Alice D. Hoag, M.S., LPC
350 Ansley Rd., Demorest, GA 30535
Phone: 706-768-9053 FAX 706-778-1795
www.hoagcounseling.com

ADULT PERSONAL INFORMATION

Name _____ Today's Date _____

Date of Birth_____ Age:_____ Email address*: _____

Home Address _____ City_____ ZIP_____

Phone Numbers: Home _____ Cell _____ Work _____
Please indicate whether I may leave a message: Home phone Y / N Cell phone Y / N Work phone Y / N
Calls will be discreet, but please indicate any restrictions: _____
*Note: I do not make appointment reminder calls, but you will receive email reminders 24-hours & 1 hour ahead.

Name of Employer _____ Occupation: _____

Address of Employer: _____ City_____ ZIP_____

Highest Education Completed (circle): Some High School High School Associates Bachelor Post Grad

Name & Address of Insurance Company _____
If you have mental health coverage through your health insurance company and your company is on my list of participating insurance carriers, please complete the Insurance Information Form if you wish me to file your claim.

Who referred you to this office? _____
If referred by a doctor or another clinician, would you like for us to communicate with one another? Y / N

Person(s) to notify in case of any emergency:_____Phone:_____
*Please note: I will only contact this person if I believe it is a "life-or-death emergency." Please provide your signature to indicate that I may call if necessary: (Your signature):_____

Counseling Questions:

Have you ever received counseling or consulted a psychiatrist, psychologist or mental health professional? Y / N

If so, approximately when & with whom?_____

Did you find counseling helpful? _____

Reason you terminated counseling _____

Please briefly describe the main reason for your visit today? _____

_____

_____

What would your life be like if this problem were no longer an issue for you? _____

_____

_____

What are your goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

Medical History:

Please explain any significant medical problems, symptoms or illnesses: _____

_____

Previous medical hospitalizations (approximate dates and reasons):_____

_____

Previous psychiatric hospitalizations (approximate dates and reasons): _____

_____

Current medications (use back of form if more space is needed):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Approximate Height: _____ Approximate Weight: _____ Gender: _____

Briefly describe your diet and exercise patterns: _____

_____

Do you smoke or use tobacco? Y / N If yes, how much per day? _____
Do you consume caffeine? Y / N If yes, how much per day? _____
Do you drink alcohol? Y / N If yes, how much per day? _____
Do you use any non-prescription drugs? Y / N If yes, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? Y / N
Have you ever been in trouble or in risky situations because of your substance use? Y / N

Mental Health Symptoms:

Please indicate any symptoms past & present on a scale from 0 (never) to 5 (all the time/severe):

DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past
Depression			Anxiety			Intense Fears		
Feeling Hopeless			Irritability			Nightmares		
Loss of Interest			Agitated/Restless			Feeling Numb/Detached		
Sleep too much			Fidgety			Easily Startled		
Sleep too little			Angry/Resentful			Obsessive Thoughts		
Excessive weight gain			Argumentative			Repetitive Behaviors		
Excessive weight loss			Dizziness			Overly Stressed		
Low Energy/Fatigue			Headaches			Sexual Concerns		
Memory Loss			Shortness of Breath			Domestic Violence		
Poor Concentration			Chills or Hot Flashes			Legal Problems		
Social Isolation			Heart Racing/Chest Pain			Financial Problems		
Grief			Muscle Tension			Drug Use		
Mood Swings			History of Head Injury			Alcohol Use		
Episodes of Crying			Blackouts			Chronic Pain		
Thoughts of Death			Completing Tasks			Problems at Work		
Self Mutilation/Harm			Hyperactive			Problems at Home		
Suicide Attempt			Paying Attention			Problems with Friends		
Thoughts of Hurting Someone Else			Easily Distracted by Noise			History of Abuse/Neglect		

Family, Relationships, Social Support & Self-Care:

Mother's age (or age at death) _____ How would you describe your relationship with your mother?_____

_____

Father's age (or age at death) _____ How would you describe your relationship with your father?_____

_____

If alive, are your parents still married Y / N If they are divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe who and how this person impacted your life:_____

_____

How many sisters do you have? _____ Ages/names? _____

How many brothers do you have? _____ Ages/names? _____

How would you describe your relationship with your siblings? _____

_____

Briefly describe any history of abuse, neglect and/or trauma:_____

_____

Please indicate if there is a family history of any of the following (if there is, please indicate the family member's relationship to you: father, grandmother, uncle, etc): Alcohol/substance abuse, anxiety, bipolar disorder, depression, domestic violence, eating disorders, hyperactivity, learning disabilities, legal trouble, "nervous breakdown," obesity, obsessive compulsive behavior, sexual abuse, schizophrenia, suicide attempts, trauma.

_____

_____

Poor Excellent

Currently in a relationship? Y / N If yes, for how long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? Y / N If yes, for how long? _____ Name of partner_____

Occupation of partner _____ Employer _____

Previously Married/Life Partnered? Y / N If yes, length of previous relationship(s) _____

Do you have children? Y / N If yes, list names/ages: _____

Describe any problems any of your children are having: _____

_____

List the names/ages of those living in your household: _____

_____

Current level of satisfaction with your friends and social support (1=poor, 7=excellent): 1 2 3 4 5 6 7
Please list the names of those you consider your close friends who you can lean on in times of distress:

_____

What are some of your strengths? _____

_____

Is spirituality important in your life? Y / N Please explain: _____

_____

Do you actively participate in a place of worship? Y / N If yes, where?_____

Do I have your permission to pray with you during our sessions? Y / N

Final Question:

Is there anything else I should know about you and/or your circumstances before we begin our work together? If so, please specify: _____

_____

_____ _____

Signature (guardian, if client is unable to sign) (Date) 8/16

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am pleased that you have selected me to be your counselor, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and other details regarding your treatment. Although this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your counseling experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

I. Background Information

I am a Licensed Professional Counselor, licensed by the State of Georgia, and a member of the American Association of Christian Counselors (www.aacc.net). I am also a Certified Professional Counselor Supervisor through the Licensed Professional Counselor's Association of Georgia (www.lpcaga.org), and Board Certified Professional Christian Counselor, through the Board of Christian Professional and Pastoral Counselors (www.thebcppc.com). I received a Bachelor of Arts degree in Psychology, a Master of Science degree in Applied Behavioral Studies with an emphasis in Marriage & Family Therapy, and am currently working on my Doctorate of Education (Ed.D.) in Community Care & Counseling – Marriage & Family Counseling. Additionally, I continue to receive ongoing training to be most effective as a counselor.

Please see my website (www.HoagCounseling.com) for more information on me, my work experience and my theoretical views.

II. Client Participation

For therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. Generally, the more of yourself you are willing to invest, the greater the return. Along those lines, it will be in your best interest to be as open and transparent as possible. My role is not to judge or condemn, but rather to come alongside to do whatever I can to help you achieve your goals. Withholding unpleasant issues from your past may feel safe, but it results in prolonging the time necessary to achieve the healing and restoration you desire.

It is my policy to work *with* you toward your goals. I will not do the work *for* you. It is my intention to empower you in your growth process so that you can face life's challenges in the future without me. I also do not believe in prolonging therapy if counseling does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development and healing are my number one priority. I encourage you to let me know if you feel that transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am committed to help you in whatever way produces maximum benefit.

III. Confidentiality, Limits of Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). I do not have electronic storage of your PHI. Your paper PHI will be kept in a file stored in a locked cabinet. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions:

(1) you direct me to tell someone else and you sign a "Release of Information" form;
(2) I determine that you are a danger to yourself or others;
(3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or
(4) I am ordered by a judge to disclose information. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed, and I will do everything in my power to keep what you say confidential.

IV. Professional Relationship

Psychotherapy is a professional service I provide to you. Because of the nature of therapy, your relationship with me must be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends may also *need* to have you do what they advise. A therapist offers you objective choices and empowers you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

Therapists are required to keep the identity of their clients a secret. As much as I would like to, I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends, or to accept "friend" requests on Facebook or any other social media. However, you may follow me professionally on my blog at www.alicehoag.com, as I occasionally post on personal growth topics. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends, as you may want counseling from me sometime in the future. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be impolite in any way; they are strictly for your long-term protection.

V. Statement Regarding Ethics, Client Welfare & Safety

My services will be rendered in a professional manner consistent with the ethical standards of the Licensed Professional Counselors Association of Georgia, the American Association of Christian Counselors, and the International Board of Christian Professional and Pastoral Counselors. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern together, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work together to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

VI. Cost of Services

These are detailed separately on the "Financial Policy" form.

VII. Scheduling Appointments & Cancellation Policy

You may schedule appointments through my website (www.hoagcounseling.com) or directly through the Client Portal at www.vCita.com/v/alice.hoag. If you are unable to keep an appointment, please notify me at least 24 hours in advance by text (706) 768-9053, email (alice.hoag@hotmail.com), or online through my appointment scheduler. If such advance notice is not received, you will be charged $25 for the face-to-face session you missed, or $50 for the video conference missed. Please see my "Financial Policy" form for specifics. Your scheduled appointment has been set for you only. Please be considerate of others who may also need help.

VIII. Technology Statement

In our ever-changing technological society, there are many ways we could communicate and/or follow each other electronically. It is important to me to maintain your confidentiality, respect your boundaries, and ensure that our relationship remains therapeutic and professional. Therefore, I need to inform you of some ethical concerns:

Cell phones: It is important for you to know that phones and cell phones are not completely secure and confidential. Since I cannot ensure your confidentiality when we talk over the phone, I will not be discussing treatment over cell phones or land lines. If you would like me to respond to you by phone for administrative issues, please indicate the phone number you would like me to use on the Personal Information form.

Text Messaging: Text messages are not secure forms of communication and sending me text messages may compromise your confidentiality. I realize that many people prefer to text because it is a quick way to convey information. **Please know that it is my policy to utilize texts strictly for brief topics such as appointment confirmations**. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. I will do my best to respond to appointment questions before the end of the next business day, Monday through Thursday. I cannot respond to crisis messages. In the case of emergency, please follow the protocol detailed below: "In Case of an Emergency." Please indicate the cell phone number where you would like me to text you on the Personal Information form.

Email, Video Conferencing, Social Media, Blogs, search engines, Client Scheduling Portal, Medical Records, etc.: Please see the separate "TeleMental Health" form for details. If you would like to connect with me by video, you will need to use Skype for Business, which is a confidential, HIPAA-compliant platform for video conferences and emails. To sign up for Skype for Business, go to www.products.office.com, which will cost you $6/month.

IX. In Case of an Emergency

My practice is considered an outpatient practice, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper and am available only during my regular office hours, Monday through Thursday. If at any time this does not feel like sufficient support, please let me know, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours during my office hours Monday-Thursday. *I do not check my voicemail or email, nor do I answer calls on Friday-Sunday.* If you have a mental health emergency, I encourage you NOT to wait for a call back, but to do one or more of the following:

- Call the Georgia Crisis & Access Line (1-800-715-4225) or email them at www.mygcal.com
- Call Laurelwood Hospital at 770-531-3800 or Peachford Hospital at 770-454-5589
- Call 911 or go to your nearest emergency room

X. Consent to Treatment (please initial each statement)

__ I voluntarily choose to participate in psychotherapy and I understand that I may pause or terminate my therapy at any time without penalty.

__ I have read the "Limits of Confidentiality" on page 2 of this document. I understand I have a right to confidentiality in therapy and that information about me or my therapy may not be released to another party without my written permission, except for my safety or the safety of others.

__ I have reviewed the office's Notice of Privacy Practices (available at www.hoagcounseling.com), which explains the terms of HIPAA, the Federal Law that protects my Medical Records.

I (Alice) am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask me.

Please sign, print, and date below indicating that you have read and understand the contents of this form, agree to the policies of your relationship with me as your therapist, and authorize me to begin treatment with you.

			Client
Signature (or responsible party, if minor)	Client Name (Please Print)	Date	12/17

Financial Policy

To keep my fees as low as possible, I do not have staff to schedule appointments, file most insurance claims, or follow up with billing. Payment in full is due at the end of each session, unless insurance reimbursement has been verified prior to the session (see below). I accept cash, local checks (payable to Alice Hoag), credit and debit cards. Please note that there is a $25 fee for any returned checks.

Usual and Customary fees:
Services eligible for insurance reimbursement (see "Insurance" section below):

- Initial Diagnostic Interview (60 minutes) @ $100/session, payable in full at time of booking
- 45 Minute Session for an established client @ $75/session

You will need to check with your insurance company to determine your co-pay or co-insurance amount. Your first session is payable in full so I can file your claim and determine what they will actually cover.

Services NOT eligible for insurance reimbursement (includes 25% discount for no insurance paperwork or claims):

- Initial Diagnostic Interview (60 minutes) @ $75/session, payable in full at time of booking
- 60 Minute Session for an established client @ $75/session

Individual Life Coaching, including Relationship, Divorce Recovery, and Life Transition Coaching:

- 60 Minute Session @ $75/session

Group Life Recovery Coaching, including Self-Compassion training, Couples Communication Training groups, Depression and Anxiety Recovery groups, Divorce Recovery groups:

- 8-week, 2-hour groups @ $40/week ($320 prepaid at first session), maximum 12 people per group

Additional services not covered by insurance, and payable at the beginning of next session:

- Telephone Calls (Any call 5-15 minutes) @ $1.50 per minute from beginning of call
- No Show / No 24-hour Cancellation notice @ $25

Additional services not covered by insurance, which must be pre-paid at time of your written request/authorization:

- Report Preparation for schools, insurance, court, Social Security @ $150/hour, minimum 1 hour
- Court @ $150/hour including travel and preparation time, 8-hour minimum
- Deposition/Hearing services @ $150/hour including travel and preparation time, 8-hour minimum
- Face-to-face meetings with other professionals @ $150/hour including travel time, 2-hour minimum

Insurance:
Insurance Companies: I am a participating provider for the following insurance companies, and file claims for these companies only: Aetna, Anthem, Beacon/Value Options, Blue Cross & Blue Shield, Cigna, Coventry/ MHNet, Humana/LifeSynch, Northeast Georgia Health Partners, Optum/United HealthCare, UMR

Please note: I cannot accept Medicare, Medicare Advantage, Medigap, or Medicaid insurance at this time.

If yours is not one of the above-listed insurance companies, I am not a preferred provider and you will need to proceed as a self-pay client. I can give you the paperwork you will need to file with your own insurance company, should you decide to do so.

Please contact your insurance company with any questions regarding your coverage and to obtain any necessary authorization numbers for counseling. Here are some questions to ask your insurance company:

- Do I have Outpatient Mental Health Benefits? If so, is Alice Hoag (Georgia license LPC001803, NPI 1477724540) in-network or out-of-network?
- Does my plan cover the following billing codes (CPT codes 90791, 90834, 90837, 09846, and 90847) by a Licensed Professional Counselor?
- How many sessions per year does my insurance cover?
- Is preapproval or authorization required? If so, what is the authorization #?
- Which do I have:
  - A Copay? If so, how much will it cost me for each session of outpatient counseling with a Licensed Professional Counselor? $_____

- A Deductible? If so,
  - How much is my deductible? $_____ (You will need to pay sessions in full, up to this amount)
  - How much deductible is left before my co-insurance begins? $_____
  - What is my co-insurance amount once I've met my deductible? _____%

Some employers provide an Employee Assistance Plan (EAP), which pays for 3 or more sessions at no charge to you. Knowing your insurance benefits is your responsibility. You can find out whether your employer has such a program by talking with your Human Resources department. If you do have EAP benefits, you will need to call your EAP directly to ask for an authorization for counseling. They will give you an authorization number, and will assign a counselor to you. (You may ask for me specifically by name, if you prefer.) Here are some EAPs which I participate in: All of the above insurance carriers plus American Behavioral, ComPsych, Concern, EAP Works, Espyr, and FEI.

Copays and deductibles. **All copays and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on my part to collect co-payments and deductibles from patients can be considered fraud. Please help me in upholding the law by paying your co-payment at each visit.

Filing Claims: If you are a policyholder with one of the companies listed above, I have agreed with the insurance company to file the paperwork directly with them. Please keep in mind that payment remains your responsibility. I do not enter in disputes over insurance benefits. You agree to pay any portion of the charges not covered by your insurance. I file claims on a monthly basis. Your insurance company may need you to supply additional information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; I am not party to that contract.

Unfortunately, you will be unable to be reimbursed for Medicare or Medicaid, as I am not eligible to provide Medicare or Medicaid services at this time.

Coverage changes: If your insurance changes, please notify me before your next visit so I can make the appropriate changes with my insurance claims management company to help you receive your maximum benefits.

Missed Appointments, Late Cancellations and No-Shows:
In order to provide the best care and treatment to all of my clients, please give 24 hour notice if you are unable to make your appointment, in order to allow open appointments for others seeking treatment. **If such advance notice is not received, you will be charged $25 for the session you missed.** Please note that insurance companies do not reimburse for missed sessions. Your scheduled appointment has been set for you only. Please be considerate of others who may also need help.

__ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, deductibles and late cancellation fees are my responsibility. I agree to pay for all of these fees at the time of service.

__ I authorize my insurance benefits be paid directly to Alice D. Hoag, M.S., LPC.

__ I authorize Alice D. Hoag, M.S., LPC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
Print Name of Client

_____ _____
Signature of Client (or responsible party if minor) Date

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Health Insurance Information

(Please note: Alice Hoag is NOT a Medicare or Medicaid provider at this time)

Name of Client_____ Date _____

Home Phone _____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Relationship to the Insured (please circle): Self Spouse Child

Name of Insurance Company _____ Phone _____

Mailing Address for claims _____

Name of Insured _____ Home Phone_____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Member ID/Policy Number _____ Group Number _____

Employer's Name _____

Please check and complete the **one** which applies to your insurance policy:

☐ Annual Deductible (amount you must pay before insurance starts to pay): $_____ , and
Co-insurance (percentage of the fee you are required to pay after meeting your deductible) _____%

☐ Co-pay (flat amount payable instead of meeting a deductible and coinsurance): $_____

Other (secondary) Insurance Company _____

Mailing Address for claims _____

Name of Insured _____ Home Phone_____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Member ID/Policy Number _____ Group Number _____

Employer's Name _____ Relationship to Insured _____

I authorize my insurance benefits be paid directly to Alice D. Hoag, M.S., LPC for services provided.

I authorize Alice D. Hoag, M.S., LPC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____
Signature of Client Date
(or responsible party, if client is a minor)

Alice D. Hoag, M.S., LPC
350 Ansley Rd., Demorest, GA 30535
FAX (706) 778-1795 Phone (706)768-9053

CONSENT & AUTHORIZATION TO COORDINATE TREATMENT

If you are on prescription medication or are under the care of a personal physician, psychiatrist, or other counselor, it will be essential to have all your specialists coordinate your treatment. The following is an authorization for two-way communication between Alice Hoag and your other physical and/or mental health provider(s). Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below. Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

****

I, _____ (client), whose date of birth is _____, hereby authorize Alice D. Hoag (therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of my treatment:

(1) _____ (Phone) _____

(2) _____ (Phone) _____

Information to be disclosed (initial each item to be disclosed):

___ Assessment
___ Diagnosis
___ Psychological Evaluation (from PhD only)
___ Psychiatric Evaluation (from MD only)
___ Treatment Plan or summary
___ Medication Management Information
___ Medical Information (from MD only)
___ Presence / Participation in Treatment (summary)
___ Progress in Treatment (summary)
___ Other _____

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limits

____ I would prefer to limit the information shared between the parties stated above, as follows:

_____

Additionally, the above-named parties, therapist, and person(s) or entity (entities) designated under (1) or (2) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates you understand you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that you have the right to revoke this authorization in writing at any time. Additionally, if you decide to revoke this authorization, such revocation must be in writing and will be effective on the date received by the above-named therapist at the above addresses. If you wish to revoke this form in person, please call first so I may have it ready when you come by.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

****

I revoke this authorization effective_____ Date: _____ 3/15