BALDWIN COUNSELING

2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Patient Information and Social History

Child (3-12)

Name: _____ Today's Date: _____
Last First MI

Address: _____

Home Phone: (___)_____ Parent Work/Cell: (___)_____

SSN: _____ DOB:_____ Present Age: _____

Father's Name: _____ Father's DOB: _____ Father's SSN: _____

Father's Home Phone: (___)_____Father's Cell: (__)_____Father's Work: (___)_____

Father's Address: _____

Father's Email Address: _____

Mother's Name: _____ Mother's DOB: _____ Mother's SSN: _____

Mother's Home Phone: (___)_____ Mother's Cell: (__)_____ Mother's Work: (___)_____

Mother's Address: _____

Mother's Email Address: _____

Guardian *(if applicable)*: _____ Guardian Home Phone:(___)_____

Guardian Cell Phone:(___)_____ Guardian Work Phone: (___)_____

Guardian Address: _____

Guardian's Email Address: _____

Type of Guardian (DHS, Grandparent, ect.): _____

Legal

Is child / parent involved in litigation/court: ____No ____Yes

If yes, answer the following questions; if no, proceed to the next section

Primary Custodial Parent: _____ Guardian *ad litem*: _____

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Guardian *ad litem* Phone: (___)_____ Guardian *ad litem* Fax: (___)_____

Guardian *ad litem* Address: _____

Consent to release / release information must be signed

Foster Care Guardian *(If applicable)*: _____

List any court ordered parental restrictions to information *(i.e. restraining orders or no legal custody)*:

_____

Identify visitation schedule of child: _____

Pending court dates: _____date _____time _____location _____reason

Financial

Please note: The party who signs the payment agreement is accountable for all charges incurred on the child's account. The party signing the payment agreement will receive all reminder calls.

Responsible party for payment/insurance: _____

Relationship to client: _____ SSN: _____ DOB: _____

Employer: _____ Email: _____

Address: _____

Presenting Problem

Please briefly describe the reason for seeking care:

_____

_____

_____

_____

_____

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Child Medical History

If currently under physician's care a primary care physician release form must be signed

Primary Care Physician: _____ Phone: _____

Address: _____

Current health concerns: _____

Prescribed medications: _____

Over the counter medications: _____

Current psychiatric care: _____No _____Yes If yes, please answer following questions

_____Psychiatrist _____Therapist _____Rehabilitation _____Inpatient Services

Provider name:_____ Provider Phone number: _____

Provider address: _____

Reason for seeking care:_____

If currently receiving care consent to exchange information must be signed

Previous psychiatric care: _____No _____Yes If yes, please answer following questions

_____Psychiatrist _____Therapist _____Rehabilitation _____In Patient Services

Provider name:_____ Provider Phone number: _____

Provider address: _____

Reason for seeking care:_____

Childhood History

At approximately what age did the following occur:

_____Held head up _____Crawled _____Sat alone _____Walked

_____First word _____ Sentences _____Toilet trained _____Dressed alone

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Difficulty using *(check all that apply)*: _____Scissors _____Coloring _____Writing

Identify any developmental concerns: _____

Describe child as a toddler: _____

Handed: ____Left ____Right Hearing Impairment: ____No ____Yes

High Fevers: ____No ____Yes Convulsions/staring spells: ____No ____Yes

Ear Infections: ____ No ____Yes Failure to Thrive: ____No _____Yes

Visual Impairment: ____No ____Yes If yes describe:_____

Speech Impairment: ____No ____Yes If yes, describe: _____

Identify any prenatal, birth or postnatal problems: _____

Injuries or accidents *(particularly blows to the head)*:_____

Describe child's health: _____

Describe any medical conditions: _____

Allergies: _____

Daily Schedule

Sleep Pattern: ____Normal ____Very Sound ____Restless ____Nightmares Hours of Sleep: _____

Bedtime: _____ Time of Waking: _____ Resists Sleep?: ____No ____Yes

Security Items: ____No ____Yes If yes, please describe_____

General appetite and eating habits: _____

Child care arrangements: _____

Educational Information

Current School: _____ City: _____ Grade:_____

Teacher's Name: _____ School Conference this year: ____No _____Yes

Signature: _____ Date: _____ Client ID: _____

If yes, describe outcome: _____

Academic progress: _____

Your expectations: _____

Schools Attended	Grade Level	Performance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's attitude toward school: _____

Unpleasant school experiences: _____

Grades retained and why: _____

Most difficult subject: _____ Best subject: _____ IEP: ☐ No ☐ Yes

504: ____No ____Yes *If yes, please provide copies* 504/IEP Triennial review date: _____

Resists attending school: ____No ____Yes Reads other than assigned books: ____No ____Yes

Truancy concerns: ____No ____Yes if yes, describe:_____

In school suspension: ____No ____Yes if yes, describe:_____

Out of school suspension: ☐ No ☐ Yes if yes, describe: _____

Educational testing: ☐ No ☐ Yes If yes, provide copies _____School Testing _____Private Testing

Where does he/she study: _____ Parents help with studying: ____No _____Yes

Other comments on school:

_____

_____

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Family Relationships

List all people living in the household (*if parents separated/divorced use second section for other parent)*

Name	Age	Grade Level	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other households that the child lives in:

Name	Age	Grade Level	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe the father-child relationship: _____

_____

Describe the emotional attachment to the father: _____

_____

Describe the mother-child relationship:_____

_____

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Describe the emotional attachment to the mother: _____

_____

Describe relationship with significant caregiver: _____

_____

Describe the emotional attachment with significant caregiver: _____

_____

Activities with father: _____

Activities with mother: _____

Family activities (Mother/Father/ Both) *circle one* *Complete next question if separated/divorced*

_____

If separated/divorced Family activities (Mother/Father)*circle one*:

_____

Mother's discipline type: _____ Consistent: _____No _____Yes

Father's discipline type: _____ Consistent: _____No _____Yes

Other guardian/caretaker's discipline type: _____ Consistent: _____No _____Yes

Who administers discipline: _____

Childs responsibilities: _____

Personality of child: ____anxious ____depressed ____extroverted ____introverted ____imaginative

____loner ____social ____sensitive ____happy ____unhappy

Activity level of child: ____active ____aggressive ____difficulty remembering ____impulsive

____organized ____loses things easily ____prefers quiet play

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Martial Situation

____Married ____Living together/not married ____Separated ____Divorced

____Widowed ____Never married If married, number of years in present marriage: _____

Describe your present marriage: ____poor ____tolerate each other ____relatively happy ____happy

Additional comments: _____

If remarried since the birth of client, how old was (s)he: when you divorced: _____ remarried:_____

If separated/divorced, who has primary physical custody: _____

Please note: Step-parents do not have access to medical information unless a release is signed

Stepfather or significant other's name: _____Role:_____

Stepmother or significant other's name: _____Role:_____

What are the legal custody arrangements: _____

Visitation Schedule: _____

Court ordered restrictions:_____

If child is in care of Department of Human Services (DHS) please complete the following:

Release must be signed for collaboration

Legal guardian:_____ Title/Role: _____

Address: _____

Contact information: _____

Foster care parent(s) name: _____

Foster care parents(s) address: _____

Foster care parent(s) phone: _____(home) _____(cell) _____(work)

Length of time in foster care: _____ Length of time in current foster home: _____

Therapeutic foster home: _____no _____yes if yes, identify reason:_____

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Identify service providers/team members:

Name	Phone	Reason for services
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parental History

Biological Father:

Name: _____ DOB: _____ SSN: _____

Birth Place: _____ Highest Level of Education Completed: _____

Describe any difficulties in school: _____

Place of employment: _____ Occupation: _____

Work hours: _____

Drug abuse: ____none ____current ____past if current/past marked, describe: _____

Alcohol abuse: ☐ none ____current ____past if current/past marked, describe: _____

Criminal history: _____

Other marriages: _____

Past physical or psychological concerns: _____

Current physical or psychological concerns: _____

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Biological Mother:

Name: _____ DOB: _____ SSN: _____

Birth Place: _____ Highest Level of Education Completed: _____

Describe any difficulties in school: _____

Place of employment: _____ Occupation: _____

Work hours: _____

Drug abuse: ____none ____current ____past if current/past marked, describe: _____

Alcohol abuse:___none ____current ____past if current/past marked, describe: _____

Criminal history: _____

Other marriages: _____

Past physical or psychological concerns: _____

Current physical or psychological concerns: _____

Reviewed By: _____ Date:_____

Baldwin Counseling Payment Agreement

Baldwin Counseling believes that a clear understanding of our financial policies is important for both client and therapist. We are fully committed to helping you accomplish the goals you establish when you enter counseling and to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. The following information clearly describes our financial policies. ***A copy for your records will be provided upon written request, with applicable fees remitted.***

PATIENT NAME _____ Date of birth ___ ___/___ ___/___ ___

INSURANCE INFORMATION

- **I agree to pay my co-payment, coinsurance, and/or deductible *at the time of service.***
- **As a courtesy we will verify insurance benefits. *Any co-payment, coinsurance, or deductible we charge are based on the benefits provided by the insurance company(s)*** Patients are responsible for any outstanding balance *in the event that the insurance carrier denies benefits, changes co-payment, alters your deductible, retracts a payment, or does not provide benefits as estimated. Patient or Responsible Party is responsible for the balance regardless of the reason the insurance denies coverage.*
- **Patients must notify our office of any changes to their insurance *no later than 48 hours prior to an appointment*** or patient may be responsible for the full standard fee for that appointment.

SELF PAY INFORMATION *(The Self Pay Rate is discounted from the Standard Fee.)*

- **I agree to pay the rate of $ 80.00 per session *at the time of service*.**
- **If payment is NOT made *at the time of service* the patient will forfeit the discounted rate and will be charged the full Standard Fee for that service date** *(Standard Fees are based on service type and provider.)*

PAYMENT INFORMATION

- **Full payment is due at the time service.** *Credit cards, cash and checks are accepted.*
- **Patients will incur a monthly interest rate of 1.67% (APR of 20%) if their account balance is not paid in full within 30 days of the billing date.** *Patient will be responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees should collection become necessary.*
- **Patients will be charged $35 for a return check or returned credit card payment.**
- **Patients will be charged a fee of 20% of the balance due if the account is sent to collections and the patient (or any member of the patient's family) cannot be seen if the account is in collections.**

MISSED APPOINTMENT FEE

- **Patients will be charged $80.00 for a missed appointment fee *for appointments that are cancelled less than 24-hours in advance.* Patients may phone the office anytime to cancel an appointment. The voice mail is date and time stamped**
- **Missed Appointment fees are not covered by insurance and are the responsibility of the patient.**

ADDITIONAL CHARGES

- **Patients are responsible for additional charges for services agreed upon by the patient and therapist** that are incurred during the course of treatment, including psychological testing, reports, and letters.
- **After hour's calls, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion and disclosed to the patient.**
- **All court related costs (preparation, travel, consultation, reports) are billed at $180.00 hour.**
- **Fifty percent of estimated court costs are due at least 48 hours before the scheduled court date/time and the remainder of incurred fees are due within 48 hours of the court date**
- **Coparenting is not covered by insurance. The rate for coparenting is $100.00 per forty five minutes and is payable at time of service.**
- **Costs associated with preparation of reports and letters, as well as consultations, that are not court related, are billable at $100.00 per hour.**
- **Specific to children: The parent who signs the payment agreement is responsible for all financial obligations. It is the responsibility of the parent(s) to comply with any court order that requires that**

the parents share costs. Baldwin Counseling will hold the parent who signs the agreement responsible for 100% of all costs, including any missed appointment fees generated by either parent.

- **If there are two missed appointments, the therapist may terminate services and return to counseling will be by mutual agreement between the therapist and the client. No further sessions will be scheduled until all fees are paid and the patient speaks to the therapist.**
- **Telephone consultation is not covered by insurance and is billed at $80.00 for forty-five minutes.**

I accept financial responsibility for the patient account and the terms of the payment agreement.

_____ ___ ___ ___-___ ___-___ ___ ___ ___ __/__/__

Name of Patient/Responsible Party *(if minor) Social Security Number* *Date of Birth*

_____

Signature of **Patient/Responsible Party***(if minor)*

Date _____ Relationship to patient _____

Witnessed:_____ Date_____ Patient Id_____

BALDWIN COUNSELING

CONSENT FOR TREATMENT/CONTACT INFORMATION

PATIENT Name (last/first/MI) _____

PATIENT Date of birth___ ___/___ ___/___ ___

I, _____, (Patient OR parent/legal guardian of minor client under 18)

_____**(initial) Have read and understand** the contents of the **Virginia Notice Form** (*A copy of this notice will be provided upon request and is available on the website, www.baldwincounselingcenter.com.)* regarding the Protected Health Information (PHI) held by Baldwin Counseling for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

_____**(initial) Have read and understand** the contents of the **Notice of Privacy Practices**. (*A copy of this notice is available on the website, www.baldwlincounselingcenter.com, and will be provided upon request).*

_____ **(initial) Give Informed Consent to Treatment-** My consent indicates a commitment to enter into treatment with the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

_____ **(initial) Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

SIGNATURE _____ **DATE** _____

REVIEWED BY _____

CONSENT TO CONTACT

May we contact you by phone? ***Please check YES or NO below***

_____ **NO**, you may not contact me by phone for appointment reminders or notify me of cancellations by leaving a phone message. I *will be responsible for keeping scheduled appointments and I understand that a missed appointment fee may be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.*

_____ **YES**, you may contact me for appointment reminders and/or to notify me of a cancellation by leaving a phone message or text* at the following #(s)

Automatic Computer Reminder Calls: Are scheduled to be sent prior to your appointment to the preferred number. Baldwin Counseling is not responsible for this service; it is a courtesy call. Only one number may be designated for these automated calls. The calls cannot be delivered to two different parties. The patient or parent who signs the payment agreement and this form will receive the automated calls.

My Preferred contact is _____Cell _____Home _____Work _____ .

CELL NUMBER _____

HOME NUMBER _____

WORK NUMBER _____

_____ _____
Signature of Patient or Responsible Party

_____
Printed Name Relationship to patient Date

_____ _____
Signature of Counselor Date

BALDWIN COUNSELING

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Baldwin Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Suzanne Baldwin.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, DHS representative, etc.) and provide appropriate documentation.

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Clinician **Date**

POLICIES AND FEE AGREEMENT FOR WITNESS TESTIMONY AND RELATED SERVICES

This document confirms that a Baldwin Counseling therapist has been asked by the undersigned client (or the parent/guardian of the client) to provide additional services related to litigation involving the client. It describes procedures and sets forth our agreement regarding payment of the costs and fees associated with those services.

Hourly Rate. The clinical therapist's current rate for services rendered is $180.00 per hour. Baldwin Counseling reserves the right to increase that rate in the future, but advance notice will be provided of any increase. All work is billed in fifteen minute increments.

Billable Time. All time spent regarding the litigation of the client's case will be billed at the hourly rate listed above. That time may include, but is not limited to, participating in conferences and/or telephone conversations related to the case, drafting and reviewing correspondence and/or emails, reviewing records or other materials, doing research, rescheduling other clients' appointments to reserve The clinical therapist's time for court appearances and/or depositions, conducting clinical interviews, participating in depositions, drafting reports, travelling and/or appearing in court.

Court Appearances. Unless other arrangements have been made in writing or email and in advance, the clinical therapist will not appear in court unless a valid witness subpoena has been issued.

The party requesting the clinical therapist's presence at court (including the party on whose behalf an attorney issued a witness subpoena) shall be liable for all Billable Time associated with the court appearance. The fees for all Billable Time shall be paid, even if the case settles or the clinical therapist's testimony is ultimately deemed to be unnecessary.

Payment Schedule for Court Appearances.

Initial Deposit. No less than fifteen (15) days before the date on which The clinical therapist is to attend court, the party requesting the clinical therapist's appearance (including the party on whose behalf an attorney issued a witness subpoena) shall pay to Baldwin Counseling the sum of $720.00 to be applied to the Invoice for all Billable Time. $500.00 of the Initial Deposit is non-refundable.

Invoice. Following The clinical therapist's appearance in court or her receipt of notice that her appearance is not required, Baldwin Counseling will remit an Invoice for the balance due for all Billable Time. The Initial Deposit will be credited to the total fees incurred. Any remaining balance shall be paid by the party requesting the clinical therapist's appearance (including the party on whose behalf an attorney issued a witness subpoena) within thirty (30) days of the date of the Invoice. In the event the balance of the Invoice is less than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the Invoice.

Payment Schedule for Depositions.

Initial Deposit. No less than fifteen (15) days before the date on which the clinical therapist's deposition is to be taken, the party taking the clinical therapist's deposition (including the party on whose behalf an attorney issued the deposition notice and/or witness subpoena) shall pay to Baldwin Counseling the sum of $720.00 to be applied to the Invoice for all Billable Time. $500.00 of the Initial Deposit is non-refundable.

Invoice. Following the clinical therapist's deposition or her receipt of notice that the deposition has been canceled, Baldwin Counseling will remit an Invoice for the balance due for all Billable Time. The Initial Deposit will be credited to the total fees incurred. Any remaining balance shall be paid by the party on whose behalf the clinical therapist's deposition was requested and/or taken within thirty (30) days of the date of the Invoice. In the event the balance of the Invoice is less than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the Invoice.

Written Reports.

In the event a party or his/her attorney requests a written report, the party on whose behalf the report was requested shall be liable for all Billable Time associated with writing that report.

Procedure for Requesting a Written Report. A report must be requested, in writing or email, at least twenty-one (21) days before the report is due.

All requests for written reports shall include a due date for submission, which shall be at least twenty-one (21) days after the date of the request. Baldwin Counseling reserves the right to refuse to prepare a written report in response to any request received less than twenty-one (21) days in advance.

In the event a request does not specify a due date for submission, the completion date of the report and the due date for the payments of the Initial Deposit and Invoice shall be designated at the sole discretion of Baldwin Counseling.

Written reports will not be provided to a third party unless Baldwin Counseling has received a valid release or a subpoena duces tecum that is compliant with HIPAA (the Health Insurance Portability and Accountability Act).

Initial Deposit. No later than twenty-one (21) days before the due date for the submission of the written report, the party requesting the report (including the party on whose behalf an attorney requested the report) shall pay to Baldwin Counseling the sum of $720.00 to be applied to the invoice for all Billable Time spent preparing the report. $500.00 of the Initial Deposit is non-refundable.

Invoice. Upon completion of the written report and no later than the due date for submission designated in the request, Baldwin Counseling will provide to the party requesting the report (or to the attorney who requested the report) an invoice for all Billable Time spent preparing the report. The Initial Deposit will be credited to the total fees incurred. *Any remaining balance* shall be paid by the party who requested the report (including the party on whose behalf an attorney requested the report) and *must be received by Baldwin Counseling before the written report will be released*. In the event the balance of the Invoice is less

than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the Invoice.

Unless other arrangements are made in advance, the report will be mailed to the party or attorney who requested the report on the due date or within two (2) business days after receipt of the payment for the written report, whichever is later.

Copying Fees and Procedures. Copies of the client's records will be provided upon request. Unless special arrangements have been made in advance, which may include payment of a rush fee, records will be available ten (10) business days after the request is received by Baldwin Counseling.

Except as otherwise stated in this Agreement, copies of the client's records will not be sent to any third party, including any attorney, unless Baldwin Counseling receives a valid release or a subpoena duces tecum that is compliant with HIPAA (the Health Insurance Portability and Accountability Act). Copies of a client's records will be released to the client's duly authorized Guardian *ad Litem*, provided that Baldwin Counseling has received a copy of the Guardian *ad Litem*'s Order of Appointment, in advance.

The party requesting copies of the client's records (defined as the party who requested the records, the party who signs a release, the party who requests a subpoena duces tecum and/or the party on whose behalf an attorney issued a subpoena duces tecum or other request for records) shall be liable for the reasonable charges for the service of maintaining, retrieving, reviewing, preparing, copying and/or mailing the records. Such charges shall include a search and handling fee of $10 per request, and copying fees of $0.50 for each page up to 50 pages and $0.25 per page thereafter. Payment for the copying fees must be received by Baldwin Counseling before the records will be provided to anyone.

Baldwin Counseling will notify the party requesting copies of the client's records of the cost of the copies. Unless other arrangements are made, the records will be available to be picked up upon payment of the copying fee. Because Baldwin Counseling has a part-time receptionist in the office, it is advisable to call first to confirm a convenient time to pick up the records. A therapeutic session will NOT be disrupted to facilitate pick-up of records. If the receptionist is not in the office, records will be distributed by the clinical therapist between appointments.

Copies that have not been picked up or otherwise delivered within 90 days from the date payment is received will be shredded. If the records were not picked up within 90 days, a new request must be made and payment of new copying costs and fees must be rendered before the records may be obtained.

Past Due Invoices. Invoices that remain due and unpaid for more than thirty days shall accrue interest at the rate of 6% per annum. In the event collection proceedings are instituted to collect the amounts due pursuant to this agreement, the party requesting any services outlined in this Agreement (including the party on whose behalf an attorney requested such services) shall be liable for all attorney's fees and costs incurred by Baldwin

Counseling which shall not be less than the actual amount billed or 25% of the past due amount, whichever is greater.

Any report, testimony or other information provided by the clinical therapist and/or Baldwin Counseling shall conform to ethical standards of practice. The party requesting such information is not guaranteed any particular result and payment of any of the fees set forth in this Agreement does not entitle the party making such request(s) to receive any particular result, testimony or recommendation by the clinical therapist or Baldwin Counseling.

NAME OF CLIENT:_____

I, _____,

am the ☐ Client ☐ Parent of Client ☐ Legal Custodian of Client

I have read and understand this Policies and Fee Agreement for Witness Testimony and Related Services. I am signing this Agreement knowingly, intelligently and voluntarily and agree to be bound by its terms.

_____ _____

Signature of Client or Client's Parent/Legal Custodian Date

_____ _____

Signature of Baldwin Counseling therapist Date

BALDWIN COUNSELING
Consent to Release Information to
Primary Care Physician(PCP) or Primary Care Manager(PCM)

Insurance companies require the patient to complete the PCP Release form

IF YOU CHECK "YES", A REVIEW OF YOUR DIAGNOSIS AND TREATMENT PLAN <u>WILL BE SENT</u> TO YOUR PRIMARY CARE PHYSICIAN.

_____ ___ ___ ___ -___ ___ -___ ___ ___ ___ ___ ___ -___ ___-___ ___

Name of Patient (last, first, MI) Patient Social Security Number Patient Date of Birth

1. Do you want your therapist to communicate with your Primary Care Physician (PCP) or Primary Care Manager (PCM) to send the treatment plan and progress notes of therapy. ***Please check ONE of the following***

☐ **NO, I DO NOT** give consent to release information to my PCP/ PCM *(Please skip to section 3)*

☐ **YES, I DO** give consent to release information to my PCP/PCM *(Please complete ALL info in section 2 & 3)*

2. If you checked YES, *please complete the following:*

I hereby give my informed consent for_____to
Baldwin Counseling Provider(s)

(check all that apply) ☐ **Talk with Physician** ☐ **Release written documentation** regarding my treatment to

Primary Care Physician or Primary Care Manager_____

Address_____

Phone __ __ __-__ __ __-__ __ __ __ Fax __ __ __-__ __ __-__ __ __ __

3. Patient Authorization: I understand

- This authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.
- My refusal to release records will not affect my ability to obtain treatment**.**
- If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed.

_____ _____ _____ _____

Signature of Patient *(Or responsible Party if Patient is a Minor)* Date Printed Name (last, first, MI) Relationship to patient

Witnessed by: Baldwin Counseling Representative_____

Date_____ Patient Id_____