Intake Packet

** *Completing the following information before your appointment will allow for you to have a shorter wait time once you arrive at our office. Please download, print, and complete the following forms. Anything you have questions or concerns with, please speak to your therapist or prescribing professional. Thank you for choosing Northshore Counseling & Wellness.

Client Information and Agreement Statement

Sessions and Payment

- Sessions typically last 45-60 minutes, although you and your therapist might choose to schedule sessions of varying lengths depending on the needs you might have.
- Contact with clients will be limited to scheduled sessions unless phone contact is mutually agreed upon for critical situations. You and your therapist can discuss how you will handle contact outside of the session.
- Your appointment fee will be due at the beginning of each session, and checks should be made out to Northshore Counseling and Wellness. We accept cash, check, or credit/debit card (AMEX, Visa, Master Card, & Discover). Please see the office assistant on duty to make your payment upon arrival. If there is not an assistant on duty, your therapist will collect from you at their discretion.
- If you are unable to attend a session, you should contact your therapist at least 24 hours in advance to avoid being charged the fee for that session. Any unpaid balances may be turned over to a collections agency.
- Although there are generally tremendous benefits associated with the therapy process, there are also some risks. These might include that you might feel "worse" before you feel "better", you might decide that certain situations or relationships are no longer helpful to you and you need to make changes in these areas, or you might not see sufficient improvement in your life.
- When you owe money to your therapist, it can impair the counseling relationship, as it is difficult to be in the role of counselor as well as creditor. For this reason, we will ask you to provide us with a credit card number to be kept on file that we can use to collect any unpaid balances, especially if such balances are due after the termination of therapy and we are unable to collect these fees through other means.
- If you accumulate a balance over $300, this might be a sign that our financial arrangement is putting a burden on you. If you are under such a burden, please discuss this with your therapist. If we are not able to come to helpful resolution with you, we might refer you to another therapy resource that can provide you with lower-cost counseling.
- Although we are willing to file your claim with your insurance company, you are ultimately responsible for any portion of the bill that is not paid by the insurance. Also, health insurance companies normally require that your therapist submit a diagnosis (indicating that you have an illness) before they will reimburse you. Diagnoses, once submitted, often remain a part of your medical record indefinitely.

Initial to indicate you have read this section _____

Code of Conduct

- All therapists at NCW adhere to the Code of Conduct for practice that has been established by our various licensing boards. Copies of these codes are available upon request. Our relationships with clients are strictly professional. Although the process of counseling can be intimate, please do not mistake your relationship as a personal one. Because your needs as a client will best be served if your relationship retains professional, your therapist will not be able to accept any gifts or socialize outside of counseling.

Confidentiality

- Everything that is said between you and your therapist is to remain confidential, except in certain instances. These instances include:
- When you sign a written release of information indicating informed consent of such release;
- When your therapist believes you might cause physical harm to yourself or another;
- Cases where your therapist knows of abuse to a child, or elderly (65 years old or older) or dependent adult;
- When a complaint is filed with our professional board;
- When you are involved in court proceedings in which mental health is at issue;
- For the collection of fees and filing insurance claims;
- When your files are subpoenaed by a court of law; **Your therapist will always assert privileged communication on your behalf**, and will consult with you when possible before a mandated disclosure; and,
- In any instances when your therapist will discuss your case with peers as part of peer supervision, the information disclosed during those meetings will also remain confidential.

Initial to indicate you have read this section _____

Issues Related to Social Media and Electronic Communications

- Your provider may be personally subscribed to various forms of social media (Facebook, Twitter, etc.)
- Although your relationship with your provider is intimate, it is with an abundance of caution to not compromise your right to confidentiality, as well as maintain professional relationship boundaries, that your provider **NOT** "friend" or "connect" with you via these sites.
- Your provider will not "look you up" or search for you online.
- Any type of public connection with your provider online could compromise your confidentiality as a client because these are publicly accessed sites.
- You are welcome to "like" any public Northshore Counseling and Wellness pages, however, you are not encouraged, required, or asked to review or share any experiences at our offices. These pages are for sharing healthcare information and advertising of services only. They are not intended as any kind of way to message your provider.
- Please be advised that **MESSAGES SENT VIA TEXT ARE NOT A SECURE METHOD OF COMMUNICATION WITH YOUR PROVIDER.**
- Please be advised that **EMAIL MESSAGES ARE TYPICALLY NOT A SECURE METHOD OF COMMUNICATION WITH YOUR PROVIDER.**
- **Aside from telephone calls, please utilize the patient portal secure message feature in our electronic medical records program to send secure messages to your provider.**
- **Any** method by which you choose to communicate with your provider should be discussed with your provider if there are privacy concerns.

Initial to indicate you have read this section _____

Issues Related to Court Appearances/Record Requests

- Should you wish or should your therapist be required to appear in court or at a deposition, the client is financially responsible for the therapist's time for that appearance at a rate of up to $350/hour depending on education level and level of expertise of the therapist.
- The client is also responsible for any and all legal fees incurred by Northshore Counseling & Wellness relevant to any court actions sought on behalf of the client.

Initial to indicate you have read this section _____

Your Rights and Responsibilities as a Client

- You have the right to expect that your therapist will maintain your confidentiality, except in those cases previously mentioned.
- You have the right to request to see the contents of your file or obtain clear information regarding your case records.
- You also have the right to actively participate in counseling plans. You may refuse any services recommended by the therapist and can terminate counseling at any time.
- In the event that you are dissatisfied with services for any reason, please let your therapist know. If you still have concerns, you may report your complaints to the State of Louisiana Licensed Professional Board of Examiners, 8631 Summa Avenue, Suite A, Baton Rouge, LA 70809 (225/765-2515).

Initial to indicate you have read this section _____

Clients are expected to uphold some responsibilities

- You are responsible for following office procedures for keeping appointments and must pay for services at the time of each visit.
- You are expected to notify your therapist of any other ongoing professional mental health services you are receiving. If you are seeing another professional for counseling, the professional must give your therapist permission to work with you.

Initial to indicate you have read this section _____

Termination of Therapy

Therapy may terminate for a number of reasons, including (but not limited to) improvement of the issues for which you originally sought counseling, if you think counseling is not helpful to you, if your therapist thinks you might be better served by working with another therapist or in a different type of setting, and if you are unable to meet your financial responsibilities in therapy.

Initial to indicate you have read this section _____

Emergencies

If you are experiencing an emergency during office hours, you should contact your therapist in accordance with your agreement about contact outside of the session. If you feel that you cannot wait for your therapist to return your call, you should go to the emergency room of your nearest hospital and ask for psychiatric services. In addition, you can call the COPE line at 800-749-2673.

Initial to indicate you have read this section _____

Missed Session Policy

The fee for a missed session is $90.00. In order to cancel your appointment without being a charged the $90 missed session fee, you must call NCW to cancel the appointment no later than 24 hours prior to the appointment time.

By signing below, you verify that you understand this policy regarding the cancellation of sessions:

_____

Client signature

Please check the boxes that apply:

- ☐ I give permission for NCW to send me information via email about future services such as groups, presentations, and workshops.
- ☐ I give permission for my therapist to contact my referral source,_____to thank him/her for the referral.

Emergency Contacts/Appointment Reminders

Please list a phone number and/or email address if you would like a courtesy email and/or phone call/voicemail to remind you of your appointment. Your appointments are confidential, and if you do not wish to receive a reminder, please inform your therapist and the office assistant if on duty.

Phone (____)_____ Email Address _____

Please list the names and contact information of three parties that we may contact in case of an emergency. Please consider doctors, family members, or a trusted friend.

_____

_____

_____

Credit Card Authorization

You are encouraged to keep a credit card on file in our Electronic Medical Records Vault.

I, _____, authorize NCW to charge the fees related to services received to my credit card. By signing below, I understand that charges will NOT be billed to this card automatically, but only in the event that I have an unpaid balance and have not made other arrangements to pay that balance. I authorize NCW to use this card for sessions fees, including for the collection of balances due that are not otherwise paid in full on my account, even if such balances are due after therapy has terminated.

Client Signature Date

I have read and understand the Client Information and Agreement statement:

Client Signature Date

The following is to be completed for minor children:

I, _____ give permission for Northshore
(parent or legal guardian)
Counseling and Wellness to conduct counseling with my son/daughter,
_____. Should I choose to revoke this permission,
(name of minor)
I understand that such revocation will be effective no sooner than two weeks after this notice is given to the therapist.

NORTHSHORE COUNSELING AND WELLNESS
201 Holiday Blvd. Ste 120. Covington, LA 70433
(p)985-624-2942 (f)985-231-1373
www.northshorecounselingandwellness.com

Notice of Privacy Practices

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and my Personal and Professional Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Healthcare Operations We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

1. Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department);
2. Required by court order;
3. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to this office (NCW, 201 Holiday Blvd, Suite 120, Covington, LA 70433).

1. **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
2. **Right to Amend**. If you feel that the PHI we have about is incorrect or incomplete, you may ask us to amend information although we are not required to agree to the amendment.
3. **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request a restriction more than one accounting in any 12-month period,
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use of disclosure of your PHI treatment, payment, or health care operations. We are not required to agree to your request.
5. **Right to Request Confidential Communication**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
6. **Right to a Copy of this Notice**. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer (Andre S. Judice, Ph.D., 985-624-2942) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D. C., 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is April 1, 2004.

NORTHSHORE COUNSELING AND WELLNESS
201 Holiday Blvd. Ste 120. Covington, LA 70433
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www.northshorecounselingandwellness.com

NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgment of Notice

Patient Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Northshore Counseling and Wellness' Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact NCW at (985)624-2942.

Signature of Patient _____ Date _____

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

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

☐ Patient refuses to acknowledge receipt:

Signature of Staff Member if patient refuses _____ Date _____

Appointments and Cancellations

As providers to you, we are invested in helping you achieve the highest level of health that you can. Therefore, we ask that you take your appointments very seriously. The people who report getting the most good from therapy are the ones who come on a consistent basis. This is why we ask that ***if you need to cancel an appointment, please make every effort to reschedule that appointment for the same week.*** In the case that your provider does not have another available appointment, please consider making other alternative arrangements to complete that session. Most therapists are willing to complete the session via phone as well in certain circumstances in order to accommodate your schedule.

Unlike a traditional doctor's office, we reserve long blocks of time specifically for your appointment, and we do not "double-book" appointments. Therefore, if you don't come to your appointment, or you don't give us enough cancellation notice, we are not able to fill that time with another client on short notice or pay your therapist. In order to make sure you are aware of your appointment time, we send you an appointment reminder two full days before your appointment. This can be done via any combination of a phone call, a text message, and an email. ***Please sure the front desk has your preferred method(s) of contact at the time of your first appointment. If you don't come to the appointment, and you fail to give us more than 24 hours notice, we will charge you a $90 missed session fee.*** For this reason, please always give us notice if you are not able to make the appointment. If you do not give us 24 hour's notice, but you can make up the appointment in the same calendar week, you will not be charged the missed session fee.

Here are some tips to getting the most out of therapy:

- Remember that ***consistent attendance*** (weekly) at therapy keeps the "momentum" going, helps you stay on track with your goals, and can thereby shorten the amount of time you need to be in therapy.
- Consider ***booking a block of appointments out at once***, such as 10 weeks of appointments. This helps us plan around your schedule better, and anticipate what we can do on weeks where you might not be in town or have other commitments.
- Make an effort to ***make up your missed or cancelled appointment in the same week***. This help keep momentum towards your goals.
- Ask your therapist if he or she is willing to do phone sessions in a pinch. This will allow you to have a fall back plan if you are unable to make your appointment for any reason.

Couples Counseling Initial Intake Form

Name:_____ **Date:** _____

Name of Partner:_____

Relationship Status: (check all that apply)

- □ Married
- □ Separated
- □ Divorced
- □ Dating
- □ Cohabitating
- □ Living together
- □ Living apart

Length of time in current relationship: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern
- □ No concern
- □ Little concern
- □ Moderate concern
- □ Serious concern
- □ Very serious concern

Frequency
- □ No occurrence
- □ Occurs rarely
- □ Occurs sometimes
- □ Occurs frequently
- □ Occurs nearly always

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No
If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? Yes □ No □
If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes ☐ No ☐ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes ☐ No ☐ If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes ☐ No ☐ If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes ☐ No ☐

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

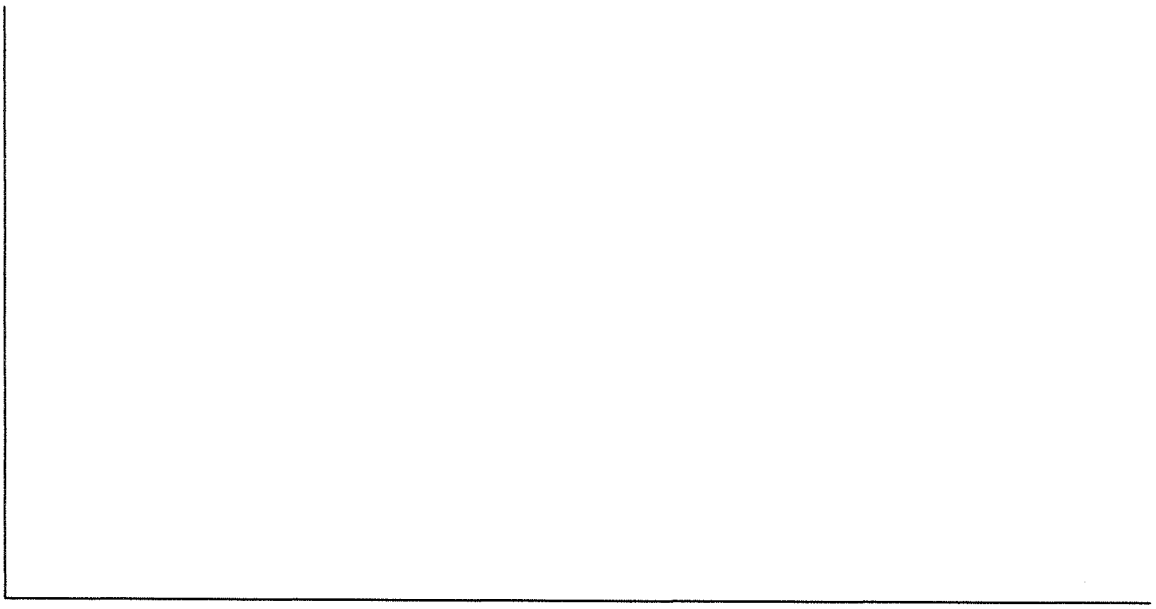
1. _____

2. _____

3. _____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction



No satisfaction

Relationship over time

When you met/began dating ***Current***

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

Comprehensive Confidential Questionnaire

Date:_____ Name:_____ Birthdate:_____

Place of birth:_____ Where were you raised:_____

Current address:_____

Phone:_____ E-mail:_____

SSN:_____ Referred by:_____

Name, Address and phone number of someone you authorize me to call in case of emergency:

_____

Your marital status:_____ Spouse's name:_____

Your children's ages and names: _____

_____

Occupation: _____ How long have you had this job? _____

Employers name, address, phone #: _____

Highest level of school completed:_____

Name, address, phone # of nearest relative: _____

_____

Name, address, phone # of person responsible for your fees if other than yourself: _____

_____

List career or work problems: _____

_____

Have you been in the military? _____ For how long? _____

What is the longest time you have held a job? _____ When? _____

Have you ever been in debt? _____ Are you currently in debt? _____

What would you like to accomplish in therapy? _____

_____

_____

Have you ever consulted a mental health professional? _____ Who? _____

Where? _____ When? _____

Did it help? _____ If no, why do you think it didn't?_____

_____

MARITAL HISTORY (IF APPLICABLE)

How many marriages have you had? _____ How many for your spouse? _____

At what ages for you? _____ for your spouse? _____

How long did they last for you? _____ for your spouse? _____

How long did you know your current spouse/mate before you married?_____

What do you like about your spouse? _____

_____

What don't you like about your spouse? _____

_____

List your children's names and ages _____

_____

Cite problems _____

_____

FAMILY OF ORIGIN HISTORY

How many children in your family of origin? _____ Names and ages of your siblings _____

_____

_____

To which sibling do you feel the closest _____ furthest _____
Is your mother still alive? _____ Father? _____ If not, how old were you when they passed away_____ Have any of your siblings died? _____
Briefly describe your mother_____,
Father_____, sisters_____
_____ brothers_____
_____
List past or current problems with parents _____
_____
_____
Do you consider yourself religious? _____ if yes, what faith?_____

PHYSICAL HISTORY

Date of last physical exam_____Reason_____
Results _____
List chronic ailments_____
Height _____ Weight _____ Any recent changes in weight? _____
Have you ever had a head injury? _____ Describe _____
_____
Did it require a hospital visit? _____ When?_____ Diagnosis_____
List diseases you have and dates_____
Have you ever been given medication for psychiatric reasons? _____
By whom? _____ When? _____
What medication? _____
What medication are you still taking? _____
List your other prescription and OTC medicines _____
_____
List street drugs you take or have used in the past _____
How often? _____ When did you start? _____ Do you want to stop? _____
How often do you drink alcohol? _____ How much? _____
Do you want to stop? _____ How many cigarettes do you smoke per day? _____

PLEASE LIST AGE OF OCCURRENCE WHERE APPLICABLE

Temper outbursts _____ Bedwetting _____ How Handled? _____
Feelings of inferiority _____ Frustration_____ Police Arrests _____
Why _____
Fights _____ Cutting yourself_____ Fingernail biting_____
Sleep walking _____ Insomnia _____ Nightmares _____
Dizziness_____ Heart pounding/racing_____ Difficulty trusting_____
Tingling/numbness_____ Headaches_____ Fears/phobias_____
Guilt_____ Obsessions_____ Seeing or hearing things that aren't there_____
Depression_____ How was it treated?_____
Suicidal thoughts or actions_____ Dates_____
How was it treated _____
Low self-esteem_____ Shyness_____ Moodiness_____ Anxiety_____
Loneliness_____ Marital problems _____ Feelings of unreality _____
Physical abuse issues_____ By whom_____
Sexual abuse issues_____ By whom_____
Emotional abuse issues_____ By whom_____
Describe current complaints and efforts to help_____
With whom do you live_____

Hobbies and interests_____

Describe your strengths_____

_____

Describe your growth points_____

_____

What weapons do you own_____ Why_____

What is your favorite activity?_____

Please list any questions you would like me to answer

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

NORTHSHORE COUNSELING & WELLNESS
BEHAVIORAL HEALTH SERVICES
RELEASE OF INFORMATION

Effective One year FROM:_____TO:_____

PARTICIPANT'S NAME (Print):_____DOB:_____

I AUTHORIZE:_____ TO **RELEASE** INFORMATION TO:
Specific Organization/Person:

_____
Name Address

INFORMATION THAT MAY BE RELEASED:

( ) Mental Health/Physical Information: ☐ Presence and Progress in Treatment ☐ Assessments
Diagnosis ☐ Diagnosis ☐ Tx/Recovery plans ☐ Psychiatric Summary
☐ Medication Records ☐ Demographic Information

( ) Drug/Alcohol Treatment Information: ☐ Presence & Progress in Treatment ☐ Assessments
☐ Diagnoses ☐ Tx/Recovery Plans ☐ Psychiatric Summary
☐ Medication Records ☐ Demographic Information

☐ Other:_____

Reason: ☐ Provide continuity of care ☐ Compliance with program ☐ Specify_____

☐ Personal use ☐ Legal purposes ☐ Social Security/disability ☐ Insurance/Managed Care

Dates of Service: From_____ To:_____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1. Review and understand the Notice of Privacy Practices
2. This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization
3. Inspect and receive a copy of the material to be released
4. Request restrictions on how my health information is used and disclosed; and
5. Receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that NCW may not condition treatment on obtaining this consent/authorization from me

_____ _____
Participant's Signature or oral consent when physically unable to sign "I understand the nature of the release and freely give oral consent" DATE

_____ _____
Signature of Authorized Person in lieu of participant DATE

_____ _____
Witness Signature DATE