Hoxworth Counseling Services
Bret Hoxworth MA, LLP
126 E. Main Street, Suite B, Middleville, MI 49333 ◆ 269-205-2402 ◆ Fax:269-205-2728
Email: info@hoxworthcounseling.com ◆ Website: hoxworthcounseling.com

Thank you for contacting Hoxworth Counseling Services for scheduling an appointment. We look forward to serving you. We are confident your time with us will prove encouraging and helpful.

Please fill out the enclosed forms and bring them along with you to your first appointment. This will save valuable time and give us more time to discuss your needs.

Our office is conveniently located at 126 E. Main Street, Suite B, Middleville, MI 49333.

Payment is due before your scheduled appointment; you can prepay online through our website or bring your payment with you the day of your appointment.

We look forward to meeting you soon.

Sincerely,

Bret Hoxworth

Bret Hoxworth MA, LLP
Psychologist/Counselor

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Counseling Minors

I/we, _____ (name of parent/guardian), give my/our permission to Bret Hoxworth, therapist with Hoxworth Counseling Services, to see my/our son or daughter _____ (name of minor child) for treatment or counseling with or without my being present during sessions.

I/we understand that I/we have the right to control the disclosure of private counseling information about my/our child. However, in the interest of resolving the issues I/we have brought to the therapist, I/we give the therapist permission to reveal or withhold information to/from us or others that in the therapist's judgment is necessary to best help and protect my/our children. The only exceptions to this discretion would be in the case of lethality and:

1) _____

2) _____

(Client should write "not applicable" in the previous space if appropriate.)

_____ Date: _____
Signature of Minor Child

_____ Date: _____
Signature of Parent/Guardian

_____ Date: _____
Signature of Therapist

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CONSENT FOR SERVICES AND FEE AGREEMENT

To acquaint you further with the procedures and policies of our practice, we are providing you with the following information. Please sign below, indicating your acceptance of the following terms:

Practice: I, Bret Hoxworth MA, LLP, am a Master's Level Psychologist. I work with individuals, families, couples, children, and organizations. It is my goal to assist you in understanding the particular problems that bring you here and help you find a way to resolve them.

Office Hours: Our normal business hours are Monday and Friday, 9:00am–5:00pm, and Saturday 9:00am–1:00pm. You may leave me a message via voicemail or send email. We will make every effort to return your call as soon as possible.

Appointment/Missed Appointments: Services are by appointment only. Scheduling appointments is done by calling our office at (269)205-2402 or through our website. If you need to cancel an appointment, please **call** the office as soon as possible. **Appointments cancelled with less than 24 hour notice may be billed to you.** Please note that insurance companies **do not** cover missed appointments.

Confidentiality: Your trust in us is extremely important. Your client records are our personal property and shall be treated as confidential. Please note that all client charts are kept for seven years following your closing date from counseling. After this time, records are destroyed. All information shared in sessions is confidential except in circumstances governed by the laws including the mandatory reporting of alleged harm to self or others. If we believe a consultation with another professional is important for your care, your confidentiality is protected under the "Privacy Practices" mandated by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Emergencies: In case of a **true** emergency/crisis situation, please call 911 and/or go to the emergency room of a local hospital, or call our office at 269-205-2402.

Financial Responsibility: Presently the fees may vary for our counseling services; we will discuss the fee structure with you before your counseling session.

Charges for extended phone calls and other services will be based upon the applicable fee structure for the time it takes to complete them. If we are contracted with your insurance company, then contracted insurance rates apply. You are fully responsible for payment of all services rendered to you. We will bill your insurance company if we can verify your benefits. Full payment is expected at the time of service, unless we are a contracted provider for your insurance company. In the event that your insurance company denies coverage, you will be responsible for the full charge. We accept cash, check, PayPal (online through our website), and credit cards. **Please make all checks payable to Hoxworth Counseling Services.** Upon review, a service charge of $5.00 per month may be added to all unpaid balances over 30 days.

We will be happy to answer any questions you may have concerning our policies. We are looking forward to serving you.

_____ _____
Client Signature Date

_____
Signature of Person responsible for payment (If other than client) *and* phone number

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Authorization for Scheduling, Billing and Payment Purposes

This form, when completed and signed by you, authorizes the person(s) whom you have indicated below to contact us on your behalf for scheduling, billing and payment purposes only.

I authorize _____

Please indicate your relationship with this person:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

----------Please fill below for more than one person – otherwise leave blank----------

I authorize _____

Please indicate your relationship with this person:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

- This authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to Hoxworth Counseling Services.

_____ _____
Client Signature Date

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Consent for Self-Pay Fee Sessions

Client's Name: _____

Initial Date of Service: _____ and all future appointments

Self-Pay Session Fee Rate: $_____per hour

I consent to pay the self-pay session fee rate for services rendered. I understand that these self-pay sessions will not be billed to nor are the responsibility of my medical insurance company.

_____ Date: _____
Client/Parent/Guardian Signature

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Application for Sliding Scale Fees

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Place of Employment: _____

Number of family members living in household: _____

☐ Un-employed How long? _____

Reason for sliding scale fee?

_____

_____

_____

_____

Do you have other resources of support to help cover your counseling expenses (i.e., family members or church)?

☐ No ☐ Yes If yes, please explain: _____

Monthly Family Income (required)

☐ Client ☐ Spouse ☐ Other (responsible party): _____

Monthly Salary (gross): $_____

Public Assistance Benefits: ☐ Yes (please list all that apply) or ☐ Doesn't apply to me

Name: _____ Amount $_____

Name: _____ Amount $_____

Name: _____ Amount $_____

Un-employment Benefits	☐ Yes $_____	or	☐ Doesn't apply to me
Social Security Benefits	☐ Yes $_____	or	☐ Doesn't apply to me
Workman's Compensation	☐ Yes $_____	or	☐ Doesn't apply to me
Child Support	☐ Yes $_____	or	☐ Doesn't apply to me
Other (Alimony, etc.)	☐ Yes $_____	or	☐ Doesn't apply to me

Total Family Income: $_____

****Verification of income by a tax return or current pay stub is required for approval****

Client must sign this form stating the above information is true and accurate to the best of their knowledge. If their financial situation changes, they will notify Hoxworth Counseling Services immediately so a review and/or a revision of this application can be conducted.

(Temporary) Co-pay Fee Agreed Upon Per Session: $_____ for only _____ sessions.
The co-pay will return to our normal rates after the ten sessions have been used.
The normal co-pay rate is $_____.

_____ Date: _____

Client's Signature

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Cancellation Policy

What if I need to Cancel or Postpone my Appointment?

Please call our office at 269-205-2402 to cancel an appointment

If for some reason you need to cancel or postpone the appointment, please be considerate of your therapist and other clients and give at least 48 hours notice.

Given the demand for appointment times, if less than 24 hours notice is given to cancel or reschedule your appointment, or if you fail to show up for your scheduled appointment, you will be charged $50.00 for the missed session.

Insurance does not pay for missed appointments. These charges are your responsibility.

Payment will be due in full before the beginning of your next session. Future appointments will not be made until the Cancellation Fee has been paid in full.

_____ _____
Client Signature Date

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PF 1000 NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (AS A CLIENT IN THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Commitment to Your Privacy

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

II. Uses and Disclosures

Treatment. Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health care provider, such as your family physician or another professional counselor.

Payment. Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the clinical condition being treated.

Health care operations. Your PHI may be used as necessary to support the day-to-day activities and management of Hoxworth Counseling Services. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your PHI may be disclosed to federal, state or local law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointments. Your PHI will be used by Hoxworth Counseling Services to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. The contact may be made by phone, U.S. mail, email, or texting.

Informative Information. Your PHI may be used to send you information on the treatment and management of your psychological/medical condition that you may find to be of interest. We may also send you information describing psychological/health-related goods and service that we believe may interest you.
**If there is ever a breach of your healthcare information and it comes to our attention, we will inform you as soon as possible.

III. Personal Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to a restriction you request.
- The right to receive confidential communications concerning your psychological/medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.
- The right to inspect and/or copy your PHI that may be used to make decisions about you, including client psychological/medical records and billing records, but not including psychotherapy notes. The client's provider can provide a summary of the client's PHI if in the professional judgment of the client's provider, providing the client with unlimited access to his/her PHI would cause emotional/mental distress or endanger the life or physical safety of the client or another person. A client does not have the right to access Psychotherapy Notes relating to him/her except (i) to the extent the client's treating professional approves such access in writing; or (ii) the client obtains a court order authorizing such access. A provider has 30 days to reply.

IV. Requests to Inspect PHI

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us at 269-205-2402. We may deny your access to PHI under certain circumstances, but in many cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

V. Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. We will post a copy of our current Notice in a visible location in our office at all times, and you may request a copy of our most current at any time.

VI. Complaints

If you are concerned that your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your concerns to:

Bret Hoxworth MA, LLP
Hoxworth Counseling Services
126 E. Main Street, Suite B
Middleville, MI 49333

Or contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

VII. Contact Person

For further information concerning our privacy practices, you can contact:

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Hoxworth Counseling Services
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PF 2000 CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Uses and Disclosure of Your Protected Health Information
Your protected health information will be used by Hoxworth Counseling Services or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the "Notice of Privacy Practices" document for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of your Information
You may request a restriction on the use or disclosure of your protected health information. Hoxworth Counseling Services may or may not agree to restrict the use or disclosure of your protected health information. If Hoxworth Counseling Services agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Hoxworth Counseling Services reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and received a copy of the Hoxworth Counseling Services "Notice of Privacy Practices" and give my permission to Hoxworth Counseling Services to use and disclose my health information in accordance with it.

_____
Date

_____ _____
Name of Client (Print or Type) Signature of Client Representative

_____ _____
Client Signature Relationship of Client Representative

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CHILD/ADOLESCENT INTAKE FORM

(Age 17 or under)

Dear Parent/Guardian: To help your clinician understand and help your child/adolescent, please answer the questions on this form and bring it with you to his/her first appointment.

Child/Adolescent's Legal Name: _____ ☐ Male ☐ Female DOB: _____

Forms completed by: _____ Relationship to child/adolescent: _____

Is this child/adolescent adopted? ☐ Yes ☐ No

Describe his/her best characteristics: _____

_____

RACE/ETHNICITY (optional)

Please check the box that best represents your child/adolescent's race/ethnic background:

☐ African-American/Black ☐ Arab American ☐ Asian or Pacific Islander ☐ Hispanic ☐ Multi-racial ☐ Native American
☐ White/Caucasian ☐ Other: _____ or check all that apply

PRESENTING PROBLEM/REASON FOR TREATMENT

What is the primary reason for having your child/adolescent seen for counseling? _____

_____

_____

DSM-5 Parent/Guardian – Rated Level 1 Cross-Cutting Symptom Measure – Child/Adolescent

	During the past **TWO (2) WEEKS**, how much (or how often) has your child/adolescent… *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
	5. Had less fun doing things than he/she used to?	0	1	2	3	4	
IV.	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Seemed angry or lost his/her temper?	0	1	2	3	4	
V.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VI.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
VII.	12. Not been able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	

	During the past **TWO (2) WEEKS**, how much (or how often) has your child/adolescent… *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
VIII.	14. Said that he/she heard voices – when there was no one there – speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
IX.	15. Said that he/she had a vision when he/she was completely awake – that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned on?	0	1	2	3	4	
XI.	18. Seemed to worry a lot about things he/she touched being dirty or having germs or be poisoned?	0	1	2	3	4	
XII.	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS**, has your child/adolescent…						
XIII.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	0	1	2	3	4	
	21. Smoked a cigarette, a cigar, or pipe, used snuff or chewing tobacco?	0	1	2	3	4	
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	0	1	2	3	4	
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Vallum], or steroids)?	0	1	2	3	4	
	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	0	1	2	3	4	
	25. Has he/she EVER attempted to kill himself/herself?	0	1	2	3	4	

Are there other concerns (not listed above) that you want to discuss? _____

_____

_____

How have these concerns impacted your child/adolescent's daily life? _____

_____

_____

YOUR CHILD/ADOLESCENT'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? ☐ No ☐ Yes

If yes, how long? _____

What are the current custody/visitation arrangements? _____

_____

Please tell us about the household/family which your child/adolescent spends the majority of his/her time (or who currently lives with your child/adolescent). List primary household information first, and then list other living situations/supportive relationships:

Name	Age	Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle)	Quality of Relationship?	Living with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

YOUR CHILD/ADOLESCENT'S LIFE STORY

Where does your child/adolescent attend school? ____________________

What is the highest grade level of school he/she has completed? ____________________

What have been his/her usual report card grades? ____________________

Has he/she experienced any of the following in school?
☐ Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Emotional Problems

Has there been any academic (IEP) or psychological testing done at school or elsewhere? ☐ No ☐ Yes

If yes, when? ____________________

Results: ____________________

Has your child/adolescent ever received previous counseling, therapy, or psychiatric treatment? ☐ No ☐ Yes

If yes, with whom? ____________________

Has your child/adolescent ever been the victim of abuse or neglect? ☐ No ☐ Yes

If yes, was the abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

Please list any contacts your child/adolescent has had with the courts (including Friend of the Court):

____

Please list any contacts your child/adolescent has had with the police or Child Protective Services:

____

Has your child/adolescent ever had a problem with alcohol or other drugs? ☐ No ☐ Yes

If yes, please explain: ____________________

____

What is your family's current religious affiliation? ____________________

Describe family involvement: ____________________

MEDICAL HISTORY

Does your child/adolescent have any current medical concerns? _____

_____

Has he/she had any past surgical procedures? ☐ No ☐ Yes

If yes, list: _____

Has he/she been exposed to any contagious diseases, such as Tuberculosis? ☐ No ☐ Yes

If yes, to what and when did the exposure take place? _____

Are immunizations current? ☐ No ☐ Yes

Please list all current medications and/or supplements your child/adolescent is currently taking:
(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

List any emergency room visits (age, reason): _____

FAMILY MEDICAL HISTORY

Were there any complications with the pregnancy of this child/adolescent that might have impacted his/her prenatal health or development (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)?

☐ No ☐ Yes

Were there significant problems with his/her health or development in the first few years of his/her life (e.g.: needed to be revived at birth, failure to thrive, or missed significant developmental milestones)? ☐ No ☐ Yes

If yes, please explain: _____

_____

Biological Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? ☐ No ☐ Yes (If yes, when? _____)

Description of relationship between father and child/adolescent: _____

Biological Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? ☐ No ☐ Yes (If yes, when? _____)

Description of relationship between mother and child/adolescent: _____

Has anyone in your child/adolescent's extended family (e.g., parent, grandparent, uncle/aunt) had a psychiatric illness?

☐ No ☐ Yes If yes, please describe to the best of your ability (who, symptoms/diagnosis, were they hospitalized?)

_____

_____

Has anyone in your child/adolescent's family attempted suicide? ☐ No ☐ Yes If yes, who? _____

Has anyone in your child/adolescent's family had a problem with, or been treated for, substance abuse problems?

☐ No ☐ Yes If yes, who? _____

Feel free to list any additional information you feel may be helpful to the clinician who will be working with your child/adolescent: _____

_____

_____

_____

Completed by: _____ Date: _____

(Please sign your name)

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Notification & Coordination with Primary Care Physician / Psychiatrist

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information	
Client Name:	**Client DOB:**
Parent/Guardian (if applicable):	
Physician Name/Clinic: _____	
Phone #: _____	Fax #: _____
Current Psychiatric Services ☐ **Yes or** ☐ **No**	
Treating Psychiatrist/Clinic: _____	
List All Current Medications: *If more room needed, please attach separate sheet	
Medication Name: _____ Dosage: _____	Reason: _____
Medication Name: _____ Dosage: _____	Reason: _____
Medication Name: _____ Dosage: _____	Reason: _____

It is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, Hoxworth Counseling Services its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.
Extent of information to be disclosed: ☐ **Verbal Exchange or Written Summary or** ☐ **Other:** _____

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

----------OR----------

☐ My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

For Office Use Only:

Therapist Name: _____

Current Diagnosis: _____

_____

Hoxworth Counseling Services Staff – Faxed by: _____ *Date:* _____

Hoxworth Counseling Services
Bret Hoxworth MA, LLP

126 E. Main Street, Suite B, Middleville, MI 49333 ◆ 269-205-2402 ◆ Fax:269-205-2728
Email: info@hoxworthcounseling.com ◆ Website: hoxworthcounseling.com

Notification & Coordination with Education Professionals

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information	
Client Name:	**Client DOB:**
Parent/Guardian:	
School Name: _____	
Address: _____	
Phone #: _____	**Fax #:** _____
School Representative(s): _____	

It is helpful for your therapist to coordinate with your school. Please indicate below whether you chose to give consent for the release of any or all information in this coordination with your school system.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed.
If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the school representative(s) identified above. I hereby authorize, Hoxworth Counseling Services its director or designee, to release and/or exchange protected health information to the individual(s) or organization listed above.
Extent of information to be disclosed: ☐ **Verbal Exchange or Written Summary or** ☐ **Other:** _____

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

----------OR----------

☐ My therapist has explained to me the importance of coordinating educational and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with the school representative(s).

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

For Office Use Only:

Therapist Name: _____
Current Diagnosis: _____
_____
Other Clinical Information: _____
_____
Hoxworth Counseling Services Staff – Faxed by: _____ *Date:* _____