

# **Gail A. Phillips, LCSW**

2734 N. Hills Drive NE

Atlanta, Georgia 30305

[gail@gailphillips.net](mailto:gail@gailphillips.net)

(404) 982-9010

## **Instructions**

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

1. Client Intake Form  
*Please complete this form and we will review the information together.*
2. Client Information  
*Please complete this form and we will review the information together.*
3. Consent for Treatment Form  
*Please complete this form.*
4. HIPAA Client Notification of Privacy Rights  
*This document is for your information only.*
5. HIPAA Client Notification of Privacy Rights Signature Page  
*Please sign this page after reading the HIPAA Information Form.*
6. Credit/Debit Card Authorization Form  
*Please complete this form.*
7. 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

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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?** \_\_\_\_\_

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**What are your expectations of counseling?** \_\_\_\_\_

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**Describe any prior counseling experiences** \_\_\_\_\_

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### **Prior treatment experiences:**

	<b>With Who/Where?</b>
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)  <i>Please specify relationship</i>				

**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 \_\_\_\_\_

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Is there any additional sexual information you would like to share?  Yes  No \_\_\_\_\_

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**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**

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

**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?
<b>DEPRESSANTS</b>				
Alcohol (beer, wine, liquor)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Anti-Anxiety (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NARCOTICS</b>				
Heroin, Opium, Morphine, Codeine, Tylenol #3/#4, Methadone, Dilaudid				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>STIMULANTS</b>				
Amphetamines (Benzedrine, Dexadrine, Ritalin, etc.)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine/Crack				<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine				<input type="checkbox"/> Yes <input type="checkbox"/> No
Nicotine				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CANNABIS</b>				
Marijuana, Hashish				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HALLUCINOGENS</b>				
LSD, PCP, MDMA, DXM				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>OTHER</b>				
				<input type="checkbox"/> Yes <input type="checkbox"/> 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

- Blackouts
- Memory Problems
- Tremors / Shakes
- Seizures
- Delirium Tremens (DT's)
- Hallucinations
- Overdose
- Appetite Problems
- Nausea/Vomiting
- Sleep Problems
- Sexual Problems
- Injury
- Accidents
- Liver Damage
- Other \_\_\_\_\_
- \_\_\_\_\_

Emotional

- Depression
- Confusion
- Concentration Problems
- Anxiety
- Irritability/Restlessness
- Aggressiveness
- Mood Swings
- Impulsivity
- Euphoria
- Relaxation
- Extreme Jealousy
- Paranoia
- Feelings of Guilt/Shame
- Suicidal Thoughts
- Homicidal Thoughts
- Other \_\_\_\_\_
- \_\_\_\_\_

Behavioral

- Morning Use
- Sneaking
- Gulping
- Loss of Control
- Using for Relief
- Impulsive Use
- Use Despite Negative Consequences
- Associate with Friends That Use
- Plan Activities Around Use
- Loss of Interest in Activities
- Change in Work/School Performance
- Work/School Lateness/Absenteeism
- Job Loss Due to Use
- Frequent Arguments
- Separation/Divorce
- 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:

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

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Client Signature

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Date

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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***

**Gail A. Phillips, LCSW**

2734 N. Hills Drive NE

Atlanta, Georgia 30305

[gail@gailphillips.net](mailto:gail@gailphillips.net)

(404) 982-9010

**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

# Gail A. Phillips, LCSW

2734 N. Hills Drive NE  
Atlanta, Georgia 30305  
[gail@gailphillips.net](mailto: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](mailto: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