Lifepath
Counseling & Wellness

Adult Intake Assessment

Client Information		
Client Name:	Age:	Today's date:
Date of Birth:	SSN:	
Address Including City, State, and ZIP:		
Primary Phone Number:	☐ I give permission to leave a message at this number about appointments and/or payments	
Mobile Phone Number:	☐ I give permission to leave a message at this number ☐ I give permission for text messages to be sent to this number	
Email:	☐ I give my permission to be contacted by email	
Self-identify as: ☐ Male ☐ Female ☐ Other	Religious Preference:	
Do you currently have an Action Plan for Recovery? Do you currently have a Psychiatric Advance Directive?	☐ Yes ☐ No ☐ Yes ☐ No	
Are services voluntary: ☐ or court ordered ☐		
Emergency Contact Name:	Relationship:	Phone Number:
Ethnicity/National Origin: ☐ Caucasian (White) ☐ African American ☐ Native American (Tribal) ☐ Hispanic or Latino ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Other_____		
Name and Address of Employer:	Phone Number of Employer:	

Payment and Insurance Information	
Person initiating services is financially responsible regardless of insurance information provided below	
Medicaid: ☐ Yes ☐ No Medicaid Number:	Employee Assistance Name: Authorization Number: Number of visits:
Clients Relationship to Policyholder: ☐ self ☐ spouse ☐ child ☐ other _____	Primary Insurance Company Name:
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Employer:
Member ID:	Group:
If applicable, Secondary INS:	Member ID:
Primary Insurance Holder Address Including City, State, and ZIP:	

LIST OF BASIC FEES AND SERVICES	
Initial Medication Management Visit	$300-$360
Medication Management Established Patient Follow-up	$250
Initial Visit with Therapist	$200
Individual Therapy w/ Therapist 16-37 minutes	$100
Individual Therapy w/ Therapist 38-52 minutes	$130
Individual Therapy w/ Therapist 53+ minutes	$160
Court Appearance	$500
Family Therapy w/Therapist with or without patient present	$150
Returned Checks	$35 per incident

Lifepath Counseling and Wellness Financial Agreement

REGARDING PAYMENT/INSURANCE:
Though we accept most insurance, our providers do not accept all insurances so please check with your insurance company prior to coming in to verify the provider you are scheduling with accepts the insurance you have. Payment is due at time of service. You are responsible for fees regardless of insurance coverage. Your health insurance company may reimburse Lifepath Counseling and Wellness for your services however, your insurance is a contract between you and the insurance company and Lifepath Counseling and Wellness is not party to the contract. We will bill your primary and secondary insurance as a service to you as long as you provide us accurate information and your account is current. If you have an outstanding balance, full payment will be required before further services can be performed. Benefits quoted are not a guarantee of payment. You are responsible for any deductibles, co-payments, or balances applicable to your individual policy. If your insurance requires an authorization or referral for services, you are responsible to obtain this referral. We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation you seek services through an agency that is more able to work with your financial situation.

By signing, I understand the Lifepath Counseling & Wellness fee schedule, appointment arrival policy, cancellation and no show policy, and the financial agreement regarding insurance and payment.

Client Signature_____Date_____

Credit/Debit Card Authorization Agreement

Instructions: Please fill out the below form completely. Do not omit any fields, signature and date required.
We ask all clients to submit a credit/debit card authorization sheet. In the unlikely event that you have a balance owed for more than 60 days, the overdue amount will be charged to your account. You may also choose to be billed at time of services or monthly. I understand that if I decide to terminate any of the services and my account is paid up in full, I may withdraw the authorization to charge my credit in the future provided I communicate revocation of authorization in writing to Lifepath Counseling and Wellness in office, by mail or fax. Please notify us if your credit card information changes or expires. Thank you.

Name on Credit/Debit Card:		
Credit Card Type (please circle): Visa MasterCard AMEX Discover		
Credit Card#:		
Expiration Date:	3-Digit Code:	Zip Code (where credit card bill is mailed):
As a convenience to you, if necessary, would you like this credit/debit card to be billed for deductibles, copays and/or co-insurance due at the time of each reoccurring appointment? _____No, thank you. _____Yes		
The undersigned hereby authorizes Lifepath Counseling and Wellness to keep my signature on file and to charge my credit/debit card account for any deductibles, co-payments, or co-insurances due for services rendered or balance due resulting from no- shows/late cancellation fees that are 60 days overdue; or sooner if specified above.		
Signature:		Date:

Clinician Information

One of our providers will be assigned for your services. We will attempt to match you to a provider based on, but not limited to: your choice, in network providers, availability, and area of expertise.

Consent for Treatment

- This is to certify that I give permission to the therapist or medication provider identified above to treat the patient identified on these documents. This treatment may include individual, family, or group psychotherapy, counseling, testing or medication management.
- This treatment may include consultation with other care providers, such as medical, educational, probation officers or court personnel.
- I understand that the therapists routinely staff cases and consults with other clinicians, doctors, and providers to insure continuity of care.
- I understand that my provider will not provide services outside the scope of their practice, and may refer me to different providers depending on my need. I understand that my provider will explain the limitations and scope of their practice and that I may ask questions about this at any time. I understand that services are voluntary.

Signature of Parent or Guardian:_____: Date:_____

Signature of client if over 14:_____: Date:_____

How did you Hear about Lifepath Counseling & Wellness?

☐ Yellow pages, Internet, or brochure
☐ Previous experience with LIFEPATH
☐ Referred by a friend/relative
☐ LIFEPATH accepts Medicare and/or Medicaid
☐ LIFEPATH accepts your private Insurance
☐ Referred to a specific therapist at LIFEPATH
☐ Referred by MD, Medical Provider, Hospital Discharge Planner, Medical Social Worker, or other Medical personnel
☐ Referred by a public agency (H&W, Juvenile Court Service, P&P, Victim Witness Coordinator, Child Protection, etc.)
☐ Other_____

Lifepath Counseling & Wellness Appointment Arrival Policy

ARRIVAL TIME: Please arrive to your appointment at least 5 minutes prior to the scheduled time. All our services have a specific timethat is reserved just for you, and early arrival allows for time to update paperwork or other necessary requirements.
Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms asinstructed, you will be asked to reschedule.

LATE ARRIVAL POLICY: In order to sufficiently meet your mental health needs we strive to ensure all appointments begin and end on time so that the next client is not delayed. If you are an established client and you arrive more than 5 minutes late for a medication management appointment or more than 10 minutes late for your counseling appointment you will likely be asked to reschedule, unless the providers schedule can still accommodate you. Priority will be given to the clients who arrive on time and you may have tobe worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late clients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see clients as close to their appointment time as possible.

CANCELLATION AND NO SHOW POLICY: If you need to cancel or change your appointment, please do so as soon as possible. If cancellation does not occur at least 24-hours in advance or you no show for your appointment, you may be charged for that appointment. In the case of extenuating circumstances, the fee will then be negotiated between the client and therapist. The therapist must document the circumstances. **Broken appointments** represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. **In the event of any client who no-shows, their recurring or 'standing' appointment will be removed from the schedule unless the therapist wishes to keep a client on his/her calendar. A behavioral contract may be initiated at this time at the discretion of each therapist. If a client no-shows three times consecutively, they will need to wait until they have paid all associated fees and a minimum of 90 (ninety) days before they may schedule another appointment.**

Office Policy

OFFICE HOURS: Our office hours are currently Monday – Thursday 8:00 am to 6:00pm

EMERGENCY SITUATIONS: For after hour emergencies, please call 911 or go to your local emergency room. In case of emergency, In the event that the named EMERGENCY CONTACT individual can't be reached: I give my consent for the client to be treated medically in an emergency situation. I also allow LIFEPATH to release any information that may be necessary to aid in providing accurate and quality care in the event that I may not be reached.

Returned Checks: There will be a $35 service charge for all returned checks.

Balances not paid with the credit card on file: Payment is due at time of services: If your account balance cannot be paid in full

within 60 days, your account will be referred to Chapman Financial Services. Once the account has been handed off, Lifepath Counseling and Wellness will no longer handle any of the account payment details. Chapman Financial Services at (800) 594-9866 will handle all inquiries.

UNATTENDED CHILDREN: Please note that our office **does not allow and are not responsible** for unattended children in the lobby.

MEDICATION MANAGEMENT POLICY:

Lifepath Counseling and Wellness strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy, and will be notified if you seek controlled substances elsewhere.

PHONE CONSULTS: **If you need to speak with the nurse, there may be a fee charged for this service. The fees are charged on the quarter hour and range from $5.00 onto $20.00 depending upon the length of time spent with the nurse.**

MEDICATION REFILLS: Please call your pharmacy for all refill requests. You will need the following information to give to them: your name, phone number, date of birth, date of last refill, name of your physician, name and dosage of medication and the date of your next appointment. Please take a moment to look at your current prescription bottle to ensure that you do not have a refill waiting at your pharmacy. Please keep in mind that we require a 48-hour notice for all non-controlled substance medication refills and a 72-hour notice for all controlled substance medication refills.

CRISIS/CALL TIMES: We will make every effort to see or talk with each person as soon as possible. However, if you are in a crisis or it is a medical emergency please call 911, OR IF YOU ARE MEDICAID CALL OPTUM'S 24-HOUR CRISIS LINE AT 1-855-202-0973 or our crisis line at 208-780-3907

INFECTIOUS DISEASE: It is your responsibility to self-report infectious diseases immediately upon your knowledge to one of our staff members. This will be reported to the local health authorities.

TRANSPORATION: I give my permission for LIFEPATH, its owners, agents, and employees to transport my child or person of guardianship to activities and treatment sessions as deemed necessary by the program employees.

MEDICATION AND FOOD ALLERGIES: It is your responsibility to self-report any medication, food or other substance allergies immediately upon your knowledge to one of our staff members. We do offer medication Management. We monitor medication and medication recalls. If you have been notified of a recall on a medication we have prescribed to you, please surrender it to the prescribing doctor or PA/NP immediately.

COURT TESTIMONY: LIFEPATH employees will testify in court only in response to a subpoena from a judge. Such time is not reimbursable by Medicaid or other insurances and additional charges will accrue. Most CBRS specialists are not licensed professionals, and are unable to offer expert witness testimony. If they are called to testify in a custody dispute, child protection case, etc., they will describe what they have seen and heard (within the limits of the law), but will offer no opinions or interpretations. Most therapists are not qualified as "custody evaluators," and are ethically obligated to say as much if they are called upon to testify. Our therapists are not qualified as "custody evaluators".

REASONS FOR TERMINATION OF CLINICIAN-PATIENT RELATIONSHIP:

1. If you feel you are not compatible with your clinician, arrangements can be made for you to be seen by another provider.
2. If you are not complying with your clinician orders, he/she may request to discontinue treatment.
3. If you are not meeting financial obligations, your clinician may discontinue treatment.
4. If you are disruptive or inappropriate towards the staff, care may be terminated.
5. Dishonesty and/or deceitfulness may require termination of treatment

Informed Disclosure and Consent

The Purpose of Therapy:

- Provide an environment that is supportive and safe in which you can explore areas of individual and family concern.
- Assists you in the process of making life decisions by exploring different options.
- Assists you to more effectively handle areas of concern in your life.

Possible Therapy Goals:

- To gain an understanding of the patterns that may be disturbing to you and others.
- To gain understanding of positive life patterns that support desired outcomes.
- To learn new information about the significant components of personal and family relationships including styles of communication, conflict resolution, and responsibility.
- To gain insight into effective methods of establishing a wellness-orientated lifestyle.
- Provide an environment that is supportive and safe in which you can explore areas of individual and family concern.
- Assists you in the process of making life decisions by exploring different options.
- Assists you to handle areas of concern more effectively in your life.

Client Rights:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health

care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- To know how decisions are made so that you can participate in the process.
- A full explanation of services offered (i.e., therapy modalities, purposes, goals, techniques, procedures, limitations, potential risks/benefits). You have the right to choose your provider and the type of services in which you would like to participate. You have the right to refuse services.
- To be served in an environment that promotes independence, self-sufficiency and productivity.
- To make an informed decision regarding your consent for outpatient mental health services.
- You have the right to revoke your informed consent at any time to indicate a desire to discontinue treatment.
- To choose whether or not you desire Enhanced Outpatient Mental Health Services.
- The following are several mental health services providers who provide comparable services:
- Tidwell Social Work Services (208-853-5095) Sage Health Care (208-323-1125) Mountain States Group (208-336-5533)

Client Responsibilities:

- To set and keep appointments, or cancel as soon as possible if you are unable to attend appointments.
- Assist in planning your service goals.
- Follow through with agreed upon goals.
- Report any changes in circumstance (i.e., financial, residential, marital, and number in household).
- Provide verification of information required.

Counseling Process:

During the process of counseling, with the use of Play Therapy, Family Therapy, Cognitive Behavioral Therapy, and Solution-Focused Therapy, we will explore possibilities for change to discover what is best for you and your family. As therapists, we will be approaching these sessions objectively, keeping your interests and concerns as top priority. We will search together for resolutions to concerns in your life whether they are past or present issues. We will attempt to find what is most helpful in each session to assist you in dealing with any issues that arise. After recognizing these issues we will set realistic goals of how you would like to see things at the end of counseling. These will be goals toward which we will work collaboratively.

There will be times when many emotions are expressed, some stronger than others. We will try to create the safest environment possible in order to assist in the expression of these feelings. You and your family should always feel free to leave counseling at any time without fear of judgment from our organization. If the decision to leave is made, we will be glad to provide you with referrals. Remember that although we do our best, desired outcomes are not always achieved.

Possible Side Effects of Counseling:

The idea of counseling is that it is supposed to help you feel better. However, there may be times during the process when you might actually feel worse, and you may question whether or not therapy is effective. Most often, this experience is temporary and usually marks an opportunity for overall improvement and progress toward your goal. If you encounter this experience and you have any questions or concerns, please feel free to contact your counselor.

Counseling Session:

A counseling session is normally 45 to 60 minutes in length. These sessions are usually scheduled once a week depending on your need. The average individual will come for three to six months. Services may be tailored to specifically meet your needs in regard to time, dates, frequencies, objective, goals, and exit criteria. Counseling sessions will be scheduled on a week-to-week basis. If you are in crisis or have an emergency, you should contact your local police or emergency services by calling 911.

Professional Standards:

Therapists are required to adhere to the code of ethics of their professional association (i.e., National Association of Social Workers, American Counseling Association). The licensure of any individual under the laws of Idaho does not imply or constitute an endorsement of that therapist, nor guarantee the effectiveness of treatment.

You may at any time throughout your treatment, seek a second opinion. It is the responsibility of the client to choose the provider and the client may terminate treatment at any time.

Minors:

If you are thirteen years of age and younger, please be aware that the law may provide your parents the right to examine your treatment records. We will provide them only with general information about the clinical work done together, unless they request further information or there is a high risk of self-destructive behaviors, indicators of serious harm toward yourself or someone else. In this case, the therapist will notify them of their concern. The Therapist will also provide them with a summary of your treatment when it is complete. Before giving them any information, the therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what they prepared to discuss.

Professional Records:

The laws and standards of this profession require that treatment records be kept. Clients are entitled to receive a copy of their treatment plan and clinical diagnostic assessment. Therapist's notes will not be released, but instead a summary of this information can be prepared for review or records requests. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers and can cause undue harm. If you wish to see your records, we recommend that you review them in the presence of the therapist so that the contents can be discussed. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Cultural Considerations:

It is the policy of Lifepath Counseling & Wellness to provide services to clients that are respectful of non-dominant languages and cultures. The following actions will ensure that all services adhere to this policy:

- Actively recruit professional staffs that are multilingual and multicultural.
- Advertise our services to diverse populations.
- Ensure that paperwork and forms necessary for service delivery are available either through interpretation or written translation to diverse populations.

Confidentiality: (Please refer to our Privacy Policy for more detailed information)

Privacy Policy

Lifepath Counseling & Wellness is committed to providing the highest quality professional services while maintaining the security of your personal health information. You may have a copy of this policy by requesting it at any time. Please read the following information carefully so that you may understand Lifepath Counseling & Wellness's policies about the protection and use of your protected consumer health information.

You have the following rights regarding your mental health and medical information, provided that you make a written request to invoke the right.

1. Right to request restriction: you may request limitations on how we use or disclose your mental health and medical information. We are not required to agree to any restrictions you request, but any restrictions that are agreed to by us in writing are binding.
2. Right to confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
3. Confidentiality (unless reporting is required by law or regulation). You can ask us **not** to use or share certain information about treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
4. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
5. Right to inspect and copy: you have the right to inspect and to request (requests are to be in writing and specify the exact information sought) a copy of your information regarding decisions about your care; however, progress notes may not be inspected and/or copied. We may charge a $15 fee for copying, mailing, and supplies. Requests will be processed within seven (30) business days. Under limited circumstances, your request may be denied. You may request review of the denial by another licensed health care professional chosen by Lifepath Counseling & Wellness (Records released to you may contain private information that if knowingly or unknowingly is released further may result in unforeseeable consequences.)
6. Right to request an amendment: if you believe that the information we have about you is incorrect or incomplete, you may request an amendment in writing. LIFEPATH is not required to accept the amendment. We may say "no" to your request but we'll tell you why in writing within 60 days.
7. Right to a copy of the agreement: you may request a paper or electronic copy of this agreement at any time.
8. Right to complain: if you believe your privacy rights have been violated, you may file a complaint with LIFEPATH or with the Idaho State Occupational Licensing board. You will not be penalized or retaliated against in any way for making a complaint. It is the policy of the agency that we will have a process for clients and family members of clients to register any complaints they might have about services or any other aspect of our program. We will create an open atmosphere in our clinic that will respect and welcome suggestions for change and complaints. Please request a grievance form from the receptionist if needed. You can also complain, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
9. Lifepath Counseling & Wellness operates on a 'need to know' basis only. This means that only those who need access to your private information for treatment and billing purposes will access your information and they will only access what they need for their specific purpose.

Confidentiality and Limitations

The law protects the privacy of all communications between a client and a mental health therapist. In most situations, we can only release information about your treatment to others if you sign a written Release of Information form. There are other situations that require only that you provide written, advanced consent. Confidentiality contains the following:

1. Your therapist may be required to consult other health and mental health professionals either because of your insurance, or to ensure compliance with the Board of Occupational Licenses about their work with you. During a consultation, every effort is made to avoid revealing the identity of the client. Other professionals are also legally bound to keep the information confidential. If you do not object, you will not be informed about these consultations unless your therapist feels that it is important to your work together.
2. You should be aware that we may need to share protected information with supervisors and staff for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations where we are permitted and/or required by law to disclose information without either your consent or authorization.

1. If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order signed by a judge. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your mental health provider to disclose information.
2. If a government agency is requesting information for health oversight activities, your therapist may be required to provide information for them.
3. If a client filed a lawsuit against LIFEPATH pertinent information may be disclosed regarding that client in order to provide a defense.

There are some situations in which your mental health provider is legally obligated to take actions which are necessary to attempt to protect others from harm. Some information may have to be revealed regarding a client's treatment. The Following may be situations where this could occur.

1. If child neglect or abuse is suspected or if a child is observed being subjected to conditions that are likely to result in abuse or neglect, the law requires the information be reported to the state Department of Health and Welfare. If it is believed the child has suffered serious physical abuse, sexual abuse, or sexual assault, the law requires that your therapist report to the police. Once such a report is filed, additional information may be required.
2. If it is believed that a client presents a clear and substantial danger or imminent injury to another, protective actions may be required including notifying the potential victim, contacting the police, or seeking hospitalization for the client.

If such a situation arises, we will attempt to limit our disclosures to what is necessary and relevant. While this summary of exceptions to confidentiality should provide helpful information about potential problems, it is important that any questions or concerns about this issue be discussed with your provider.

To comply with Idaho Code (16-2428) regarding the confidentiality of records for children over the age of fourteen (14) years of age, parents/guardians and children for which this code applies should take note of the following:

1. No person in possession of confidential statements made by a child over the age of fourteen (14) years in the course of treatment may disclose such information to the child's parent or others without the written permission of the child, unless such disclosure is necessary to obtain insurance coverage, to carry out the treatment plan or prevent harm to the child or others, or, unless authorized to disclose such information by order of a court.
2. The child has the right of access to information regarding his treatment and has the right to have copies of information and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with his treatment record.
3. Nothing in this section shall prohibit the denial of access to records, by a child when a physician or other mental health professional believes, and notes in the child's medical records, that the disclosure would be damaging to the child. In any case, the child has the right to petition the court for an order granting access.

This policy is subject to change. We will communicate any significant changes to you as required by applicable law.
If you have any questions about this policy, please don't hesitate to address them to your service provider.
Our designated Privacy Officer is: Ann Turner at (208) 780-3900. We hope to be able to assist you in the journey that you have undertaken. Please sign this sheet to indicate you have read the information and understand your rights as a client. Also, by signing, you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive service through Lifepath Counseling &Wellness.

I have read and understand the Lifepath Counseling & Wellness Arrival Policy, Office Policy, Informed Disclosure and Consent, and Privacy Policy. I agree to assign insurance benefits to Lifepath Counseling & Wellness whenever necessary. I acknowledge that I can ask for a paper copy of this notice at any time, even if I have agreed to receive the notice electronically; a prompt copy will be provided. This policy is also available at all times at www.lifepathidaho.com.

_____ _____

(Signature) (Date)

_____

(Printed Name)

Lifepath Counseling & Wellness Adult Intake Assessment

Please take a moment to complete this questionnaire thoroughly but be brief with your responses when possible. Feel free to put 'NA" or a question mark when the answer is not known. But please respond to every item-medical record accuracy and completeness make for a good foundation for successful treatment. Know that we honor your confidentiality: consequently, you can be sure that none of your medical record information, including what is provided on this form, will be released without your full knowledge and/or expressed consent. Thank you.

Clients Name_____AGE:_____Todays Date: _____

Name of person completing this form (if different than patient) and relationship to patient:
Please, briefly describe the reason you are here / current problem(s):
Will your family, if necessary, be ready and motivated to participate in services to help you achieve your treatment goals?

Medical Information		
Primary Care Provider:	Phone:	
Psychiatrist or Med Provider:	Phone:	
Other current treating clinicians or therapeutic interventions?		
When was your last check up or medical exam? If it has been more than 12 months we encourage you to schedule one as soon as possible.	**When** and by **whom**?	
Current Medications	**Treatment For:**	**Dosage prescribed:**
Past Medications	**Treatment For:**	**Dosage prescribed:**

Current Psychiatric Medications		
Name of Medication:	**Treatment For:**	**Dosage prescribed:**

Current Psychiatric Care			
Other Mental Health Providers:			
☐ Psychiatrist	☐Developmental Therapy	☐ Case Management	☐ Service Coordination
☐ CBRS	☐ Peer Support	☐ Other:	
Of the psychiatric medications listed above, what were the benefits and/or side effect you had from them?			
Medical hospitalizations, surgeries, chronic serious illnesses, or injuries?			
Condition:	Year:	Condition:	Year:
Condition:	Year:	Condition:	Year:
Please list **all** allergies including drug allergies:			

SYMPTOMS SCREENERS **Over the past *two weeks, how often have you been bothered by any of the following problems…***	Not at All	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating?	☐	☐	☐	☐
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
If you checked **<u>any</u>** problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.				
Not difficult at all ☐	Somewhat Difficult ☐	Very difficult ☐	Extremely Difficult ☐	

Over the past *two weeks, how often have you been bothered by the following problems?*	Not at All	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge?	☐	☐	☐	☐
Not being able to sleep or control worrying?	☐	☐	☐	☐
Worrying too much about different things?	☐	☐	☐	☐
Trouble relaxing?	☐	☐	☐	☐
Being so restless that it is hard to sit still?	☐	☐	☐	☐
Becoming easily annoyed or irritable?	☐	☐	☐	☐
Feeling afraid, as if something awful might happen?	☐	☐	☐	☐
If you checked **<u>any</u>** problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.				
Not difficult at all ☐	Somewhat Difficult ☐	Very difficult ☐	Extremely Difficult ☐	

Has there ever been a period of time when you were not your usual self and…		
You felt so good or hyper that other people thought you were not your normal self or were so hyper that you got into trouble?	Yes ☐	No ☐
You were so irritable that you shouted at people or started fights or arguments?	Yes ☐	No ☐
You felt much more self-confident than usual?	Yes ☐	No ☐
You got much less sleep than usual and found you didn't really miss it?	Yes ☐	No ☐
You were much more talkative or spoke much faster than usual?	Yes ☐	No ☐
Thoughts raced through your head or you couldn't slow your mind down?	Yes ☐	No ☐
You were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes ☐	No ☐
You had much more energy than usual?	Yes ☐	No ☐
You were much more active or did many more things than usual	Yes ☐	No ☐
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes ☐	No ☐
You were much more interested in sex than usual?	Yes ☐	No ☐
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes ☐	No ☐
Spending money got you or your family into trouble?	Yes ☐	No ☐
*If you checked **YES** to more than one of the above, have several of these ever happened during the same period of time?*	Yes ☐	No ☐
How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? (*Only choose one)*		
No Problem☐ Minor Problem ☐ Moderate Problem☐ Serious Problem☐		
Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts uncles) had manic-depressive illness or bipolar disorder?	Yes ☐	No ☐
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes ☐	No ☐

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For Example: a serious accident or fire, a physical or sexual assault/abuse, an earthquake or flood, a war, seeing someone be killed/seriously injured, having a loved one die through homicide/suicide.		
Have you ever experienced this kind of event? Yes ☐ No ☐ *(If yes, please answer the next 5 questions)*		
Had nightmares about the event(s) or thought about the event(s) when you did not want to?	Yes ☐	No ☐
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	Yes ☐	No ☐
Been constantly on guard, watchful, or easily startled?	Yes ☐	No ☐
Felt numb or detached from people, activities, or your surroundings?	Yes ☐	No ☐
Feeling guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	Yes ☐	No ☐

When thinking about substance use, including illegal drug use and prescription drug use other than as prescribed…		
Have you ever felt that you ought to cut down on your drinking or drug use?	Yes ☐	No ☐
Have people annoyed you by criticizing your drinking or drug use?	Yes ☐	No ☐
Have you ever felt bad or guilty about your drinking or drug use?	Yes ☐	No ☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes ☐	No ☐
How much distress would you say these experiences caused you?	Mild ☐ Moderate ☐	Severe☐

Life problem currently effecting you…	
☐ Problems/losses within my family	☐ Financial/economic problems
☐ Problems/ losses among my friends/community	☐ Can't get adequate health care
☐ Educational problems	☐ Problems with the law, legal system
☐ Occupational problems	☐ Discipline
☐ Housing problems	☐ Problems at work
☐ Careless, high-risk behavior	

Medical History		
☐ Chest Pain	☐ Diabetes	☐ Muscle Cramps
☐ Heart Attack	☐ Thyroid Disease	☐ Muscle Stiffness
☐ Coronary Artery Disease	☐ Hormone Problems	☐ Weakness
☐ Rheumatic Fever	☐ Fever or Sweats	☐ Tremors
☐ Low Blood Pressure	☐ Blood Disease	☐ Numbness
☐ High Blood Pressure	☐ Anemia	☐ Difficulty Walking
☐ Stroke	☐ Bruise Easily	☐ Uncontrolled Movements
☐ Heart Palpations	☐ Nose Bleed	☐ Liver Disease
☐ Heart Surgery	☐ Sexually Transmitted Disease	☐ Jaundice
☐ Pace Maker Implant	☐ HIV	☐ Hepatitis

☐ Neurological Disorders	☐ Sexual Difficulties	☐ Stomach Ulcers
☐ Seizures	☐ Gynecological Problems	☐ Nausea/Vomiting
☐ Epilepsy	☐ Prostate Problems	☐ Unusual Diet
☐ Fainting	☐ Cancer	☐ Abdominal Pain
☐ Vertigo	☐ Lung Disease	☐ Skin Rash
☐ Dizziness	☐ Asthma	☐ Skin Ulcer/Lesion
☐ Motor Difficulties	☐ Emphysema	☐ Glaucoma
☐ Serious Head Injury	☐ Chronic Cough	☐ Visual Spots
☐ Recurring Headaches	☐ Bronchitis	☐ Double Vision
☐ Memory Problems	☐ Pneumonia	☐ Hearing Problems
☐ Early Fatigue	☐ Tuberculosis	☐ Speaking Problems
☐ Daytime Sleepiness	☐ Shortness of Breath	☐ Depressed Immune System
☐ Difficulty Sleeping	☐ Sinus or Nasal Problems	☐ Recent Trauma
☐ Concentration Problems	☐ Recurrent Infection of any kind	☐ Other: _____
☐ Kidney Disease	☐ Arthritis	

Family History of Illness:

☐ None ☐ Diabetes ☐ Dementia/Alzheimer's ☐ Cancer ☐ High Blood Pressure ☐ Epilepsy
☐ Hormone Imbalance ☐ Asthma ☐ Thyroid ☐ Migraines ☐ Heart Disease
☐ If other, explain: _____

Educational History			
High School Graduate?	Yes ☐	No ☐	If no, Last grade attended?
GED?	Yes ☐	No ☐	
Special Education?	Yes ☐	No ☐	
College?	Yes ☐	No ☐	Degree?
Academic performance: ☐ Failing ☐Below average ☐Average ☐ Above average ☐Well above average			

Employment History			
Currently Employed?	Yes ☐	No ☐	If no, year last employed?
Last type of employment/work preformed?			

Social Development			
How would you describe your social skills?	☐ Below Average	☐ Average	☐ Above Average

Do you have difficulty making friends?	☐ Yes ☐ No ☐ Don't know
How many friends do you have?	☐ No friends ☐1 – 3 friends ☐4 – 6 friends ☐ More than 7 friends
Friends are mostly…	☐ Younger ☐ Same Age ☐ Older
I would describe myself as?	☐ Very shy ☐ Somewhat shy ☐Average ☐Outgoing ☐Very outgoing

Adult Relationships	
☐ Never Married ☐ Married ☐ Domestic Partnership ☐ Cohabitating ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____	
If divorced and remarried, at what age and how many times?	
With whom do you live and how are you supported at present?	

Current Living Situation	
Do you live in a(n)? ☐ House ☐ Apartment ☐ Manufactured Home	Do you: ☐ Own ☐ Rent ☐ Other _____
Do you live in: ☐ Boise ☐ Meridian ☐ Eagle ☐ Kuna ☐ Nampa ☐ other_____	
Do you live alone? ☐ Yes ☐ No If no, who else do you live with? _____	
Do you have plans to move in the near future? ☐ Yes ☐ No If yes, where? _____	
Do you have any pets? Yes ☐ No ☐ Please List: _____	

Psychosocial and Family History			
Are there any current community resources you oryour family are already accessing?	Yes ☐	No ☐	If yes, please list services
Are there any spiritual or cultural barriers thatcould impact your treatment?	Yes ☐	No ☐	If yes, please explain
Childhood Okay?	Yes ☐	No ☐	If no, briefly state **why**?
Have you **experienced** neglect or emotional abuse?	Yes ☐	No ☐	At what **age** and which **issue** and by **whom**?
Have you **experienced** physical or sexual abuse?	Yes ☐	No ☐	At what **age** and which **issue** and by **whom**?
Have you **witnessed** violence or domestic abuse?	Yes ☐	No ☐	When?
Have you experienced or witnessed an accident, natural disaster or other traumatic event?	Yes ☐	No ☐	If yes, what?
Did your parents stay together while you were growing up?	Yes ☐	No ☐	How old were you when they separated?
Where did you grow up?			
Father's occupation while you were growing up?			
Mother's occupation while you were growing up?			
How many siblings do you have?			

Past Psychiatric History			
Do you have a current mental health diagnosis?	Yes ☐	No ☐	What is it, and at what age?
Have you ever received counseling or psychotherapy in the past?	Yes ☐	No ☐	If so **when**, **where** and with **whom**?
Have you been hospitalized for ***psychiatric*** reasons?	Yes ☐	No ☐	If yes, how many **times**?
Do you have any family, immediate or extended, with ***psychiatric*** illness?	Yes ☐	No ☐	If so, **how old** and **who** suffers from **what**?
Have you had any past **suicide attempts**?	Yes ☐	No ☐	If yes, how many **times** and by what **method**?

If you have attempted suicide more than once, how old were you when first attempted, and when last?	

Legal History			
Legal Problems in the past?	Yes ☐	No ☐	Describe
Current Legal Problems?	Yes ☐	No ☐	Describe

Safety Information			
Do you have access to large quantities of medication?	Yes ☐	No ☐	Comments
Do you have any Firearms or other weapons?	Yes ☐	No ☐	List which types
Have you ever intentionally hurt yourself?	Yes ☐	No ☐	Comments
Have you ever intentionally hurt someone else?	Yes ☐	No ☐	Comments
Are you worried for your safety?	Yes ☐	No ☐	Comments
Are you worried for the safety of others because of your behavior?	Yes ☐	No ☐	Comments

Social Supports			
Is there anyone you trust or confide in during times of trouble?	Yes ☐	No ☐	(First Name Supports)
Do you have any religious/spiritual ties or involvement in a church?	Yes ☐	No ☐	Please describe:

Drug and Alcohol History ***(Check if none)*** ☐						
SUBSTANCE	**DATE OF FIRST AND OF LAST USE**	**PROBLEMS RELATED TO USE**		**TREAMENT REQUIRED**	
Alcohol (hard alcohol)		Yes ☐	No ☐	Yes ☐	No ☐
Beer and/or Wine		Yes ☐	No ☐	Yes ☐	No ☐
Benzodiazepines (Valium, Xanax, Ativan)		Yes ☐	No ☐	Yes ☐	No ☐
Caffeine		Yes ☐	No ☐	Yes ☐	No ☐
Marijuana		Yes ☐	No ☐	Yes ☐	No ☐
Cocaine		Yes ☐	No ☐	Yes ☐	No ☐
Designer Drugs (Club Drugs: G, X)		Yes ☐	No ☐	Yes ☐	No ☐
Hallucinogens (LSD, Mushrooms)		Yes ☐	No ☐	Yes ☐	No ☐
Methamphetamines (Speed, Ice, Ritalin)		Yes ☐	No ☐	Yes ☐	No ☐
Opiates/Methadone (Vicodin, Oxycontin, Heroin)		Yes ☐	No ☐	Yes ☐	No ☐
Inhalants (Gasoline, Glue, Aerosol)		Yes ☐	No ☐	Yes ☐	No ☐
Tobacco Use?		Yes ☐	No ☐	Amount Per day?_____	

To be completed by therapist:
Date of service:_____
People present at the initial interview (Name and relationship): _____
_____.

- ☐ Reviewed intake form and referral information.
- ☐ Client verbalizes understanding of informed consent and privacy policies.
- ☐ Completed release of information as indicated.

Lifepath Counseling and Wellness
Client Email and Text Message Informed Consent

You may give permission to Lifepath Counseling and Wellness Clinic or community programs staff to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1. **How we will use email and text messaging**: We use these methods to communicate only about non-sensitive and non- urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another Lifepath staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as topermitted uses of your health information and your rights regarding privacy matters.
2. **Risk of using email and text messages**: The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:
    a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
    b. Lifepath is not responsible for any costs that may occur if you do not have an unlimited texting/data plan.
    c. Senders can easily misaddress an email or text and send the information to an undesired recipient.
    d. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
    e. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
    f. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
    g. Emails and texts can be used as evidence in court.
    h. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. **Conditions for the use of email and text messages**: Lifepath cannot guarantee, but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

    a. **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call your Community Programs provider, or the office at 208-780-3900. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
    b. Emails should not be time-sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow up if we have received your email.
    c. You should speak with your staff person to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
    d. Email and text messages may be filed electronically into your medical record.
    e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except asauthorized by law.
    f. You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
    g. Lifepath is not liable for breaches of confidentiality caused by you or any third party.
    h. It is your responsibility to follow up with your Community Programs provider if warranted.

4. **Withdrawal of Consent**: I understand that I may revoke this consent at any time by so advising Lifepath in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which Iam otherwise entitled.
5. **Client Acknowledgement and Agreement**: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Lifepath staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that Lifepath may impose to communicate with me by email or text message.

Client Name:_____ Client Signature:_____ Date:_____

Lifepath Counseling and Wellness
ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH being transported in Lifepath employee vehicles, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.
I certify that I am physically fit enough to ride in a provider's vehicle. I certify that there are no health-related reasons or problems which preclude my participation in riding in vehicles owned by Lifepath staff. I acknowledge that this Accident Waiver and Release of Liability Form will be used by providers, in which I mayparticipate, and that it will govern my actions and responsibilities.

In consideration of my application and permitting me to participate in the possibility of transportation, I hereby take action for myself and or my child or and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur while riding in my provider's vehicle.

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in while riding in their vehicle, whether caused by the negligence of release or otherwise.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness while being transported.

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT.I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

_____	_____
Client's Name (Please print legibly)	**Age**
_____	_____
Client's Signature	**Date**
_____	_____
Parent/Guardian Signature	**Date**

Lifepath Counseling & Wellness
Telehealth Informed Consent

Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals ("Treatment Providers") at different locations to share individual client medical information for the purpose of improving client care.

Treatment Providers may include, but are not limited to psychiatrists, psychologists, nurse practitioners, counselors, clinical social workers, and marriage and family therapists.

The information may be used for healthcare delivery, diagnosis, treatment, transfer of medical data, therapy, coordination of care, follow-up and/or education, and may include any of the following: : Live two-way audio and video. Electronic systems usedwill incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

The telehealth provider will initiate the contact at time session is scheduled.

Since this may be different than the type of treatment with which you are familiar, it is important that you understand and agree to the following statements:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to information demonstrating a probability of imminent physical injury to myself or others; immediate mental or emotional injury to myself; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to researchers or other entities shall not occur without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a Telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. I understand that I may ask my Treatment Provider about alternative methods of care to Telehealth.
5. I understand that it is my duty to inform my Treatment Provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that Telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my Treatment Provider believes I would be better served by another form of service (e.g. face-to-face services), I will be referred to a Treatment Provider who can provide such services in my area.
7. I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Treatment Provider, my condition may not improve, and in some cases may even get worse.
8. I understand that I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.
9. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider and call the Lifepath line at **(208)780-3900.**

Expected Benefits

1. Improved access to medical care by enabling a client to remain at a remote site while the Treatment Provider obtains test results and consults from healthcare practitioners at distant/other sites.
2. More efficient evaluation and management for continuity of care.
3. Obtaining the expertise of a distant specialist as rapport has been developed.

Possible Risks

1. Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Treatment Provider and consultant(s).
2. Delays in medical evaluation and treatment could occur due to technical deficiencies or failures.
3. The transmission of Client's medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Necessity of In-Person Evaluation

If it becomes clear that the Telehealth modality is unable to provide all pertinent clinical information during a particular Telehealth encounter, the Treatment Provider must make it known to the client prior to the conclusion of the live Telehealth encounter. The Treatment Provider must also counsel the client prior to the conclusion of the live Telehealth encounter regarding the need for the client to obtain an additional in-person evaluation reasonably able to meet the client's needs.

Platform:

Lifepath Counseling & Wellness recommends using the app software Zoom as it meets HIPAA compliance.

In case of emergency

Call 911 immediately
Or backup support person (208)780-3900

Complaints against Treatment Providers: Or other health care providers, may be reported for investigation to the Medical Board or other appropriate licensing board of the state in which client received the services.

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding Telehealth and understand I have the opportunity to discuss it with my Treatment Provider or such assistants as may be designated. I hereby give my informed consent for the use of Telehealth in my medical care. Furthermore, I agree that the Released Parties have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.

I hereby authorize **Lifepath Counseling & Wellness** to use "Telehealth" in the course of my diagnosis and treatment.

I have read and understand and/or obtained a copy (at my request) of documentation explaining the Telehealth guidelines that Lifepath Counseling & Wellness Telehealth providers adhere to.

_____ _____

Client Signature Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____DOB: _____

I hereby authorize **Lifepath Counseling & Wellness** to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re -disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. Time period of

_____Obtain information from: AND/OR_____Disclose information to:

Name and Address _____

Phone #:_____ Fax#_____

Category and Time Period of PHI Please initial the Category of PHI you wish to release:

_____Initial Evaluation _____Claims/Billing Information _____Lab Results _____Medication List _____CDA

_____Entire Medical Record _____Appt. Scheduling & info _____History and Physical _____Verbal/written Communication

_____Other: _____

Time period of healthcare treatment records you wish to be included:

_____Anytime_____Healthcare provided between (date)_____and (date)_____.

Limit of PHI I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I DO NOT wish to be released.

_____HIV/AIDS test results or diagnosis_____Alcohol/drug abuse_____Other_____

Please limit the use and disclosure of my PHI to only include the following dates:_____. [Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI_____Continuity of Care_____Contact with Referring Supervisor_____Family Involvement _____Aftercare Planning

_____Referral_____other_____

I understand that this authorization will expire on the following date or event:_____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 8675 W. Ardene St. Boise, ID 83709. Phone (208)780-3900. Fax (208)375-2882.

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consentof the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.