**TeleMental Health Paperwork**



yourceus

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**Disclaimer**

These forms are provided to assist mental health professionals in obtaining the necessary information from their clients and maintaining an orderly, ethical system for record keeping. of their services. The information below has been carefully researched and updated for the use of mental health professionals who have attended our TMH seminars. However, regulatory updates as well as technological advancements are continually being made. Please be advised that HIPAA regulations may be amended (i.e., High Tech Act of 2010), as well as state rules and regulation (i.e., Georgia Composite Board requirement for 6 hours TMH training and 3 hours TMH supervisor training) may change. Each clinician must be responsible for obtaining the necessary information and applying it to their professional practice with clients. The mental health professional would be wise to seek professional supervision, legal consultation and contact their professional association and professional liability insurance carrier. Ken Scroggs/EAP Works a division of North Pines Center, Inc. or Charlie Safford/Yourceus is not responsible and expressly disclaims liability for, or damages of any kind arising from the use of this information. This information is for educational and informational purposes only, and not intended to be a legal document. Each country, state and/or district may have distinctly different rules, regulations and licensure requirements. Therefore, it is recommended that an attorney be contacted for final interpretation and/or recommendations when necessary.

Under HITECH 20140 mandatory penalties will be imposed for "willful neglect." Civil penalties for willful neglect are increased under the [HITECH Act](http://www.hipaasurvivalguide.com/hitech-act-text.php). These penalties can extend up to $250,000, with repeat/uncorrected violations extending up to $1.5 million.

**SAMPLE FORMS:(Name of Business)**

**(Your Name & Credentials)**

**(Contact Information: Phone, Fax, Email, Website, etc.)**

**Initial Information Form for TMH**

Privacy Case #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: DOB: Sex: \_\_\_M \_\_\_F

Address: City/State/Zip:

Home Phone: Work Phone:

Cell phone: Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Contact Phone:

Client is: \_\_\_Married \_\_\_Single \_\_\_Other \_\_\_Employed \_\_\_Full-time Student \_\_\_Part-time Student

**Insurance Information**

Insurance Plan Insurance ID#:

Insurance Group#: Insured’s Employer:

Client’s relationship to insured: \_\_\_Self\* \_\_\_Spouse \_\_\_Child \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If you checked “Self” above, leave these blank

\*Insured’s Name: \*DOB: \*Sex: \_\_\_M \_\_\_F

\*Address: \*City/State/Zip:

Is there a second insurance plan? \_\_\_Yes \_\_\_No If yes, fill out information below for second insurance plan

Insurance Plan Insurance ID#:

Insurance Group#: Insured’s Employer:

Insured’s Name: Insured’s DOB:

Address: City/State/Zip:

**Please list other providers of health and mental health services**

Primary Care Physician (PCP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other counselor (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Local Resources:**

Primary Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Counseling resource: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Local Police Dept \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nearest Hospital Emergency Room: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nearest Psychiatric Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Local DFACS Office Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other contact (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Practice Name or Therapist’s Name and Credentials**

TeleMental Health Protocol

**Informed Consent for TeleMental Health Treatment** **Date: \_\_\_\_\_\_\_\_\_\_\_**

Client Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address of Client: Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Physical Address of Client: Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

(It is required that the client announce their location at each session, and it may be required that the client be at that same location for each session for the purposes of insurance payments.)

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_

Local Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_

# Introduction to TeleMental Health Services

As a licensed mental health provider I am obliged to inform your that TeleMental health services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. TeleMental health may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting. TeleMental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are fairly minor depending the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the counselor be located in a private place during their sessions, and that the security of their technology be up-to-date with appropriate security protection.

# Expected TeleMental Health Benefits:

* Improved access to care by enabling individuals to remain in their community
* Access to the expertise of a specific specialist

# Possible Risks:

There are potential risks associated with the use of TeleMental health. These risks include, but may not be limited to:

* Information transmitted may not be sufficient (e.g. poor sound or resolution of images) to allow for appropriate treatment such as play therapy
* Delays in treatment could occur due to deficiencies or failures of the equipment
* In very rare instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a breach of privacy

## Additional Points for Client Understanding:

1. I understand that TeleMental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.

1. I understand that none of the TeleMental health sessions will be recorded or photographed without my written permission.
2. I understand that the laws that protect privacy and the confidentiality of client information also apply to TeleMental health, and that no information obtained in the use of TeleMental health, which identifies me will be disclosed to other entities without my consent.
3. I understand that because this is a technologically based method sometimes it may be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
4. I understand that TeleMental health is done over a secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality.
5. My therapist has explained to me how the video conferencing technology and telephone procedures that will be used. I understand that TeleMental Health sessions will not be exactly the same as an in person session due to the fact that I will not be in the same room as my therapist.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or myself can discontinue the TeleMental sessions if it is felt that the videoconferencing or telephone connections are not adequate for the situation.
7. I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.
8. I understand that I may experience benefits from the use of TeleMental health in my care, but that no results can be guaranteed or assured.
9. I understand that if there is an emergency during a TeleMental health session, then my therapist will call emergency services and my emergency contacts.
10. I understand that if the video conferencing or telephone connection drops while I am in a session, that I will have a phone line available to contact my therapist.
11. I understand that I will create a safety plan with my therapist in case of an emergency.

I understand the information provided above regarding TeleMental health. I have discussed the consent with my therapist or assistant as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleMental health in my care.

Signature of Client (or person authorized to sign for client):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If authorized signer, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been offered a copy of this consent form (client's initials) \_\_\_\_

Appendix C: Client Safety Form

## TeleMental Health Safety Plan

I have provided two emergency contact numbers and the number to the local hospital.

If there is an emergency during a session, my therapist has permission to contact my emergency contacts and the local hospital.

I have provided a working telephone number to reach me if the video conferencing connection fails during a session.

My counselor has provided me with a contact number. If connections fail and my counselor does not call me back within 5 minutes, then I will call my counselor.

Additional Items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (or person authorized to sign for client:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If authorized signer, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Services/Notice of Privacy Practices**

**Clinician’s Name, Credentials** (Briefly Describe the services you provide.)

EXAMPLE: Pat R. Goodall LPC provides counseling services that include assessment, evaluation, and professional counseling in accordance with professional standards of practice. These standards of practice include providing each client with information concerning several aspects of the counseling process and the counseling relationship.

**The Risks and Benefits of Therapy**

Psychotherapy has been shown to be effective for the improvement and resolution of many kinds of personal problems. The process of psychotherapy, however, does involve risks on the part of the client. Change, and the processes involved in creating positive change, can at times be difficult and unsettling. While every attempt will be made to prepare each client for this, each client must make the decision to enter into this process with a clear understanding of these risks.

**Estimated Length of Therapy**

The length of the course of psychotherapy treatment can vary depending upon the severity of the problems presented, and the ability of each client to utilize therapeutic approaches. Whenever possible, each client will be given an estimation of how much time the psychotherapy process will take.

**Length and Cost of Therapy Sessions**

Unless otherwise stated, psychotherapy sessions will consist of 45-50 minutes of direct treatment, with 10-15 minutes allotted after the direct treatment for the clinician to complete treatment notes and review the content of the psychotherapy session. Unless otherwise agreed to, each psychotherapy session will be charged at the rate of $125. Clients who have mental health benefits through their insurance will be billed at the rate covered by their insurance, under the arrangement noted in a section below.

# Insurance Policy

Where a professional relationship exists between the provider and the client’s insurance carrier, the client will be expected to pay the co-insurance amount designated under the policies of the insurance carrier. Claims will be filed by the provider of services. Where a professional relationship does not exist with a client’s insurance policy, the client will be expected to pay the full amount for each psychotherapy session and to file his/her own claims. In such cases, where necessary, insurance forms and receipts will be filled out by the provider so as to allow the filing of claims by the client.

**Cost for Secondary Services**

Time spent performing services that support the counseling, such as writing reports, contact with outside parties by phone or letter, and supportive phone contact to the client outside of regular sessions, will be billed at the rate of $100, prorated for the amount of time spent engaged in the service. Time spent in phone contact to set or re-arrange appointment times, or brief phone contact to give or receive relevant treatment information will not be billed. These services are generally not covered by insurance mental health benefits and will be billed directly to the client.

# Payment Policy

# Unless otherwise agreed to, payment will be expected at the end of each psychotherapy session.

# Cancellation Policy

Clients are expected to provide 24 hours notice of cancellation of any scheduled psychotherapy session. For any unkept session not cancelled prior to 24 hours, the client will be billed the full amount of the cost of the session, unless agreed to otherwise prior to the unkept session. This cost is not covered by insurance, and the full amount will be billed to the client.

# Client Rights

Each client has the right to expect competent psychotherapy treatment in accordance with accepted professional standards. Each client has the right to request information about any aspect of treatment, including but not limited to assessment results, treatment techniques utilized, course and direction of treatment. Each client has the right to provide feedback to the provider about where treatment is being successful and unsuccessful, and to terminate treatment at any time.

# Client Responsibilities

Each client is held to be responsible for engaging in the therapeutic process in ways that further treatment progress, making available to the provider such information as is needed to provide effective treatment, and participating in directing the course and direction of treatment.

# Confidentiality

The confidentiality of all records is covered by state and federal law. Federal standards for maintenance of your records have been defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The records of clients with alcohol and drug abuse problems may also subject to further restrictions as outlined in Federal Law 42 CFR Part 2. These guidelines mean that all client information, including records of treatment, may not be released except under the following conditions:

**1) When the client signs a valid release of information;**

**2) When a disclosure is made to medical personnel in a medical emergency;**

**3) When a client expresses suicidal or homicidal intent with imminent risk;**

**4) When there is suspected child or elder abuse or neglect;**

**5) When disclosure is required by a valid court order.**

**Your Rights**

Under HIPAA, you have the following rights:

**1) The right to inspect or copy your own health information, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding.**

**2) The right to request restrictions on certain uses and disclosures of your treatment information.**

**3) The right to amend health care information maintained in your client record.**

**4) The right to request and receive an accounting of disclosures of your health related information made during a period up to six years prior to your request.**

**Clinician Duties**

**Therapist’s Name and Credentials** is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices concerning your health information. In addition to fulfilling this obligation through the provision of this Statement of Services/Notice of Privacy Practice, the clinician is responsible for providing any additional information that may be required to make you fully aware of your privacy and treatment rights.

**Statement of Validation.**

**I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.**

By Client(s) including couples and family members as appropriate.

# Print Name Here Sign Here Date

# Print Name Here Sign Here Date

# Print Name Here Sign Here Date

# Print Name Here Sign Here Date

**By (Therapist’s Name)**

# Print Name Here Signature Date

**Communication Addendum to the Informed Consent Agreement**

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client’s right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact your Clinician will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be updated at any time should circumstances or preferences change.

In the event that client chooses not to allow non-secure modes of communication, contact will only be made on Clinician’s secure portal site, via wire to wire phone, wire to wire fax, or mail.

Voice communication to client’s cell/smart phone for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

Voice communication from Clinician’s cell/smart phone for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

Fax communication to client’s non-secure fax or E-fax for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

If permitted, list permitted fax number(s):

Text communication to client’s cell/smart phone for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

Text communication from Clinician’s cell/smart phone

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

Contact via the client’s email

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

If permitted, list permitted email address(es):

Teleconferencing based communication to client’s portal for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

If permitted, list permitted portal site(s):

Teleconferencing based communication from your Clinician’s portal for:

Scheduling appointments \_\_\_Permitted \_\_\_Not permitted

Appointment reminders \_\_\_Permitted \_\_\_Not permitted

Between session contact \_\_\_Permitted \_\_\_Not permitted

If permitted, list permitted portal site(s):

**Statement of Validation.**

**I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.**

By Client(s) including couples and family members as appropriate.

**Print Name Here Sign Here Date**

**Print Name Here Sign Here Date**

**Print Name Here Sign Here Date**

**Print Name Here Sign Here Date**

**By (Therapist’s Name)**

**Print Name Here Signature Date**

Clinician Information and Notes

Concise Client Assessment Form

Client Name: Date of birth:

Address: Town/State/Zip:

Home Phone: Work Phone:

Emergency Contact: Contact Phone:

Name of PCP: PCP Address:

Insurance Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#:

**Parties in attendance/relationship to client:**

**Presenting Problem** (Chief complaint/concern; precipitating event; signs and symptoms; history of problems)

**Symptom Inventory / Mental Status** (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

\_\_Generalized Anxiety \_\_Weight change \_\_Suspiciousness

\_\_ Phobias \_\_Impaired memory \_\_Paranoid ideation

\_\_ Panic Attacks \_\_Irritability \_\_ Bizarre Behaviors

\_\_Depersonalization \_\_ Anger control problems \_\_ Tangential/Circumstantial thinking

\_\_Obsessions/Compulsions \_\_ Aggressiveness \_\_Confused

\_\_Depression \_\_Impulsiveness \_\_Delusions

\_\_Psychomotor retardation \_\_Focus/concentration problems \_\_Agitation

\_\_Low energy \_\_Distractibility \_\_ Dissociation

\_\_Fatigue \_\_Negative Self Image \_\_ Hallucinations

\_\_Withdrawal \_\_Disorientation \_\_ Loose Associations

\_\_Hopelessness \_\_Mania/Hypomania \_\_ Flight of Ideas

\_\_Sleep disturbance \_\_Tremors \_\_Intrusive thoughts

**Mood:** \_\_ Normal \_\_Anxious \_\_Depressed \_\_Irritable \_\_Euphoric \_\_Expansive \_\_Dysphoric \_\_Calm

**Affect:** \_\_Normal \_\_Unconstrained \_\_Blunted/Restricted \_\_Inappropriate \_\_Labile \_\_Flat

**Behavior:** \_\_Normal \_\_Aggressive \_\_Impulsive \_\_Angry \_\_Oppositional \_\_Agitated \_\_Explosive

# Social Relating / Executive Functioning (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

**Eye Contact:** \_\_Normal \_\_Fleeting \_\_Avoidant \_\_Staring \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facial Expression:** \_\_Responsive \_\_Flat \_\_Tense \_\_Anxious \_\_Sad \_\_Angry

**Attitude Toward Clinician:** \_\_Normal/Cooperative \_\_Uninterested \_\_Passive \_\_Guarded \_\_Dramatic \_\_Manipulative \_\_Suspicious \_\_Rigid \_\_Sarcastic \_\_Resistant \_\_Critical \_\_Irritable \_\_Hostile \_\_Threatening

**Appearance:** \_\_Normal \_\_Disheveled \_\_Unclean \_\_Inappropriate \_\_Unhealthy looking

**Insight:** \_\_Good \_\_Impairments in insight **Decision Making:** \_\_Good \_\_Impairments in decision making

**Reality Testing**: \_\_Good \_\_Impairments in reality testing **Judgment:** \_\_Good \_\_Impairments in judgment

**Interpersonal Skills:** \_\_Normal \_\_Impaired **Intellect:** \_\_Average or above \_\_Impaired

**Impairments caused by symptoms/mental status problems**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments on symptoms/mental status problems**:

**Risk Assessment**

**Suicide** \_\_None \_\_Ideation \_\_Intent \_\_Plan \_\_Means \_\_Attempt

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homicide** \_\_None \_\_Ideation \_\_Intent \_\_Plan \_\_Means \_\_Attempt

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical/sexual abuse: \_ \_Denies \_\_\_Yes Explain:

Child/elder neglect or abuse:\_ \_Denies \_\_\_Yes Explain:

* If risk of any of the above exists, client \_\_\_can \_\_\_cannot agree to a contract not to harm

\_\_\_self \_\_\_others \_\_\_both

**Domestic Violence** (1=Client 2=Partner 3=Both)

Have you (your partner)? Current Past

Slapped, kicked, pushed, choked, or punched the other? \_\_\_ \_\_\_

Forced or coerced the other to have sex? \_\_\_ \_\_\_

Threatened the other with a knife or gun? \_\_\_ \_\_\_

Made the other afraid that they could be physically hurt? \_\_\_ \_\_\_

Repeatedly used words, yelled, or screamed in a way \_\_\_ \_\_\_

that frightened, threatened, put down, or made the other feel rejected?

Comments:

**Drug/ETOH Use** (Please rate amount and frequency, present and past: e.g., 2B = moderate, infrequent)

(Amount of use ratings: 0=No use 1=Light or limited use 2=Moderate use 3=Heavy use 4=Extreme use) (Frequency of use modifier: A=Almost never B=Infrequent / Occasional C=Regular, not constant D=Constant)

Current use Past use

Alcohol \_\_\_ \_\_\_

Marijuana \_\_\_ \_\_\_

Cocaine \_\_\_ \_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

**Substance Use Problem Effects** (Ratings: 0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

Current use Past use

Used alcohol/drugs more than intended \_\_\_ \_\_\_

Spent more time using/drinking than intended \_\_\_ \_\_\_

Neglected some usual responsibilities because of alcohol or drugs \_\_\_ \_\_\_

Wanted or needed to cut down on drinking or drug use in past year \_\_\_ \_\_\_

Someone has objected to client’s drinking/drug use \_\_\_ \_\_\_

Preoccupied with wanting to use alcohol or drugs \_\_\_ \_\_\_

Used alcohol or drugs to relieve emotional discomfort, \_\_\_ \_\_\_

such as sadness, anger, or boredom

Comments:

**Important Family History**

**Prior counseling/Psychiatric history** (Inpatient / outpatient; dates (if known); providers; results)

**Medical Status** (Include current and past medical conditions, last visit to MD, and current and past medications)

**Psychosocial problems/ Stressors** (Current Ratings: 0=None 1=Mild 2=Moderate 3=Severe)

\_\_\_Work / career (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Financial (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Housing (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Legal (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Health (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Family (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Coping Resources** (Include coping skills/deficits, social supports, hobbies, exercise, nutrition, etc.)

# Diagnostic Impressions/Therapeutic Recommendations:

**DSM-5 Diagnosis**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_

Significant psychosocial and contextual features: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prognosis:**

**Disposition/Referral:**

**Comments:**

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

Signature Date

**Group Practice Name or Therapist’s Name and Credentials**

**Treatment Plan**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Original Date: \_\_\_\_\_\_\_\_\_ Revised date:\_\_\_\_\_\_\_\_\_**

**Target Problems/Symptoms:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments/Functional Impairment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Objectives:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interventions:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intervention Plan Overview / Time Frame:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prognosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Practice Name or Therapist’s Name and Credentials**

**Treatment Plan**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Original Date: \_\_\_\_\_\_\_\_\_ Revised date:\_\_\_\_\_\_\_\_\_**

**Treatment Domain Addressed: Medical\_\_\_ Psychologic\_\_\_ Social\_\_\_ System\_\_\_**

**Target Problem or Symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments/Functional Impairment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Party Assigned to Intervention**

**Intervention**

**Treatment Objective**

**Party Assigned to Intervention**

**Intervention**

**Treatment Objective**

**Intervention Plan Overview / Time Frame:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments/prognosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Practice Name or Therapist’s Name and Credentials**

**Progress Notes**

**Client Name:** ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Session:** \_\_\_\_\_\_\_ **Start time: \_\_\_\_\_\_\_\_ End time: \_\_\_\_\_\_\_\_\_**

**Other parties present / Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Objectives for session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Changes in medications:** \_\_None Changes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Changes in biopsychosocial status** (health, work, family, relationships, etc.)**:** \_\_None Changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Current Assessment of Functioning (1=mild 2=moderate 3=serious 4=severe 5=extreme)

**Mental status:** \_\_Normal \_\_Lessened awareness \_\_Memory deficiencies \_\_Disoriented \_\_Disorganized \_\_Delusional \_\_Hallucinating \_\_Vigilant \_\_Other (list):

**Suicide/violence risk:** \_\_None \_\_Ideation only \_\_Plans \_\_Threat \_\_Gesture \_\_Rehearsal \_\_Attempt

**Mood:** \_\_Normal \_\_Anxious \_\_Depressed \_\_Irritable \_\_Expansive \_\_Euphoric \_\_Dysphoric \_\_Tearful

**Affect:** \_\_Normal/appropriate \_\_Unconstrained \_\_Blunted/Restricted \_\_Inappropriate \_\_Labile \_\_Flat

**Insight:** \_\_Good \_\_Impairments in insight **Judgment:** \_\_Good \_\_Impairments in judgment

**Behavioral problems:** \_\_\_None \_\_Aggressive \_\_Impulsive \_\_Angry \_\_Oppositional \_\_Agitated

**Substance misuse:** \_\_None \_\_Level of misuse (list substance(s)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Data / Issue(s) Addressed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intervention(s) Utilized:** \_\_Cognitive \_\_Supportive \_\_Educational \_\_Insight oriented \_\_Solution focused \_\_Systems

\_\_Behavioral \_\_EFT \_\_DBT \_\_Relapse Prevention \_\_Other(list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resources provided (e.g., handouts, contracts)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referrals made**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Assessment / Progress made towards achievement of treatment goals / Effectiveness of interventions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Topics / Plans for next session:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:

**Group Practice Name or Therapist’s Name and Credentials**

**Case Activity Record**

**Client Name:**   **Date/Time**:

**Activity Type (Phone call, letter, Case conference, etc.):**

**Parties Involved:**

**Activity Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Comments:**

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**Clinician Name and Credentials Date**

**Rights to Privacy**

**Individual Rights to Privacy of your Personal Health Information, PHI**

**The information has been adapted from the HHS website for your convenience.**

**Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your Rights**

You have the right to:

* Get a copy of your paper or electronic medical record
* Correct your paper or electronic medical record
* Request confidential communication
* Ask us to limit the information we share
* Get a list of those with whom we’ve shared your information
* Get a copy of this privacy notice
* Choose someone to act for you
* File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

* Tell family and friends about your condition
* Provide disaster relief
* Include you in a hospital directory
* Provide mental health care
* Market our services and sell your information
* Raise funds

**Our Uses and Disclosures**

We may use and share your information as we:

|  |
| --- |
| * Treat you * Run our organization * Bill for your services * Help with public health and safety issues * Do research * Comply with the law * Respond to organ and tissue donation requests * Work with a medical examiner or funeral director * Address workers’ compensation, law enforcement, and other government requests * Respond to lawsuits and legal actions |

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
* We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
* We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
* We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
* 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 say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

* If you have given someone medical power of attorney or 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.

**File a complaint if you feel your rights are violated**

* You can complain if you feel we have violated your rights by contacting us using the information on page 1.
* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
* We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in your care
* Share information in a disaster relief situation
* Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

* Marketing purposes
* Sale of your information
* Most sharing of psychotherapy notes

In the case of fundraising:

* We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)**.**