* social media sites. This constitutes a multiple relationship, and has the potential of compromising your confidentiality. For the same reason, we request that clients do not communicate with counselors via messaging on any interactive social networking sites. If you need to contact your counselor, please contact our office, or utilize our TherapyAppointment portal, which provides an encrypted, HIPAA compliant platform.

Search Engine

Though it is not a regular part of our practice to search for clients on search engines, at times we may conduct a web search on clients, before the beginning of therapy, or during therapy. If you have concerns or questions regarding this practice, please discuss it with your counselor.

Testimonials

Our primary concern is your privacy. Confidentiality means that we take great measures to protect your privacy. This is why we do not request testimonials. However, you are welcome to tell anyone you wish that you are receiving services from Summit, and how you feel about the services provided you, in any forum of your choosing.

We're glad you chose Summit Wellness Centers, and we look forward to the journey ahead!

_____ _____

Client Signature Date

Appointment Reminders and Online Appointment Scheduling

You can receive appointment reminders to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.schedule.care to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Email address: _____

Home phone number: _____ Cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments.
(Missed appointment fees will still apply)

—— I am choosing to **Opt In** to communications via the method specified above.

If you would like to **Opt Out** at any time of future communications from our office, please email lbeddingfield@summitwellnesscenters.com indicating the method of communication from which you would like to opt out.

Appointment information is considered to be "Protected Health Information" under HIPAA. I understand that email and standard SMS messages are not confidential methods of communication, and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my mental/ behavioral health care may be intercepted and read by a third party. Accordingly, by my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

Summit Wellness Centers, PLLC

Authorization to Release/Exchange Confidential Records and Protected Health Information

Client: _____ **Date:** _____

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

(List individual/office/facility)

Name: _____ **Relationship:** _____

Address: _____

Phone Number: _____

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

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

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

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

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

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

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

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

_____ _____

Client / Parent / Guardian Signature Date

_____ _____

Witness Signature Date