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CLIENT INFORMATION **Date:**_____

Name: _____

Parent's Name (if client under 18): _____

Address: (Street/City/State/Zip): _____

_____

Email Address: _____

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

Date of Birth: _____ **Age:** _____ **SSN:** _____ - _____ - _____

Marital Status (Circle One) M S D W **Gender: (Circle One) M F**

Place of Employment: _____

Student? _____ **If yes, Full Time** _____ **Part Time:** _____

Emergency Contact (Name/ Phone Number): _____

Referred By: _____

May We Acknowledged This Referral? Y N

Allergies or Significant Medical Problems: _____

Current Meds	Date Begun	Dosage/Day	Prescribing Doctor

(Use back of page for extra space)

Availability:

	Tuesday	Wednesday	Thursday	Friday
9:00				
10:00				
11:00				
12:00				
13:00				
14:00				
15:00				
16:00				
17:00				
18:00				
19:00				

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We are pleased that you have chosen Chambless Counseling/Michael Chambless LLC (MCLLC)!

There are several things we want you to know before we begin discussing your reason for coming.

I. Confidentiality and Privacy

Personal problems are sometimes difficult to talk about. That is why confidentiality is extremely important to us. We take every precaution in protecting the confidentiality of your visit with us, and we hope you will also do the same.

Recent legislation (the Health Insurance Portability and Accountability Act, HIPPA) is also meant to protect your privacy. In accordance with HIPPA, we have given you the "Georgia Notice Form" describing in detail how psychological and medical information about you may be used and disclosed and how you can get access to this information.

Your signature below indicates you have been given the "Georgia Notice Form" regarding "MCLLC Policies and Practices to Protect the Privacy of Your Health Information."

II. Billing, Payments, and Missed Appointments

You will be expected to pay for each session at the time it is held unless we agree otherwise. If you have insurance, we are glad to provide you with a statement of the services received.

If it is necessary to cancel an appointment, we ask that you do so a full working day before the scheduled time. It is our policy to charge for appointments cancelled with less than the requested notice and missed appointments. If late 10 minutes or more, session will have to be rescheduled.

If there has been no contact with Chambless Counseling/Michael Chambless, LLC for 90 days, client will be considered inactive. To restart active psychotherapeutic counseling associated with Michael Chambless, LLC, client will have to restart the Treatment Process which will include, but not limited to, assessment, insurance verification, scheduling, and an intake session.

Please note there is a $25.00 charge for any returned checks.

Please sign below to indicate (1) that you have been given the "Georgia Notice Form/Informed Consent" with MCLLC Policies and Practices to Protect the Privacy of Your Health Information and (2) that you agree to our billing, payments and missed appointment policies.

_____ _____

Client signature Date

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GEORGIA NOTICE FORM/INFORMED CONSENT

Notice of Chambless Counseling/Michael Chambless LLC Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE DESCRIBES POLICIES AND PROCEDURES.

I. Uses and Disclosure for Treatment, Payment and Health Care Operations

Chambless Counseling/Chambless Counseling/Michael Chambless LLC may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment Payment and Health Care Operations"

- Treatment is when Chambless Counseling/Michael Chambless LLC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Chambless Counseling/Michael Chambless LLC consults with another health care provider, such as your family physician or another psychotherapist.

- Payment is when Chambless Counseling/Michael Chambless LLC obtains reimbursement for your healthcare. Examples of payment are when Chambless Counseling/Michael Chambless LLC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of Health Care Operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies to only activities within my [office, clinic, practicing group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practicing group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

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II. Uses and Disclosure Requiring Authorization

Chambless Counseling/Michael Chambless LLC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when Chambless Counseling/Michael Chambless LLC is asked for information for purposes outside of treatment, payment of health care operations, Chambless Counseling/Michael Chambless LLC will obtain an authorization from you before releasing this information in the form of a signed and dated

"Release of Information" form (ROI). Chambless Counseling/Michael Chambless LLC will also need to obtain an authorization before releasing your Psychotherapy Notes. Psychotherapy Notes are notes Chambless Counseling/Michael Chambless LLC has made about our conversation during a private, group, joint or family counseling session, which Chambless Counseling/Michael Chambless LLC has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI and are guarded as such.

You may also revoke all such authorizations (of PHI Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Chambless Counseling/Michael Chambless LLC has relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Federal and State Laws provide the insurer the right contest a claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization

Chambless Counseling/Michael Chambless LLC may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If Chambless Counseling/Michael Chambless LLC has reasonable cause to believe that a child has been abused, Chambless Counseling/Michael Chambless LLC must report that belief to the appropriate authority.

- Adult and Domestic Abuse – If Chambless Counseling/Michael Chambless LLC has reasonable cause to believe that a disabled adult or elder person has had a psychical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or have been neglected or exploited, Chambless Counseling/Michael Chambless LLC must report that belief to the appropriate authority.

- Health Oversight Activities – If Chambless Counseling/Michael Chambless LLC is subject to an inquiry by my GA State Licensing Board, Chambless Counseling/Michael Chambless LLC may be required to disclose PHI regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services Chambless Counseling/Michael Chambless LLC provided you or the records thereof, such information is privileged under state law, and Chambless Counseling/Michael Chambless LLC will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety - If Chambless Counseling/Michael Chambless LLC determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, Chambless Counseling/Michael Chambless LLC I may disclose information in order to provide protection against such danger for you or the intended victim.

- Worker's Compensation – Michael Chambless LLC may disclose PHI regarding you as authorized by and to the extend necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapist's Duties

As a client of Michael Chambless LLC, you shall not be deprived of any rights guaranteed to you by law.

Your rights include:

- The right to impartial access to care without discrimination due to race, color, sex, age, religion, national origin, sexual orientation, political belief, or mental or physical handicap.
- The right to receive care that is suited to your needs in the least restrictive environment available.
- The right to be fully informed of the charges for services provided.
- The right to prompt and confidential services even if it has been determined that you are unable to pay.
- The right to participate in the planning of your care, including any changes in the plan.

- The right to be informed, in a manner that is understandable to you, about the benefits, side effects, and risks of the medications prescribed to you.
- The right to accept or refuse service unless a physician or licensed psychologist feels that refusal would be unsafe for you or others.
- The right to be informed of the name, business, telephone number, and business address of the person supervising your plan of care.
- The right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- The right to receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member knowing you are seeing me. On your request, I will send your bills to another address.)
- The right you inspect or obtain a copy (or both) of your PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny you access to PHI under certain circumstances, but in some cases you may have the decision reviewed. On you request, I will discuss with you the details of the request and denial process.
- The right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss the details of the amendment process.
- You generally have the right to receive an accounting of disclosures of PHI. On you request, I will discuss with you the details of the accounting process.
- You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to the notice electronically.
- The right to remain free from physical restraints or time-out procedures unless such measures are required to protect the safety of you or others.
- The right to be free from any fiduciary, physical or verbal abuse, and sexual activity or coercion by staff.
- The right to be free from psychological abuse, including humiliating, threatening, and exploiting actions.

- The right to review and obtain copies of you service record, unless the team physician determines it is not therapeutically in your best interest.
- The right to exercise all civil, political, personal, or property rights to which you are entitled as a citizen.
- The right to the pursuit of employment education, and religious expression.
- The right (where applicable) to have property and residence treated with respect.
- The right (where applicable) to private conversation, reasonable access to the telephone, mail, and visitors unless denial is determined necessary for treatment by a physician or licensed psychologist.
- The right (where applicable) to retain your personal belongings except where determined that such possession could endanger the health and safety of you or others.
- The right to be informed of the complaint procedures and to file a complaint without fear of discrimination or retaliation. If you feel you have been deprived of your rights, you have the right to have your complaint investigated by the provider within a reasonable period.
- The right to be provided with information to facilitate decision making.
- The right to express his or her preferences regarding choice of case manager, therapist, or other service provider
- The right to be informed of any procedures governing use of special treatment interventions and restrictions of rights.
- The right to receive information, referral and access to other services, examples: Guardians and conservators, self-help groups, advocacy services, legal services, etc.
- The right that pregnant women will have priority to access of treatment services.

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Psychotherapist's Duties:

- Chambless Counseling/Michael Chambless LLC is required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- Chambless Counseling/Michael Chambless LLC reserves the right to change the privacy policies and practices described in this notice. Unless Chambless Counseling/Michael Chambless LLC notifies you of such changes, however, Chambless Counseling/Michael Chambless LLC is required abide by the terms currently in effect.

- Chambless Counseling/Michael Chambless LLC will use electronic media as needed for treatment-related communication (e.g. scheduling, questions, clarification). Electronic media includes, but is not limited to, email, SMS (texting), telephone, video conferencing and facsimile. Content of communication will be minimal to ensure confidentiality.

- Therapy Sessions are for identified client(s) only. No minors, friends, or associates will be allowed to attend the sessions unless prearranged with Chambless Counseling/Michael Chambless LLC. Should Chambless Counseling/Michael Chambless LLC determine that other's session attendance in the session best serves the client(s), a signed written Release of Information will be required for all parties in attendance prior to the session commencement. Note that the third party is not joining the support session for his or her own therapy, nor will Chambless Counseling/Michael Chambless LLC work with them as a therapist.

- Sessions are scheduled for 50 minutes, unless previously arranged. Intake sessions are scheduled for 70 minutes, unless previously arranged.

- If Chambless Counseling/Michael Chambless LLC revises policies and procedures, Chambless Counseling/Michael Chambless LLC will provide individuals with a revised notice in person at their next appointment.

V. Therapeutic Approach & Style

The goal of Chambless Counseling/Michael Chambless LLC is to help people navigate through difficulties in their life and relationships while providing a safe place to heal, explore, develop insight, practice healthy coping tools, and integrate and take responsibility for their changes. We facilitate a process where the client becomes able to move toward healing, self-acceptance, and to ultimately grow and thrive in a supportive environment. We will meet you each step of the way in your therapy process with accountability, compassion and empathy, a therapist is not a cure-all, a parent, a friend, or a miracle worker.

The style of Chambless Counseling/Michael Chambless LLC is collaborative, honest, challenging, and direct with solid boundaries and empathy. We reflect, assist, encourage, and point out incongruent patterns around actions and words. We will not work harder than our clients or accept responsibility for your choices or consequences. We respect our client's decisions, and do not advise or direct our clients, as we believe that you are the expert in your own life and are fully capable of creating the life that you want with support and tools.

Chambless Counseling/Michael Chambless LLC formulates the therapeutic plan collaboratively with clients based on each client's needs, their presenting problems, and the goals they wish to achieve. We believe that each client has the potential for healing and change and is responsible for their choices and changes, and for meeting their therapy goals – we do not make guarantees for healing. We use a combination of cognitive behavioral, existential, and client-centered therapy with most clients.

Cognitive Behavioral (CBT) Therapy stresses the role of thinking patterns in how we feel and what we do. It is based on the belief that our thoughts, rather than people or outside events, cause our negative feelings. Chambless Counseling/Michael Chambless LLC assists the client in identifying, testing the reality of, and correcting dysfunctional beliefs underlying his or her thinking – uncovering the 'root to the fruit' so to speak. Chambless Counseling/Michael Chambless LLC then helps the client modify those thoughts and the behaviors that flow from them. CBT is a structured collaboration between therapist and client and often calls for homework assignments.

Existential psychotherapy is based on the philosophical belief that human beings are fully equipped to create one's own meaning and exercising one's freedom to choose. Chambless Counseling/Michael Chambless LLC encourages clients to face life's anxieties and to start making his or her own decisions while reflecting on consequences and moving away from fear-based thinking. We will emphasize that along with having the freedom to carve out meaning comes the need to take full responsibility and accountability for the consequences of one's decisions.

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VI. Telemental Health Counseling

Overview

- You will need access to the certain technological services and tools to engage in telemental health-based services with your provider
- Telemental health has both benefits and risks, which you and your provider will be monitoring as you proceed with your work
- It is possible that receiving services by telemental health will turn out to be inappropriate for you, and that you and your provider may have to cease work by telemental health
- You can stop work by telemental health at any time without prejudice
- You will need to participate in creating an appropriate space for your telemental health sessions
- You will need to participate in making a plan for managing technology failures, mental health crises, and medical emergencies
- Your provider follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy

What is Telemental Health?

Telemental Health "means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (State of Georgia, Rule 135-11-.01, TeleMental Health)

Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, and others. Chambless Counseling/Michael Chambless LLC uses a HIPPA-compliant platform in which only a link to the session is provided to the client so technological prowess is not needed. An internet connection is necessary for video sessions.

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Benefits and Risks of Telemental Health

Benefits:

- Receive services at times or in places where the service may not otherwise be available.
- Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.
- Receive services when you are unable to travel to the service provider's office.
- The unique characteristics of telemental health media may also help some people make improved progress on health goals that may not have been otherwise achievable without telemental health.

Risks:

Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

- Internet connections and cloud services could cease working or become too unstable to use
- Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.
- Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly or using the most effective tools. Your provider may also be unable to help you in-person.

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and your Counselor at the time of service, and the technological tools used to deliver services. Your Counselor will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

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Is Telemental Health a Good Fit for You?

Although it is well validated by research, service delivery via telemental health is not a good fit for every person. Your Counselor will continuously assess if working via telemental health is appropriate for your case. If it is not appropriate, your Counselor will help you find in-person providers with whom to continue services.

Please talk to your Counselor if you find the telemental health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telemental health medium seems to be causing problems in receiving services. Raising your questions or concerns will not, by itself, result in termination of services. Bringing your concerns to your Counselor is often a part of the process.

VII. Complaints

If you want to know more about your rights, a full copy of the rules and regulations for Client's-Rights-Chapter 290-4-9 is available on request and a summary of the client's Rights Complaint Process is also available. If you are concerned that Chambless Counseling/Michael Chambless LLC has violated your privacy rights, or you disagree with a decision Chambless Counseling/Michael Chambless LLC made about access to your records, you may contact the GA Licensing Board at +1 (404) 370-0200.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The number listed above can provide you with the appropriate address upon request.

VIII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 28, 2020.

Chambless Counseling/Michael Chambless LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI records that Chambless Counseling/ Michael Chambless LLC maintains.

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INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time that my therapist spends over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

_____ _____

Client signature Date

Client Information			
Full Name: Name that you like to be called (nickname):			Relationship Status: □ S □ M □ D □ Sep □ W
Date of Birth:	Sex: □ M □ F	Driver's License Number: Driver's License State:	
Occupation:		Highest level of education:	
Employer/Company Name:			
What are the reasons you are seeking counseling?			

Have you previously attended therapy? □ Yes □ No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?

BioPsychoSocial History			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Appetite Disturbances	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Worthless/Helpless Feelings	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Anxiety Symptoms/ Panic Attacks	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High

Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Obsessions/ Compulsions	□Yes	□ No	If "Yes", please describe:
Phobias	□Yes	□ No	If "Yes", please describe:
Medical Conditions	□Yes	□ No	If "Yes", please describe:
Hyperactivity	□Yes	□ No	If "Yes", please describe:
Are you having suicidal thoughts?	□Yes	□ No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□ No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□ No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	□Yes	□ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	□Yes	□ No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.
2.
3.
4.

List anything other medications or comments that your therapist should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living with You? (Y/N)	Deceased? (Y/N)
Spouse/Partner				
Parent				
Parent				
Stepparent				
Stepparent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				
Child				
Child				
Other				

Are your parents divorced? □ Yes □ No Remarried? □ Yes □ No
Religion (if any) _____
Sexual orientation _____
Gender orientation___(female, male, transgender, transsexual)

Ethnic Group (select all that apply):

American Indian Alaskan Native Caucasian Middle Eastern Asian Filipino Native Hawaiian/Pacific Islander Hispanic Latino Black African American Multi-Ethnic Other_____

Family of Origin (Circle Your Answer):

Have you experienced any abuse in your family or relationships? **(select all that apply):**
None Emotional Physical Sexual Uncertain

In general, how happy were you growing up? None Somewhat Mostly Extremely

How much is your family of origin a source of support for you? None Somewhat Very Extremely

How much conflict in values do you experience with your parents? None Somewhat Substantial

Legal Issues

Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so, please describe:

Briefly describe concerns in your life and/or in your relationships that would be relevant for your therapist to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):

1.

2.

3.

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process.

Mike Chambless LPC, CCMHC, MAC, NCC, SAP
Chambless Counseling/Michael Chambless LLC

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108 International Drive
Rincon, Georgia 31326-3934
Phone (912) 826-2760
Fax (912) 330-1004

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize and request Michael Chambless LLC to
(Name of Client)

obtain from/release to: _____
(Name of person or organization disclosing/obtaining information)

information regarding_____, date of birth_____,
(Name of Client)

Social Security Number_____-_____-_____, from: _____ to_____,
(Date) (Date)

The following information: _____

The purpose for the disclose authorized in this consent is to: _____

_____.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been talent in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that generally Chambless Counseling/Michael Chambless LLC may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form;

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date