Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

Instructions (Couples)

Please print and complete the following forms and bring them in to your initial appointment.

1. Client Intake Form
   Each client completes this form. We will review the information together.

2. Client Information
   Each client completes this form. We will review the information together.

3. Couples Intake Questionnaire
   Each client completes this form. We will review the information together.

4. Consent for Treatment Form
   Both clients sign this page.

5. HIPAA Client Notification of Privacy Rights
   This document is for your information only.

6. HIPAA Client Notification of Privacy Rights Signature Page
   Both clients sign this page after reading the HIPAA Client Notification of Privacy Rights.

7. Credit/Debit Card Authorization Form
   Please complete this form.

8. Authorization for Release of Information
   This form is optional. If you would like Gail to consult with one of your health care providers, complete this form.

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Client Intake Form

Full Name _____

Address _____

_____

Primary Phone _____ Alternate Phone _____

Email Address _____

Date of Birth _____ Age _____ Marital Status _____

Referred by _____ Phone _____

May I have your permission to contact your referral source to thank him or her? Yes No

Reason for seeking counseling _____

_____

Is there any other information you would like to share with me today? _____

_____

I understand that I am responsible for all charges incurred, that I must cancel an appointment at least 24 hours in advance or I will be charged for that appointment, and that I am responsible for missed appointment charges.

_____ _____

Signature Date

Gail A. Phillips, LCSW

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Client Information Form

Please complete this form and we will review the information together.

Name: _____ **Date:** _____

What made you decide to seek counseling now? _____

_____

_____

What are your expectations of counseling? _____

_____

_____

Describe any prior counseling experiences _____

_____

_____

Prior treatment experiences:

	With Who/Where?
Counseling/Psychiatric treatment	
Drug/alcohol treatment	
Self-help groups (AA,EDA, Al-Anon, etc.)	

Currently experiencing (check all that apply)

Emotional Difficulties
- ☐ Anger
- ☐ Anxiety
- ☐ Depression
- ☐ Fear
- ☐ Grief
- ☐ Guilt
- ☐ Loneliness
- ☐ Mania

Relationship Difficulties
- ☐ Boss/Coworker
- ☐ Couple
- ☐ Friends
- ☐ Parent/Child
- ☐ Sibling
- ☐ Roommate
- ☐ Other: _____
- _____

Compulsive/Addictive Difficulties
- ☐ Alcohol
- ☐ Food
- ☐ Gaming/Internet/TV
- ☐ Illegal Drugs
- ☐ OTC/Prescription Drugs
- ☐ Relationships/Co-dependent
- ☐ Sex
- ☐ Shopping/Gambling/Spending

Recent changes? (check all that apply)

☐ Sleeping Patterns ☐ Eating Patterns ☐ Energy Level
☐ Physical Activity ☐ Weight ☐ General Mood/Disposition
☐ Moved ☐ New Baby ☐ Marriage/Divorce
☐ Increased Tension ☐ New/Lost Job ☐ Other: _____

If yes to any of the above, please describe _____

_____

_____

Family and Relationship Information

Current living arrangements ☐ Alone ☐ With Family ☐ With Significant Other ☐ Roommate(s)
☐ Other: _____

Are you happy with this arrangement? ☐ Yes ☐ No

Relationship	**Name**	**Living with You?**		**Current Age (or deceased date)**
		Y	**N**	
Mother				
Father				
Spouse				
Children				
Significant Others (siblings, grandparents, step-relatives, half-relatives) *Please specify relationship*				

Where were you born? _____

Where did you grow up? _____

Who raised you? _____

Parent Information

☐ Parents Legally Married ☐ Parents Separated ☐ Parents Divorced ☐ Mother Remarried (# times: ___)

☐ Father Remarried (number of times: ___) ☐ Other: _____

Describe your relationship with your mother:

As a child _____

_____

Current _____

_____

Describe your relationship with your father:

As a child _____

_____

Current _____

_____

Describe your relationship with your sibling(s):

As a child _____

_____

Current _____

_____

Marital Information

☐ Single ☐ Legally Married ☐ Living with Significant Other ☐ Widowed

☐ Separated (length of time: _____) ☐ Divorce in Process ☐ Divorced (length of time: _____)

Describe any problems in your current relationship _____

_____

_____

_____

Sexual Information

When did you first become sexually active? _____

What is your sexual preference? ☐ Male ☐ Female ☐ Both ☐ Uncertain

Are you currently sexually active? ☐ Yes ☐ No

Do you enjoy sex? ☐ Yes ☐ No ☐ Sometimes

Are you content with your sex life? ☐ Yes ☐ No ☐ Sometimes

Describe any past or current sexual problems or concerns _____

_____

_____

Is there any additional sexual information you would like to share? ☐ Yes ☐ No _____

_____

_____

Painful Life Experiences

Have you ever been abused (emotionally, physically, sexually, verbally)?

Who/What?	When?

Have you experienced any significant losses (deaths, moves, financial, etc.)?

Who/What?	When?

Have you experienced any trauma (witnessed or experienced violence, accident, war, criminal act, etc.) ?

Who/What?	When?

Interests and Hobbies

☐ Art ☐ Outdoor Activities ☐ Books

☐ Diet/Health ☐ Films ☐ Cooking

☐ Music ☐ Physical Fitness ☐ Other: _____

☐ Crafts ☐ Sports _____

Do you participate in any activities/clubs/organizations? _____

_____

Religious and Spiritual Information

Do you believe in a god or power greater than yourself? ☐ Yes ☐ No

What was your religious or spiritual upbringing? _____

What is your current religious or spiritual practice? _____

How often do you engage in this religious or spiritual practice? _____

How important is this religious or spiritual practice to you? _____

Education

☐ Did not complete high school (Last grade completed? _____)

☐ Currently enrolled in high school (Grade? _____)

☐ High School diploma/GED

☐ Currently enrolled in college/vocational training (Year/Specialty? _____)

☐ College degree/Vocational certificate earned (_____)

Learning Differences

☐ Gifted ☐ ADHD ☐ Dyslexia ☐ Processing ☐ Other: _____

Employment

Briefly describe your employment history, beginning with your most recent job/internship.

Employer	Dates	Job Description

Military Experience

Branch/Rank	Date Drafted/Enlisted	Type/Date of Discharge	Combat Experience – Where?

Nutritional Information

Are you contented with your nutritional intake? Concerned? _____

_____

Do you have an illness/condition that impacts your eating (diabetes, allergies, etc.)? _____

_____

How often do you eat every day (meals and snacks)? _____

How much protein do you eat daily? Vegetarian? _____

How many fruits and vegetables do you eat daily? _____

How many starches do you eat daily? Simple? Complex? _____

How many fats do you eat daily? Saturated? Unsaturated? _____

How many sweets/desserts do you eat daily? _____

How many dairy products do you eat daily? _____

Have you lost or gained more than 10 lbs in the last six months? _____

Are you concerned that you might have some eating disorder symptoms? ☐ Yes ☐ No
If yes, please complete the Eating Disorder Questionnaire.

Legal Information

Are you presently on probation or parole? If yes, please explain. ☐ Yes ☐ No

_____

Are you currently involved in any active legal traffic/civil/criminal cases? If yes, explain. ☐ Yes ☐ No

_____

_____

Please describe any past convictions (age/sentence/traffic, civil or criminal). _____

_____

_____

Alcohol and Other Drug Use Information

Drug Type	When First Used	When Last Used	Frequency	Problem for You?
DEPRESSANTS				
Alcohol (beer, wine, liquor)				□ Yes □ No
Anti-Anxiety (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)				□ Yes □ No
NARCOTICS				
Heroin, Opium, Morphine, Codeine, Tylenol #3/#4, Methadone, Dilaudid				□ Yes □ No
STIMULANTS				
Amphetamines (Benzedrine, Dexadrine, Ritalin, etc.)				□ Yes □ No
Cocaine/Crack				□ Yes □ No
Caffeine				□ Yes □ No
Nicotine				□ Yes □ No
CANNABIS				
Marijuana, Hashish				□ Yes □ No
HALLUCINOGENS				
LSD, PCP, MDMA, DXM				□ Yes □ No
OTHER				
				□ Yes □ No

Have you ever had any legal problems related to your use of alcohol/drugs? ☐ Yes ☐ No

Have you ever had any relationship problems related to your use of alcohol/drugs? ☐ Yes ☐ No

Family Alcohol and Other Drug Information

Please describe the alcohol/drug problems of others in your family, past and present.

Who/Relationship	Problem Type	Treatment Recovery

Impact of Alcohol and Other Drugs

Please check all that apply.

Physical	Emotional	Behavioral
☐ Blackouts	☐ Depression	☐ Morning Use
☐ Memory Problems	☐ Confusion	☐ Sneaking
☐ Tremors / Shakes	☐ Concentration Problems	☐ Gulping
☐ Seizures	☐ Anxiety	☐ Loss of Control
☐ Delirium Tremens (DT's)	☐ Irritability/Restlessness	☐ Using for Relief
☐ Hallucinations	☐ Aggressiveness	☐ Impulsive Use
☐ Overdose	☐ Mood Swings	☐ Use Despite Negative Consequences
☐ Appetite Problems	☐ Impulsivity	☐ Associate with Friends That Use
☐ Nausea/Vomiting	☐ Euphoria	☐ Plan Activities Around Use
☐ Sleep Problems	☐ Relaxation	☐ Loss of Interest in Activities
☐ Sexual Problems	☐ Extreme Jealousy	☐ Change in Work/School Performance
☐ Injury	☐ Paranoia	☐ Work/School Lateness/Absenteeism
☐ Accidents	☐ Feelings of Guilt/Shame	☐ Job Loss Due to Use
☐ Liver Damage	☐ Suicidal Thoughts	☐ Frequent Arguments
☐ Other _____	☐ Homicidal Thoughts	☐ Separation/Divorce
_____	☐ Other _____	☐ Financial Problems
	_____	☐ Legal Problems
		☐ Physically Abusive to Self
		☐ Physically Abusive to Others
		☐ Suicide Attempts
		☐ Homicide Attempts
		☐ Other _____

Medical Information

Primary Care Physician _____ **Phone** _____

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

Please check any of the following medical problems you have had:

☐ Adrenal problems ☐ Head Injury/Loss of Consciousness ☐ Anemia ☐ Brain Tumor ☐ Diabetes

☐ Kidney/Bladder problems ☐ Liver problems ☐ Cancer ☐ Thyroid problems ☐ High Blood Pressure

☐ Lung problems ☐ Glaucoma ☐ Seizures/Epilepsy ☐ Stroke ☐ Heart problems ☐ Asthma

☐ Meningitis or Encephalitis ☐ Sexually transmitted disease ☐ Allergies

If yes to any of the above, please describe and give dates: _____

_____

Current Medical Problems

Please check all that pertain to you now:

Eyes:	□ Double Vision □ Eye Pain □ Problems with Vision
Ears:	□ Hearing Aid □ Buzzing/Ringing □ Infection □ Problems with balancing □ Hearing problems
Nose:	□ Nose bleeds □ Stuffy nose
Mouth:	□ Loss of taste □ Problems with teeth □ Dentures
Respiratory:	□ Shortness of breath □ Chronic cough □ Mucus production □ Positive TB test □ Coughing up blood
Skin/Joint/Muscle:	□ Changes in skin □ Changes in nails □ Changes in hair □ Skin rash □ Itchy/Dry skin □ Cramps in legs/arms □ Stiff/swollen joints □ Difficulty walking
Gastrointestinal:	□ Difficulty swallowing □ Heartburn □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Blood in stool □ Black tarry stool □ Abdominal pain
Genito/Urinary:	□ Pain/burning with urination □ Frequent urination at night □ Bloody/brown urine □ Difficulty starting urine flow □ Constant need to urinate
Nervous System:	□ Headaches □ Numbness □ Fainting spells □ Convulsions/seizures □ Memory problems □ Coordination problems □ Tremors/shakes □ Loss of movement □ Loss of sensation
General Health:	□ Overweight □ Underweight □ Chills □ Fever □ Tire easily □ Night/day sweats □ Chronic pain
Cardiovascular:	□ High blood pressure □ Low blood pressure □ Heart skips a beat □ Palpitations □ Fast heart rate □ Chest pains □ Swollen ankles
Females Only:	□ Menstrual irregularities □ Menopause □ Problem pregnancy □ Miscarriage #: □ Abortion #: □ Premenstrual problems □ Infertility □ Currently pregnant

If you checked any of the above, please describe: _____

_____

_____

Any medication allergies? If yes, please describe. ☐ Yes ☐ No _____

_____

Counseling and psychotherapy can be most helpful when every aspect of you and your life is taken into consideration. Please reflect on the emotional, psychological, behavioral, physical, social, occupational and spiritual aspects of yourself.

At this point in your life, what is most important to you? _____

_____

_____

Is there anything else you would like to tell me about yourself? _____

_____

_____

_____

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Client Intake Questionnaire (Couples)

Name _____ Date _____

Why do you think you are having relationship difficulties? _____

_____

_____

What do you think needs to happen to fix these problems? _____

_____

_____

What are three positive character traits that you love about your partner? _____

_____

_____

What are three negative character traits that you don't like about your partner? _____

_____

_____

In what ways do you think your partner needs to change to help your relationship? _____

_____

_____

In what ways do you think **you** need to change to help your relationship? _____

_____

_____

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CONSENT FOR TREATMENT

PROFESSIONAL BACKGROUND:

I am a licensed clinical social worker. I have a master's degree in Social Work from the University of Southern California and a bachelor's degree from the University of Georgia. I have held licensure as a master social worker since 1988 and a clinical social worker since 1990.

COUNSELING PHILOSOPHY & EXPECTATIONS OF CLIENTS:

I believe all individuals have the capacity to thrive, and my job is to help you remove the roadblocks that are keeping you from thriving. I see our psychotherapy relationship as one in which ***you*** set your goals because you know what is best for you, and I am privileged to work with you to attain those goals. I take my job as your psychotherapist seriously and believe it is courageous of you to engage in this process. I expect you to be actively involved in our work together: to talk about whatever is on your mind and to share your past experiences, your dreams, your fears, your thoughts, your feelings and anything else that is meaningful to you. By doing so, you will uncover and attempt to work through whatever is preventing you from thriving. It is impossible to guarantee any specific results regarding psychotherapy. However, we will work together to achieve the best possible results for you. If we both agree to begin a psychotherapy relationship, we will sign, date, and keep a copy of this informed consent. I will be considered your psychotherapist until termination occurs.

MY PERSONAL STATEMENT & PHILOSOPHY:

I believe it is crucial for me to take very good care of myself physically, emotionally, psychologically, educationally, and spiritually. I do this in a number of ways: by taking time to rest, refresh myself, and renew my spirit; by taking time to be physically active and to exercise regularly; by taking time to attend professional and personal workshops; and by taking time to do other things that give me joy including being with the people I love, giving workshops, traveling, reading, and writing. It is my belief that being happy, healthy and thriving in life requires a balance between work and play, and I do my best to manage my life in ways that reflect this belief. Therefore, there will be times when I will not be available. Occasionally, I may be unavailable for 2 weeks at a time. I will inform you in advance when I will be unavailable and will provide you with the name and number of another psychotherapist you can contact if you feel the need to do so.

CONFIDENTIALITY & EXCEPTIONS:

Please understand that I will keep confidential anything you tell me, with the following exceptions:

1. You allow me to talk with someone else by signing a release of information.
2. I determine you are a danger to yourself or to others.

3. You abuse a child or an elderly or disabled person.

ETHICAL GUIDELINES & STANDARDS:

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards for licensed clinical social workers. For a copy of the code of ethics to which I adhere, you may contact the Georgia Composite Board for Licensed Counselors, Social Workers, and Marriage and Family Therapists.

FEES:

My fee is $200.00 for a 50-minute appointment. For extraordinary appointment length, telephone consultations, and written work my fee is prorated in keeping with the above rate. The fee for a returned check is the bank charge, plus $25. Payment for additional charges is due at your next appointment.

PAYMENT:

You may pay by check, cash, money order or credit card. If you chose to pay by credit card, there is a $5.00 processing fee and a credit card form to be completed.

APPOINTMENTS:

If you cannot keep your appointment time, please give me ***at least 24 hours notice*** (more is appreciated) so I can make the time available to others. If you cancel with less than 24 hours notice or you miss a scheduled appointment, you will be charged for the appointment. Please add the fee for that appointment to your payment for the next appointment. If you are going to be more than 20 minutes late for your appointment, please let me know by calling me at **(404) 982-9010** and leaving a message if you do not reach me directly. Otherwise, if you are more than 20 minutes late, I will assume you are not coming and I may be unavailable. If this happens, you will be charged for the missed appointment. Fees are not prorated if you are late.

INSURANCE:

I choose not to be an approved provider for any insurance or managed care companies. This decision is based on my concerns about their lack of confidentiality of your personal information and that treatment decisions are made by outside third parties who may not be qualified to make those decisions and who may not have your best interest in mind. The responsibility is yours for checking with your insurance company to determine if they will reimburse you for my services. My fee is still due from you at the beginning of each appointment. Please let me know if you would like a receipt for you to file with your insurance company.

TERMINATION:

Your decision to enter psychotherapy is voluntary and you may terminate at any time. Termination of the psychotherapy relationship is also a natural occurrence when your goals have been met. The psychotherapy relationship may also be terminated if, in my professional opinion, it is in your best interest for me to refer you to another psychotherapist, as ethical standards dictate this course of action. Choosing to continue psychotherapy with another psychotherapist is your decision. Termination will occur if I have not seen you in an appointment for 8 weeks

from the date of our last appointment, unless you and I have a prior agreement to leave your case open for a specified amount of time.

CONSULTATION:

In keeping with accepted standards of practice and to ensure quality of care, I regularly consult with other mental health professionals regarding my work with clients. Client identity is protected at all times.

RECORDS:

Your records are kept for 7 years from the date of our first appointment. They contain my copy of this informed consent, your client information form, and all materials that pertain to you including my notes. It is confidential with the exceptions noted in the **Confidentiality & Exceptions** section. It is kept in a locked file cabinet and will be destroyed by shredding at the end of 7 years.

SIGNATURE:

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction, and that you agree to adhere to the policies specified in this document.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Gail A. Phillips, LCSW

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This page does not need to be returned, it is for your information only.

HIPAA Client Notification of Privacy Rights

This notice shall go into effect January 1, 2006 and remain so unless new notice provisions effective for all protected health information are enacted accordingly. It describes how your mental health records may be used and disclosed and how you can access them.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations. Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition. Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you. Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which an insurance company reviews our work together to see if your care is "really medically necessary." The use of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain

much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as "Business Associates." I do not currently employ business associates to assist with my administrative matters.

IV. Uses and Disclosures Not Requiring Consent or Authorization

Protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

V. Client's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location;
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health

information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

I am the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers. As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification. By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Gail A. Phillips, LCSW

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HIPAA Client Notification of Privacy Rights

Signature Page

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Signature Date

_____ _____
Signature Date

Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

Credit / Debit Card Authorization

Client Name _____
(Parent/Guardian if Minor Client)

Name as shown on card (please print) _____

Type of Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER DEBIT

_____ _____ _____
Credit/Debit Card Number Exp Date (MM/YY) Security Code

Billing Address _____

_____

Email Address for Receipt _____

Please note: Credit/Debit card payments are processed on a weekly basis. An insurance receipt will be emailed to you.

By signing this you:

- authorize Gail Phillips, LCSW to charge your credit or debit card.
- agree to allow charges to be made on your card without you present.
- **understand that you will be charged a $5.00 processing fee per transaction.**
- agree to be bound by the terms set forth in the Cardholder's Agreement.
- understand that you will be charged for missed appointments and late cancellations.

_____ _____
Signature Date

Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

Authorization for Release of Information

For continuity of care, I _____, authorize
(print full name)

Gail Phillips, LCSW, to communicate with the following person(s):

Name _____

Address _____

_____

Phone _____ Email _____

Name _____

Address _____

_____

Phone _____ Email _____

I understand that this authorization will remain effective for one year and that I may revoke it at any time.

_____ _____
Client Signature Date

_____ _____
Witness Signature (Gail Phillips, LCSW) Date