The Westwood Group
Established 1983

Child and Adolescent Forms Packet

This packet includes:

- Child and Adolescent Registration Form -- for clients 17 and younger. This form should be filled out by the parent/guardian
- Privacy Notice -- completed by all clients
- Informed Consent to Treatment Agreement -- completed by all clients
- Financial Agreement -- completed by all clients
- Agreement to Participate in Credit/Debit Card on File Policy -- completed by all clients
- Insurance Benefits form -- completed by those using insurance
- Primary Care Physician Notification -- completed by those using insurance

Northside/West End Office 5821 Staples Mill Road
Richmond, Virginia 23228-5427
(804) 264-0966
Fax: (804) 264-1029

Southside Office
1241 Mall Drive
Richmond, Virginia
(804) 794-5928
Fax: (804) 379-6385

CHILD AND ADOLESCENT REGISTRATION FORM

All Information will be treated confidentially

Today's Date: _____

Child's Name: _____

Parent or Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home ( ) _____ Cell: _____ Email: _____

Age: _____ Birth Date: _____

Gender: _____ Grade: _____ School: _____

Father's Name: _____ Business Phone: _____

Father's Occupation: _____ Highest Education Level: _____

Employer: _____

Mother's Name: _____ Business Phone: _____

Mother's Occupation: _____ Highest Education Level: _____

Employer: _____

Siblings (Gender and Age):

If you believe your insurance may cover part of these costs, and you would like this office to file insurance, we will need the following information:

Is this an EAP (Employee Assistance Program) visit? ☐ Yes ☐ No
Does your insurance require pre-authorization? ☐ Yes ☐ No

Subscriber's Name Date of Birth Employer ID Number

Primary Insurance Company Address

Secondary Insurance Company (if any) Subscriber's Name Date of Birth ID Number

In Emergency, notify: _____ Telephone #: _____

Who referred you to us? _____

Your child's physician's name and number: _____

Date of Last Doctor's Visit: _____ Purpose: _____

Current or Chronic Illnesses? _____

Current Mental Health-Related Medications? _____

Current Physical Health: Good Fair Poor

If your child has ever received a psychological or psychiatric evaluation or treatment, please indicate the following:

_____ Date Began: _____ Date Ended: _____
Therapist's Name and Address

_____ Date Began: _____ Date Ended: _____
Therapist's Name and Address

1. As completely as possible, please describe the problems you feel your child is experiencing, or the reason you are bringing your child for services:

_____

_____

2. Does your child have the following problems (please check all that apply)? Has he/she has them in the past (mark **past** behaviors not currently a problem wit a P)?

_____ Depression
_____ Crying Spells
_____ Loneliness
_____ Low Self Esteem
_____ Irritable Mood
_____ Feeling Hopeless
_____ Feeling Worthless
_____ Excessive Guilt
_____ Overly Self-Conscious
_____ Loss of Interest in Pleasurable Activities
_____ Indecisive
_____ Cannot Relax
_____ Fear of Physical Harm
_____ Fear of Dying
_____ Other Fears/Phobias
_____ Overly Dependent for Age
_____ Panic Attacks
_____ Problems Making or Keeping Friends
_____ Hallucinations
_____ Harm or Injury to Self
_____ Thinking/Talking of Death or Suicide
_____ Suicide Attempt(s)
_____ Excessive Worry
_____ Shy/Timid
_____ Picked on by Peers
_____ Bad Temper
_____ Defiance of Rules
_____ Annoying Behavior
_____ Frequent Swearing

_____ Spiteful or Vindictive
_____ Frequent Fights
_____ Difficult to Control
_____ Lying
_____ Argumentative
_____ Conflict with Parents
_____ Distant from Parents
_____ Stealing
_____ Problems with Authority
_____ Destructive
_____ Fire Setting
_____ Poor Judgment
_____ Harming Other Children
_____ Harming Animals
_____ Verbal Aggression toward Peers
_____ Verbal Aggression toward Siblings
_____ Physical Aggression toward Peers
_____ Physical Aggression toward Siblings
_____ Poor Attention or Concentration
_____ Impulsive
_____ Overactive
_____ Distractible
_____ Low Academic Motivation
_____ Homework Problems
_____ Achieving Below Potential
_____ Refuses to go to School
_____ Frequent Detentions
_____ School Suspensions
_____ Other Problems or Unusual Behaviors:

_____ Speech/Language Problems
_____ Problems with Reading
_____ Problems with Math
_____ Problems with Writing
_____ Problems Understanding Written Instructions
_____ Problems Understanding Verbal Instructions
_____ Smoking
_____ Alcohol Use
_____ Legal Charges
_____ Drug Use (specify):

_____ Physical Abuse/Neglect
_____ History of Sex Abuse
_____ Bad Home Conditions
_____ Inappropriate Sexual Behaviors or Interests
_____ Eating Problems
_____ Underweight
_____ Overweight
_____ Thumb Sucking after Age 3
_____ Problems Getting to Sleep
_____ Bedwetting after Age 4
_____ Soiling Pants
_____ Frequent Nightmares

Medical History: (check all that apply)

Any difficulties during pregnancy or delivery?

_____

Motor Milestones achieved on time, such as sitting up or crawling? ☐ Yes ☐ No

Language Milestones achieved on time, such as saying first word and sentence? ☐ Yes ☐ No

Appetite Disturbance _____ Seizures _____ Ear Infections _____

Head Trauma _____ Allergies _____

Other illnesses or concerns? _____

Hospitalizations? ☐ Yes ☐ No (If yes, explain;) _____

_____

Please circle any of the following that have been present in the history of the family (including the extended family on both mother's and father's side):

Drug/Alcohol Use	Depression	Learning Disabilities	Uncontrolled Anger
Eating Problems	Schizophrenia	Attention-Deficit/Hyperactivity Disorder	
Bi-Polar Disorder	Hospitalization for treatment of mental illnesses		Suicide
Anxiety	Sexual Abuse	Physical Abuse	Social Fears

Any history of academic difficulties? ☐ Yes ☐ No If "Yes", please describe them:

_____

_____

Any other information you would like us to have:

_____

_____

Note: An initial evaluation is $150 for 45-minute session. A regular treatment is $125 for adults and $135 for children and adolescents. Payment is requested at the time services are rendered. If you wish to make other arrangements, please discuss them with your therapist at your first appointment.

_____ _____

Date Signature of Person Responsible for Payment

The Westwood Group Privacy Notice
Effective April 14, 2003

THIS NOTICE DESCRIBES 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 Privacy Is Important

The Westwood Group understands and respects your need for privacy. We are required by law to maintain the privacy of protected health information, which is information in your record that could identify you. We are required to notify you of our legal duties and privacy practices in regard to protected health information. We are further required to adhere to the terms of this notice. We will handle your protected health information only as allowed by federal and state law and according to this practice's policies, using the most rigorous law that protect your health information.

If at any time you believe that your privacy rights have been violated, you may contact any of the following sources verbally or in writing:

- Westwood Group Privacy Officer
- State Advocate
- Secretary of Health and Human Services of the federal government

Contact information is listed at the end of this notice. Utilizing this right will cause no change in services provided to you nor will it lead to retaliation from anyone in this practice.

Your federally defined rights under 45 CFR Parts 160 and 164 (HIPPA Privacy Standards), and under The Commonwealth of Virginia's Administrative Code, Title 12, sections 35-115-80 and 35-115-90 (Human Rights)

Each time that you receive services from The Westwood Group, the provider makes a record of the visit. The record generally contains diagnosis, changes in functioning, intervention(s), and plans for future services. You should be aware of the following rights concerning your protected health information:

- You have the right to inspect or request copies of your medical record. You must make this request to your provider or to the Westwood Group Privacy Officer. The request is confidential. This right is not an absolute. If access could cause harm, we can deny your request. If denied, you will be given a timely, written notice that includes the reason for the denial. The notice will become a part of your record.

- You have the right to request an amendment of your medical record if you believe the information in the record is inaccurate or incomplete. You must make this request to your provider or to the Privacy Officer. We may deny the request for appropriate reasons. You will be provided a written explanation of the denial.

- You have the right to receive an accounting of The Westwood Group disclosures of your protected information that were not for the purposes of treatment, payment, health care operations, or that were not otherwise authorized by you. You also have the right to be given the names of anyone other than employees of The Westwood Group that received information about you from the Westwood Group.

- You have the right to request from your provider a restriction regarding the use or disclosure of your protected health information. We will give this request serious consideration. You will promptly be informed whether we can honor the requested restriction while continuing to offer effective services, receive payment, and maintain health care operations. We are not legally required to agree to any restrictions. If we agree to do so, we are bound by the agreement except under certain emergency situations.

- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Such requests must be made in writing to your provider. We will accommodate all reasonable requests.

- You have the right to obtain a paper copy of this Privacy Notice at any time upon your request.

Use and Disclosure of Your Information

Upon signing The Westwood Group consent form and financial agreement you are allowing us to use and disclose necessary information about you within the practice and with business associates in order to provide treatment/service, receive payment of provided treatment/service, and conduct our day-to-day health care operations.

Examples:
Your provider may consult with other providers in The Westwood Group in order to effectively render service to you. During those consultations health information about you may be shared.

In order to receive payment for services provided, your health information may be sent to those companies or groups responsible for reimbursement. A monthly statement may be sent to the responsible party identified by you and noted on the financial agreement.

In daily health care operations, trained staff may handle your

physical medical record in order to prepare it for your provider's use or for filing or to obtain information used for billing purposes.

Emergencies

We may use or disclose necessary protected health information about you in an emergency situation. In the event that this occurs, we will notify you as soon as reasonably possible.

Individuals Involved in Your Care or Payment for That Care

Unless you object, The Westwood Group may release information about you to a friend or family member who is involved in your medical care. We may also give information to someone that you identified as an individual that helps pay for your care.

Specific Circumstances for Disclosure

Federal and state law allows The Westwood Group to disclose specific health information about you in the following specific circumstances:

- As required by law. For example, reports required for public health purposes such as reporting certain contagious diseases.
- Judicial and administrative proceedings such as an order from a court, or legal counsel for The Westwood Group or for your provider.
- Law enforcement purposes. For example, material witnesses, missing persons, criminal conduct on premises.
- To avoid a serious threat to the health and safety of another person, such as in response to a specific threat made by a person to harm another.
- Children or incapacitated adults that are victims of abuse, neglect, or exploitation.
- Health oversight activities by the Westwood Group
- Military services. For example, in response to appropriate military command to assure the proper execution of the military mission.
- National Security and Intelligence activities such as those authorized by the National Security Act or in relation to protective services to the President of the United States.
- State Department requests such as medical suitability for the purpose of security clearance.
- Correctional facilities. For example, to a correctional facility about an inmate.
- Workers Compensation to facilitate processing and payment.
- Coroners and medical examiners for identification of a deceased person or to determine cause of death
- To the department of Health and Human Services in connection with an investigation of The Westwood Group for compliance with federal regulations.

Substance Abuse Regulations

The use and disclosure of protected health information for substance abuse patients is subject to additional regulations under federal law. Some regulations may prohibit the uses and disclosures outlined in this notice. If such a case occurs, we will adhere to the more restrictive abuse regulations.

Other Uses and Disclosures of Your Information by Authorization Only

The Westwood Group is required to obtain your authorization to use or disclose your protected health information for any reason other than for treatment/services, payment, or health care operations, and those specific circumstances outlined previously. We use an authorization form that specifies what information will be provided to whom, and for what purposes. You or your legal representative must sign the form. You have the right to revoke the authorization at any time with a written statement unless we have acted on the request.

Changes to Privacy Practices

The Westwood Group reserves the right to change any of its privacy policies and related practices at any time, as allowed by federal and state law. Changes will be effective for all protected health information that we maintain.

The Westwood Group will post all revised Privacy Notices at all service sites. They will be available upon a verbal or written request made to your provider, another Westwood Group provider, or staff of the Westwood Group.

For additional information concerning our Privacy Policy or the federal and state laws pertaining to privacy, please contact:

- Your provider
- Privacy Officer
  The Westwood Group
  5821 Staples Mill Road
  Richmond, Virginia 23228
  (804) 264-0966
- Regional Advocate,
  Virginia Secretary of Health & Human Services
  202 North 9th Street, Suite 622
  Richmond, Virginia 23219
  (804) 786-7765
- Secretary of Health & Human Services
  Hubert Humphrey Building
  2000 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 690-7000

Your signature below indicates that you have received and read this Privacy Notice.

_____

Signature ***Date***

Rev 4/14/03

INFORMED CONSENT TO TREATMENT AGREEMENT

As your mental health professional, I will disclose no information obtained from your contacts with me or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law:

1. It is my policy to provide information to others without your further consent, in certain circumstances:
   a) Harm to Yourself or Someone Else. (If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety or the safety of others.)
   b) Vacations and Emergencies. (When I am on vacation or away from the office for extended periods of time, a colleague may cover for my practice and take emergency calls. If she/he will need information in order to assist you in my absence, I will provide it without using your full name; you and I will discuss that plan in advance.)
   c) Consultation. (To insure that I am providing quality care, I sometimes meet with a consultant. In so doing, I do not reveal identifying information. I will provide names of my consultants upon request.)
   d) Answering Service. (On nights and weekends, I use the Hello, Inc. Answering Service. They understand my confidentiality policies, and after paging me they will keep no record of your name or phone number.)
   e) Billing Service. (The Westwood Group office staff has access to the information necessary for preparing monthly statements and submitting insurance claims.)
   f) Partners and Employees. (My office partners do not have access to my records. However, we share a clerical staff which takes messages when the office is open.)

2. Virginia law requires psychologists to release information to others in certain circumstances:
   a) Virginia therapists are required by law to report certain information:
      1) Suspicion of abuse or neglect of a child or of an aged or incapacitated adult must be reported to the Board of Social Services.
      2) Information that a Psychologist is engaging in unethical or illegal practice must be reported to the Board of Psychology.
      3) If you are licensed by a Health Regulatory Board, I am required to report that you are receiving therapy if I believe that your condition places the public at risk.
   b) Virginia law imposes upon therapists the legal duty to protect other members of society from harmful actions by their patients. Voiced threats of direct harm to another person can result in notification of the potential victim, law enforcement officers, and/or others as specified by statute.
   c) In Virginia court cases, therapist-patient privilege may not apply in certain cases, including::
      1) criminal cases
      2) child abuse cases
      3) any court case in which your mental health is an issue, and/or
      4) any case in which the judge "in the exercise of sound discretion deems it necessary to the proper administration of justice." This means that information communicated to a therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records or testimony from your present or former therapist as evidence in a court case (including child custody cases). If I receive such a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and requesting that the confidentiality of the therapy relationship be protected. However, only the judge may decide whether or not the requested information or records must be disclosed.
   d) Virginia law allows certain others to request access to treatment records in specific circumstances, including
      1) Protective Service Workers to whom I have reported suspicion of abuse or neglect, if they so request;
      2) Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders and
      3) Evaluators for minors' involuntary commitment to inpatient treatment, if they so request.

   In such cases, I will make every attempt to limit the information disclosed by substituting an oral or written report rather than submit actual treatment records.

   d) If you are under 18, Virginia law allows your parents to obtain information and/or records related to your treatment. There is an exception to this if you are in treatment for drug or alcohol abuse (substance abuse).

3. Information will be provided to third party payers, i.e., insurance companies, only with your consent:

If you wish to obtain third party reimbursement for mental health services, certain information must be provided. You must decide whether to give consent for me to release the necessary information to an insurance company (or other third party payer) in order to receive reimbursement. Initially, that usually involves providing information about dates of treatment, type of treatment, and nature of your problem (diagnosis). If I receive requests for further information, these will be disclosed with you before the information is provided.

Regarding Managed Care Insurance:

If your insurance company contracts with a company to administer (manage) the mental health portion of your health care benefits, this is called managed care. Many managed care companies require that you obtain a referral from your primary care physician and/or pre-authorization from a case manager in order to receive mental health services. In advance, (1) we will discuss possible limits on the benefits available through your plan; (2) we will review a Treatment Plan so that you understand what information I would be required to submit in order to request authorization for your treatment; and (3) we will discuss the payment plan that will be in effect in the event that our work together continues past the point when third party authorization/reimbursement is no available.

Most managed care companies initially authorize a limited number of sessions, then require that I complete a form (Outpatient Treatment Plan) pertaining to your presenting issues, your diagnosis, a brief description of your current situation, and goals for our work together. If additional sessions are authorized, updated Treatment Plans about your progress may be required throughout our work together; we will discuss the content of each Treatment Plan before it is sent to the managed care company.

As a consumer of mental health services, you need to know that the information provided to any third party becomes a permanent part of your file with them, and that neither you nor I will have control over the further confidentiality of that information, including whether it is made available to an insurance data bank and/or your employer or is re-released for other purposes.

DOCUMENTATION OF PATIENT AUTHORIZATION:

I understand that if I receive mental health services from Dr./Mr. /Ms. _____ the above limitations may be imposed on confidentiality. I hereby accept those limits of confidentiality and consent to receive treatment under those conditions.

I do ____ do not ____ give consent for claims to be submitted for third-party/insurance reimbursement..

PATIENT/ /PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

FINANCIAL AGREEMENT

- The Westwood Group's therapy fees are as follows:
  - 45 min. Initial Evaluation session $150
  - 45 min. Individual Therapy session for adults $125
  - 45 min. Individual Therapy session for children and adolescents $135
  - 45 min. Family or Marital Therapy session $135
- If you would like to use your health insurance, you need to call the number on your insurance ID card and fill in the Insurance Benefits Form, included with this set of forms, before your first session and bring it with you. This will instruct you to confirm that your therapist is covered by your insurance plan and to obtain pre-authorization of services, if necessary. It will also help you determine if there is an annual deductible amount to be met before coverage starts each year, and if you need to pay a copayment (which is a fixed amount due at each session) or coinsurance (which is an amount based on a certain percentage of the allowable charge for each session).
- Payment of the client's portion of the fees is due at the time of service. This may be made in the form of check, cash, or credit card.
- There is a $75 charge for missed appointments or appointments cancelled less than 24 hours in advance. This notice is needed in order to reschedule the appointment time with another client. This charge is not covered by insurance policies.
- The cost of psychological evaluation/testing varies with the tests administered and will be explained by the examiner prior to testing.
- Services not covered by health insurance include sessions exceeding 50 minutes, court testimony, letter- and report-writing, phone calls lasting more than 5 minutes, and authorized contact with other professionals, including attorneys, teachers, physicians, and therapists. These services will be discussed with the client in advance, and are usually prorated on the time involved, based on an hourly rate set by your therapist.
- There is a $35 charge for all returned checks.
- A service fee of up to 10% per month will be added to any bill that is 90 days past due. If referral to a collection agency is necessary, an additional charge of up to 50% of the balance will be added to cover the cost of collection and any court costs.
- Credit Card on File Program: The Westwood Group requests that you keep a credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, as well as any other services or fees for which you are responsible. This agreement is included with this set of forms.

I have read the above terms and accept treatment under them.

Date: _____

Printed name of client or person responsible for payment_____

Signature of client or person responsible for payment _____

THE WESTWOOD GROUP
AGREEMENT TO PARTICIPATE IN CREDIT/DEBIT CARD ON FILE POLICY

Your provider requests that you keep a credit or debit card on file (which is kept confidential in accordance with HIPAA standards and regulations at all times) as a convenient method of payment for the portion of services that your insurance does not cover, as well as any other services or fees for which you are responsible. Your signature authorizes your provider to charge this card for the any remaining balance for services as outlined in the Financial Agreement.

Before your card will be charged, you will receive a mailed invoice itemizing the charges. These expenses will be applied to your card after a minimum of 10 business days from the time the invoice is sent out. Unless you have made arrangements with our billing office for a payment plan your card will be charged the full amount of any remaining balance due. Requests for payment plans must be made in writing to our billing office and approved by your provider at the address below.

The Westwood Group
5821 Staples Mill Rd.
Richmond, VA 23228

I _____authorize my provider to charge the portion of my bill that is my financial responsibility to the following credit or debit card: I understand that my information will be saved to file for future transactions on my account.

☐Visa ☐ MasterCard ☐ American Express ☐ Discover
Card Number: _____
Expiration Date: _____ / _____ / _____
CCV Code on back of card: _____
Name as it appears on card: _____
Credit Card Billing Address Street Name and Number: _____
City: _____ State:_____
Zip Code (from credit card billing address): _____.

I (we), the undersigned, authorize and request my (our) clinician to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for psychological services. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to our billing office in writing and the account must be in good standing.

Card Holder Name (Print): _____
Card Holder Signature: _____
Date: _____ / _____ / _____

INSURANCE BENEFITS FORM

Please call the "Member Services" or "Customer Service" number on the front or back of your insurance card, and ask for the following information regarding your outpatient mental health benefits. This form must be completed in its entirety, signed, and turned in with your paperwork when you check-in for your first appointment or you may be responsible for all charges incurred.

Patient's name: _____

Insurance company: _____

Telephone number you called: _____

Name of customer service representative: _____

1. Does the mental health portion of my coverage have **my therapist** (give therapist's name) listed as a participating provider? Yes ☐ No: ☐
   If "No", will a portion of the services be covered by "out-of-network" benefits? Yes ☐ No: ☐
   What percentage will be covered? _____

2. When does my "**benefit year**" begin? _____

3. Do outpatient mental health charges apply to a yearly **deductible** amount? Yes ☐ No: ☐
   If "yes", what is the yearly deductible amount? _____
   How much of that deductible has already been met this year? _____

4. For outpatient mental health services, what is the **copayment** amount? _____
   Or the **coinsurance percentage**? _____

5. Is **pre-authorization** required for outpatient mental health services? Yes ☐ No: ☐
   If "yes", provide them the date of your first appointment and ask them to give you:
   Authorization Number: _____
   Number of Sessions: _____
   Dates of authorization Starting: _____ Through: _____

6. What is the **mailing address** for MENTAL HEALTH claims?
   (Do not assume the address on your insurance card applies to mental health.)

   _____
   _____
   _____

We appreciate your help in providing insurance information to our billing department to ensure correct and prompt payments. We also hope this will help our patients better understand their mental health benefits.

I understand that I may be responsible for full payment of all charges if this form is not completed as required.

_____ _____

Date Signature of Person Responsible for Payment

THE•WESTWOOD•GROUP

Northside/West End Office

5821 Staples Mill Road
Richmond, VA 23228-5427
(804) 264-0966
Fax: 264-1029
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Southside Office

1241 Mall Drive
Richmond, VA 23235
(804) 794-5928
Fax: 379-6385

Teresa A. Buczek, Ph.D.
John E. Ehrmantraut, Ed.D.

Primary Care Physician Notification

Patient Name: _____ Date of Birth: ___/___/___

To: _____ M.D. _____
(Primary Care Physician) (Today's Date)

Address: _____

_____

Phone # _____ Fax #_____

Dear Dr. _____

In an effort to coordinate treatment, I am informing you that the above individual has requested services through our practice. I look forward to the opportunity to coordinate treatment with you.

Please feel free to contact me at 264-0966 extension ____ if you have any further questions or if I can be of further assistance. I look forward to working with you on this case.

Sincerely, _____

Permission to Exchange Information with your Primary Care Physician

Many insurance companies are now requesting that primary care physicians are contacted in order to coordinate care. It is your choice as to whether we communicate with your or your child's physician. Please indicate whether you authorize or decline this communication.

_____ **I do give permission for my therapist to share information regarding my therapy with my primary care physician. I understand that this release shall be valid for ninety (90) days after my last date of treatment. I understand that I may revoke this authorization at any time during the course of my treatment.**

_____ **I do not authorize my therapist to exchange information about my current treatment with my primary care physician.**

_____ _____
Name of Patient **Date**

_____
Signature of Patient or Guardian