Child & Family Therapy Associates, LLC
5215 Starkey Road, SW, Roanoke, VA 24018
Phone: (540) 293-9788; Fax (540) 904-7731
childandfamilytherapy@yahoo.com

Child & Family Therapy Intake - Child

Office Use Only:

Today's Date: _____ Dx: _____

_____

Client Information

Name: _____ _____ ___
First Last M.I.

Address:_____
Street and Number City State Zip

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

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

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

A second phone number in case of an emergency:_____

Name of person:_____ Relationship to you:_____

Billing Information

Responsible Party #1

Name:_____ _____ _____
First Last M.I.

Address:_____
Street and Number City State Zip

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

Responsible Party #2

Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip

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

Authorization to Bill Insurance

Primary Insurance:

Insurance Company:_____ Plan Name:_____

Address:_____
Street and Number

_____
City State Zip

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

Phone Number:_____ Fax Number:_____

Insured Information:

Name of Person Insured:_____ _____ ____
First Last MI

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

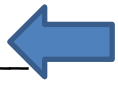
Insured's Address:_____
Street and Number City State Zip

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

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

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

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



_____ _____
Client or Guardian's Signature Date

_____
Printed Name

CHILDHOOD HISTORY FORM

Child's Name _____ Date_____

Birthdate _____ Age_____ Sex _____

Adopted ___ yes ___ no Is your child aware of adoption? ___ yes ___ no

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

Briefly state your main concerns about your child:

To your knowledge, have any of the child's blood relatives experienced similar problems?

Did the child's mother or the child experience any complications during pregnancy/delivery?

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

Childhood diseases: _____
Operations: _____
Psychiatric hospitalizations: _____
Head injuries:_____
Convulsions/seizures: _____
Persistent high fevers: _____
Eye problems: _____
Tics (eye blinking, sniffing, or any repetitive movement): _____
Ear problems: _____
Allergies or asthma: _____
Sleep problems (restless, night waking, sleepwalking): _____
Bedwetting or soiling pants in daytime: _____
Describe the child's appetite: _____
Please list previous doctors/prof's consulted: _____
Current medications and dosage: _____
Prescriber & Phone#: _____ Last Visit: _____ Next Visit _____
Previous Counselor Name & Phone#: _____ Last Visit: _____
Substance Abuse Treatment Information: _____
Other Services Provided: _____
Overall Health: _____

FAMILY/SOCIAL HISTORY

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

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality
__ Other: _____

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__ Homosexuality
__ Other: _____

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality
__ Other: _____

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality
__ Other: _____

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality
__ Other: _____

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

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Physical Neglect
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality
__ Other: _____

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

INFANCY - TODDLERHOOD

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

_____ did not enjoy cuddling
_____ difficult to comfort
_____ excessive restlessness
_____ frequent head banging
_____ was not calmed by being held
_____ colic
_____ excessive irritability
_____ constantly into everything

TEMPERAMENT: please rate the following as your child appeared in infancy and toddlerhood:

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

DEVELOPMENTAL MILESTONES:

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

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

COORDINATION: Rate your child on the following skills:

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

COMPREHENSION AND UNDERSTANDING:

Do you consider your child to understand directions and situations as well as other children his/her age? _____

How would you rate your child's overall level of intelligence?

_____ Below average _____ Above average _____ Average

PEER RELATIONSHIPS:

How does your child get along with others his/her age? Describe any problems.

SCHOOL HISTORY

School currently attending: _____Grade level _____

Is your child receiving any special ed classes? _____

Has your child ever repeated a grade? If so, which? _____

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

Preschool - K _____

1st - 5th _____

6th - 8th _____

9th - 12th _____

Describe any conduct problems your child has had in school:

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

Describe difficulties (beh, lack of understanding, etc): _____

_____

Has your child had tutoring or remedial work? _____

Does your child like to read? _____ How often (circle one): Never Seldom Some Often

Reading Preferences: _____

Please rate reading ability as _____ Good _____ Fair _____ Poor

How much screen time a day does your child have? _____

What does your child play on video? _____

Any other comments on your child's performance and behavior:

HOME BEHAVIOR AND MOOD

Please check which of the following applies to your child:

_____ **frequently irritable or moody**
_____ **doesn't seem to enjoy doing anything**
_____ **sad**
_____ **crying spells**
_____ **easily bored**
_____ **poor or low motivation**
_____ **low self-esteem** (makes negative statements about self)
_____ **can't seem to concentrate**
_____ **has had thoughts of or made comments about suicide/homicide**
_____ **self-harm**: _____
_____ **eats (too much)** or **(too little)**
_____ **frequent arguing at home**
_____ **fearfulness**
_____ **nervous, anxious**
_____ **frequent headaches**
_____ **frequent stomach aches**
_____ **has had panic attacks** (rapid heartbeat, sweaty palms, feeling something bad about to happen)
_____ **difficulty sleeping**:
___ goes to sleep very late
___ hard to get up in morning
___ very restless sleep
___ bad dreams
_____ **acts like driven by a motor** (constant moving, can't sit still, climbing furniture, etc.)
_____ **doesn't seem to learn from experience**
_____ **very disorganized** (loses things, has very messy room, messy bookbag, etc)
_____ **has ever been a victim of physical or sexual abuse**
_____ **drug or tobacco use**: _____
_____ **argues with or rude to teachers**
_____ **struggles with authority figures**

Has your child experienced any stressful or traumatic situations in the past few months or in the last few years, if so, please describe:

Any additional comments you would like to make about your child's (mood, behavior, personality, etc.)?

TRAUMA/LOSS: Has your child experienced any of the following? Check all applicable.

___ Emotional Abuse
___ Sexual Abuse
___ Parent Sub. Abuse
___ Childhood Surgery
___ Homelessness
___ Car Accident
___ Neglect
___ Violence in the home
___ Parent Illness
___ Multiple Home Moves
___ Loss of Family Member
___ Serious Injury/Fall
___ Physical Abuse
___ Crime Victim
___ Teen Pregnancy
___ Foster Care
___ Other: _____

INFORMED CONSENT for TREATMENT

CFT Fees are as follows:

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

Cancellation Policy

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

I will provide additional services which include school visits, teacher conferences, IEP meetings, consultations with other providers, and reports at an additional cost, which are generally not covered by insurance. Rates can vary.

Payments

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

Safety

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

Emergency Situations

After Hour Emergency calls into the office will be forwarded to my voice mail. If the situation is urgent enough, you may text me. If I am available, I will respond. If I am unavailable and the situation is desperate, please take your child to Lewis-Gale Medical Center or Carilion Roanoke Memorial Hospital ER to receive a mental health screaning, which both hospital's have Child/Adolescent Inpatient Psychiatric Units.

Client Responsibilities

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

Medical Records Policy

A child's mental health record will only be released with the signature of both natural parents or legal guardians. The record will not be produced until 24 hours after the written request is received. The record must be picked up by the requesting party within 48 hours of production or record will be destroyed. We reserve the right to not release if we feel detrimental to our client. Additional cost and fees will apply.

CFT Court/Fee Policy

Fees for Angela N. Mitchell, LCSW to appear in court or other fees are as follows: Attorney issuing the subpoena is to contact therapist's office ***at least 2 weeks in advance*** of the court date at ***Child & Family Therapy Associates, LLC, 5215 Starkey Road, SW, Roanoke, VA 24018*** and block out either:

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

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

Rates & Fees:

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

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

Sincerely,

_____

Client Signature & Date

Angela N. Mitchell, LCSW

Child & Family Therapy Associates, LLC

NOTICE OF PRIVACY PRACTICES

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

Child & Family Therapy Associates, LLC (CFT) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at CFT, please contact:

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

YOUR INFORMATION IS CONFIDENTIAL

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

'HIPAA PRIVACY RULE"

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

WHO WILL FOLLOW THIS NOTICE

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

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

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

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

We are required by law to:

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

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

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

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

For Health Care Operations: We may use and disclose mental health information about you for CFT operations. These use's and disclosures are necessary to run CFT, and make sure that all of our Clients receive quality care. For example, we may use mental health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine mental health information about many Clients to decide what additional services CFT should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, mental health students, and peer supervision groups. We may also combine the mental health information we have with mental health information from another agency to

compare how we are doing and see where we can make improvements in the care and services we offer. We will remove information that identifies you from this set of mental health information, so others may use it to study health care and health care delivery without learning who the specific Clients are.

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

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

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

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

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

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

SPECIAL SITUATIONS

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

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

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

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

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

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

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

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

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

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

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

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU

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

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

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

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

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

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

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

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

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

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

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

CHANGES TO THIS NOTICE

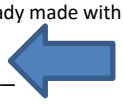
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility.

COMPLAINTS

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

OTHER USES OF MENTAL HEALTH INFORMATION

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



_____ _____

Client/Guardian Date

_____ _____

Witness Date