



Child & Family Therapy Intake - Adult

Office Use Only:

Today's Date: _____

Dx: _____

Client Information

Name: _____
First Last M.I.

Address: _____
Street and Number City State Zip

Phone: _____ Age: _____ Social Security No.: ____-____-____

Date of Birth: ____/____/____ Gender: _____ Marital Status: _____

Did someone refer you? Yes/No If yes, who? _____

A second phone number in case of an emergency: _____

Name of person: _____ Relationship to you: _____

Billing Information

Responsible Party #1

Name: _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible Party #2

Name: _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Authorization to Bill Insurance

Primary Insurance:

Insurance Company: _____ Plan Name: _____

Address: _____

Street and Number

City

State

Zip

Policy #: _____ Group: _____ Insured's ID #: _____

Phone Number: _____ Fax Number: _____

Insured Information:

Name of Person Insured: _____

First

Last

MI

SSN: ____-____-____ Home Phone: _____ Cell Phone: _____

Insured's Address: _____

Street and Number

City

State

Zip

Birth Date: ____/____/____ Gender: ____Male ____Female

I, _____ (client name), DOB _____, authorize Child & Family Therapy Associates, LLC and it's providers to bill our insurance company/employee assistance program for treatment.

The primary subscriber (if not self) is _____, DOB _____, whose address is _____ (different from mine) and is employed by _____.

I understand this diagnosis will be provided to the insurance company. I understand the insurance company may request additional clinical information regarding treatment progress in order to authorize sessions and/or payment. I hereby authorize Child & Family Therapy Associates, LLC and it's providers to submit information as necessary.

Client or Guardian's Signature

Date



Printed Name

CHILDHOOD HISTORY FORM

Client's Name _____ Date _____

Birthdate _____ Age _____ Sex _____

Adopted ___ yes ___ no Were you aware of adoption? ___ yes ___ no ___ age

Others in Household:	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly state your main concerns for therapy:

To your knowledge, have any of your blood relatives experienced similar problems?

Did you or your mother experience any complications during pregnancy/delivery?

MEDICAL HISTORY: Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____

Operations: _____

Psychiatric hospitalizations: _____

Head injuries: _____

Convulsions/seizures: _____

Persistent high fevers: _____

Eye problems: _____

Tics (eye blinking, sniffing, or any repetitive movement): _____

Ear problems: _____

Allergies or asthma: _____

Sleep problems (restless, night waking, sleepwalking): _____

Bedwetting or soiling pants in daytime: _____

Describe the child's appetite: _____

Please list previous doctors/ prof's consulted: _____

Current medications and dose: _____

Prescriber & Phone#: _____ Last Visit: _____ Next Visit _____

Previous Counselor Name & Phone#: _____ Last Visit: _____

Substance Abuse Treatment Information: _____

Other Services Provided: _____

Overall Health: _____

FAMILY/SOCIAL HISTORY

Include any brothers or sisters have/had as well as your (the parent) natural parents.
(In other words, YOUR childhood history). Be sure to include PAST or PRESENT behavior.

Birth Mother (First Name Only: _____) Childhood History (Check all that apply)

___ Alcoholism _____ Drug Usage

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- | | |
|--|--|
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Birth Father (First Name Only: _____) Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Step-Mother (First Name Only: _____) Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Step-Father (First Name Only: _____) Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Adopted Mother (First Name Only: _____) Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Adopted Father (First Name Only: _____) Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Other: _____ |

Which family member has the best relationship with the client? _____

INFANCY - TODDLERHOOD

Were any of the following present during the first few years?

- | | |
|---|---|
| <input type="checkbox"/> did not enjoy cuddling | <input type="checkbox"/> was not calmed by being held |
| <input type="checkbox"/> difficult to comfort | <input type="checkbox"/> colic |
| <input type="checkbox"/> excessive restlessness | <input type="checkbox"/> excessive irritability |
| <input type="checkbox"/> frequent head banging | <input type="checkbox"/> constantly into everything |

TEMPERAMENT: please rate the following as you were reportedly appeared in infancy and toddlerhood:

- Activity level: underactive average activity level overactive
 Adaptability: adapted easily to change resisted change
 Intensity: average feelings were often intense
 Mood: often happy average range of moods

_____ often dissatisfied or irritable

DEVELOPMENTAL MILESTONES:

As best you can recall, list age of development, or check applicable items at right:

	Age	or	Early	Normal	Late
Walked without assistance	_____		_____	_____	_____
Spoke first words	_____		_____	_____	_____
Any speech problems?	_____				
Toilet trained daytime	_____		_____	_____	_____
Toilet trained nighttime	_____		_____	_____	_____

COORDINATION: Rate your development on the following skills:

	Good	Average	Poor
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____

COMPREHENSION AND UNDERSTANDING:

Do you consider yourself able to understand directions and situations as well as other adults your age?

How would you rate your overall level of intelligence?

_____ Below average _____ Above average _____ Average

PEER RELATIONSHIPS:

How do you get along with others your age? Describe any problems.

PAST SCHOOL HISTORY

School attended: _____ Highest Grade level _____

Were you in any special classes? _____

Did you ever have an IEP? _____ Yes _____ No _____ Reason (ID/DD or ED)

Did you ever repeat a grade? If so, which? _____

Briefly describe your school progress. Note usual grades, any problems or successes, strong subjects and weak subjects:

Preschool - K _____

1st - 5th _____

6th - 8th _____

9th - 12th _____

Describe any conduct problems you had in school:

How would you rate your homework/study skills? ___ Good ___ Average ___ Poor

Describe difficulties (beh, comprehension): _____

Did you have tutoring or remedial work? _____

Do you like to read? _____ How often (circle one): Never Seldom Some Often

Please rate reading ability as _____ Good _____ Fair _____ Poor

Reading Preferences: _____ Screen Time (Video/TV) _____ hrs/day

Any other comments on you school performance and behavior:

HOME BEHAVIOR AND MOOD

Please check which of the following applies to you:

- | | |
|--|--|
| <p><input type="checkbox"/> frequently irritable or moody</p> <p><input type="checkbox"/> doesn't seem to enjoy doing anything</p> <p><input type="checkbox"/> sad</p> <p><input type="checkbox"/> crying spells</p>
<p><input type="checkbox"/> easily bored</p>
<p><input type="checkbox"/> poor or low motivation</p> <p><input type="checkbox"/> low self-esteem (makes negative statements about self)</p> <p><input type="checkbox"/> can't seem to concentrate</p> <p><input type="checkbox"/> has had thoughts of or made comments about suicide/homicide</p> <p><input type="checkbox"/> self-harm: _____</p>
<p><input type="checkbox"/> eats (too much) or (too little)</p> <p><input type="checkbox"/> frequent arguing at home</p> <p><input type="checkbox"/> fearfulness</p> | <p><input type="checkbox"/> nervous, anxious</p> <p><input type="checkbox"/> frequent headaches</p> <p><input type="checkbox"/> frequent stomach aches</p> <p><input type="checkbox"/> has had panic attacks (rapid heartbeat, sweaty palms, feeling something bad about to happen)</p>
<p><input type="checkbox"/> difficulty sleeping:</p> <p style="padding-left: 20px;"><input type="checkbox"/> goes to sleep very late</p> <p style="padding-left: 20px;"><input type="checkbox"/> hard to get up in morning</p> <p style="padding-left: 20px;"><input type="checkbox"/> very restless sleep</p> <p style="padding-left: 20px;"><input type="checkbox"/> bad dreams</p> <p><input type="checkbox"/> acts like driven by a motor (talks excessively, can't sit still, can't watch a movie/tv)</p> <p><input type="checkbox"/> doesn't seem to learn from experience</p> <p><input type="checkbox"/> very disorganized (loses things, has very messy room)</p> <p><input type="checkbox"/> has ever been a victim of physical or sexual abuse</p> <p><input type="checkbox"/> drug or tobacco use: _____</p> <p><input type="checkbox"/> argues with or rude to teachers</p> <p><input type="checkbox"/> physically aggressive or bullying</p> <p><input type="checkbox"/> Struggles with authority figures</p> |
|--|--|

If you have experienced any stressful or traumatic situations in the past few months or in the last few years, please describe:

Any additional comments you would like to make about your mood, behavior, personality, etc.?

TRAUMA/LOSS: Have you experienced any of the following? Check all applicable.

- | | | |
|--|---|---|
| <p><input type="checkbox"/> Emotional Abuse</p> <p><input type="checkbox"/> Sexual Abuse</p> <p><input type="checkbox"/> Parent Sub. Abuse</p> <p><input type="checkbox"/> Childhood Surgery</p> <p><input type="checkbox"/> Homelessness</p> <p><input type="checkbox"/> Car Accident</p> | <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Violence in the home</p> <p><input type="checkbox"/> Parent Illness</p> <p><input type="checkbox"/> Multiple Home Moves</p> <p><input type="checkbox"/> Loss of Family Member</p> <p><input type="checkbox"/> Serious Injury/Fall</p> | <p><input type="checkbox"/> Physical Abuse</p> <p><input type="checkbox"/> Crime Victim</p> <p><input type="checkbox"/> Teen Pregnancy</p> <p><input type="checkbox"/> Foster Care</p> <p><input type="checkbox"/> Other: _____</p> |
|--|---|---|

INFORMED CONSENT for TREATMENT

Fees are as follows:

Initial Assmt.....	\$200.00
1 Hour:	\$145.00
½ Hour:	\$ 73.00
Phone Calls over 10 minutes.....	\$18.25 for every 15 minutes

Cancellation Policy

Scheduling appointments can be made over the phone or in person. You will primarily be responsible for scheduling appointments and keeping blocked out times up-to-date. Your time has been reserved exclusively for you and I do not double book appointments; therefore, **I reserve the right to bill for missed appointments or cancellations within 24 hours**. First missed or cancelled appointment without 24 hours notice, for any reason other than an emergency, will be billed at a rate of **\$65.00**. Any missed visit after that will be billed at full price. After 3 missed consecutive appts, your case may be subject to close.

Payments

Payments are expected at the time of your visit unless previously arranged. Please do not let financial concerns restrict your participation in the child's treatment. Clients are not expected to bill their insurance company as we utilize the billing services of **7 Medical Systems**. Certain exceptions apply in cases where a Preferred Provider agreement has previously been reached between the insurance company and therapist. A sliding fee scale is available if deemed necessary.

Safety

This office is equipped with a closed-circuit video surveillance system. This system is in place exclusively for the safety of our Clients and staff. The videotapes are completely confidential and are for security purposes; the videotapes are NOT for treatment purposes, unless otherwise needed and approved (such as Attachment Assessments) in writing by parent/guardian.

Emergency Situations

After Hour Emergency calls into the office will be forwarded to my voice mail. If the situation is urgent enough, you may text me. If I am available, I will respond. If I am unavailable and the situation is desperate, you may go to Lewis-Gale Medical Center or Carilion Roanoke Memorial Hospital to receive a mental health screening, which both have Inpatient Psychiatric Units.

Client Responsibilities

Clients are expected to follow all office procedures for scheduling and keeping appointments, payment of co-pays or services, and notification of termination of primary mental health professional. Clients are also expected to be motivated for treatment and show improvement in overall functioning over time. If for some reason the Client does not show improvement over a determined amount of time and/or in your opinion treatment is ineffective, you can be referred to another qualified professional.

Medical Records Policy

A child's mental health record will only be released with the signature you. The record will not be produced until 24 hours after the written request is received. The record must be picked up by the requesting party within 48 hours of production or record will be destroyed. Additional cost and fees will apply.



Court Policy

Fees for Angela N. Mitchell, LCSW to appear in court are as follows:

Attorney issuing the subpoena is to contact therapist's office at least 2 weeks in advance of the court date at Child & Family Therapy Associates, LLC, 5215 Starkey Road, SW, Roanoke, VA 24018 and block out either:

A.) 8:00 a.m. to 12:00 p.m. and/or

B.) 1:00 p.m. to 5:00 p.m.

Rates & Fees:

- **Blocked Time** will be billed at a rate of **\$800.00**, per blocked (due to loss of client appointment times).
- **"Standby" fees** are billed at regular office rate of **\$145.00 an hour**.
- **Appearance fees** are billed at a court rate of **\$175.00 an hour** (which includes preparation time, travel time, phone calls, report writing, etc.)
- **Deposition fees** are billed at **\$175.00 for first four hours**, and **\$100.00 for every hour** thereafter.
- **Report fees** are billed at **\$200.00** (per letter), due to the timeliness and complexity of letter.
- **Case Summary** fee is billed **\$25.00**.

To help keep client costs low, this therapist prefers not to attend court and discourages such requests. However, if it is necessary for therapist to provide expert witness testimony, the above fees will apply, despite which party subpoena's this therapist. If the Department of Social Services subpoena's therapist, generally they are responsible for the cost. It is important to know that if this therapist is called to provide expert testimony for more than one child (even in a family), an invoice will be submitted **for each child**. Each child has their own record and research and preparation is completed for each child. Attending court can be a timely and challenging task. Thus, a subpoena must always be issued for therapist to attend court. Copies of progress notes are not released without a judge's order. However, a written report and/or case summary with the appropriate consents being signed can be provided. Please know that if client's records are subpoenaed, the client will be notified immediately. Thank you for your professional courtesy and cooperation.

Sincerely,

Angela N. Mitchell, LCSW

Client Signature

Date



CFT Intake

Client Name _____

**Child & Family Therapy Associates, LLC
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL/ MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Child & Family Therapy Associates, LLC (CFT) 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 with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at CFT, please contact:

Privacy Officer: Angela N. Mitchell, LCSW
Street Address: 5215 Starkey Road, SW
City, State, Zip: Roanoke, VA 24018
Phone Number: (540) 293-9788

YOUR INFORMATION IS CONFIDENTIAL

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

‘HIPAA PRIVACY RULE’

A federal regulation, known as the “HIPPA Privacy Rule”, requires that we provide detailed notice in writing of our privacy practices.

WHO WILL FOLLOW THIS NOTICE

- Any health care professional authorized to enter information into CFT, Angela N. Mitchell, LCSW client’s chart.
- All departments and units of CFT, Angela N. Mitchell, LCSW.
- Any member of a volunteer group we allow to help you while you are our Client.
- All employees, staff and other 7 Medical Systems personnel, for billing purposes.

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

We understand that mental health information about you and your health is personal. We are committed to protecting mental health information about you. We create a record of the care and services you receive at CFT. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by CFT, Angela N. Mitchell, LCSW, whether made by CFT personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose mental health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of mental health information.

We are required by law to:

- make sure that mental health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to mental health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose mental health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use mental health information about you to provide you with mental health treatment or services. We may disclose mental health information about you to doctors, nurses, technicians, mental health students, or 7 Medical Systems personnel who are involved in taking care of you at CFT. We also may disclose mental health information about you to people outside the CFT who may be involved in your mental health care, such as family members, clergy or others we use to provide services that are part of your care, so long as your case is still open and a signed Authorization for Release of Information is signed.

For Payment: We may use and disclose mental health information about you so that the treatment and services you receive at CFT, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at CFT, your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose mental health information about you for CFT operations. These uses and disclosures are necessary to run CFT, and make sure that all of our Clients receive quality care. For example, we may use mental health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine mental health information about many Clients to decide what additional

CFT Intake

Client Name _____

services CFT should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, mental health students, and peer supervision groups. We may also combine the mental health information we have with mental health information from another agency to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove information that identifies you from this set of mental health information, so others may use it to study health care and health care delivery without learning who the specific Clients are.

Appointment Reminders. We may use and disclose mental health information to contact you as a reminder that you have an appointment for treatment or mental health care at CFT and/or 7 Medical Systems.

Treatment Alternatives. We may use and disclose mental health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose mental health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release mental health information about you to a friend or family member who is involved in your mental health care. We may also give information to someone who helps pay for your care. An Authorization for Release of Information will be used.

As Required By Law. We will disclose mental health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose mental health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, we may release mental health information about you as required by military command authorities. We may also release mental health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation/Disability. We may release mental health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose mental health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems as with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a Client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree and/or when required or authorized by law.

Health Oversight Activities. We may disclose mental health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose mental health information about you in response to a court order. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request and to obtain an order protecting the information requested.

Law Enforcement. We may release mental health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at CFT; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release mental health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose mental health information about you to authorized federal officials, so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release mental health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU

You have the following rights regarding mental health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy mental health information that may be used to make decisions about your care. Usually, this includes mental health and billing records, but does not include psychotherapy notes.

To inspect; and copy mental health information that may be used to make decisions about you, you must submit your request in writing to CFT. If you request a copy of the information, we will charge fees for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances if deemed detrimental to the Client's care.

Right to Amend. If you feel that mental health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for CFT.

To request an amendment, your request must be made in writing and submitted to CFT. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support, the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the mental health information kept by or for CFT;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Request Restrictions. You have the right to request a restriction or limitation on the mental health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the mental health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to CFT. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to CFT. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, please contact our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with CFT, or with the Secretary of the Department of Health and Human Services. To file a complaint with CFT, contact Angela N. Mitchell, LCSW at (540) 293-9788. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

COLLECTIONS

In order for us to service your account or to collect any amounts you may owe us, you authorize us and our affiliated clinicians, as well as their affiliates which include debt collectors, to contact you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact include but are not limited to the use of pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and facsimile as applicable.



OTHER USES OF MENTAL HEALTH INFORMATION

Other uses and disclosures of mental health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose mental health information about you, you may revoke that permission, in writing or verbally, at any time. If you revoke your permission, we will no longer use or disclose mental health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Client/Guardian

Date

Witness

Date