NEW CLIENT INTAKE FORM

GENERAL INFORMATION

Full Name: _____

Name you prefer: _____

Age: _____ Date of Birth: _____

Race: □ White □ Black □ Latino □ Asian □ Other: _____

Gender Identity: □ Male □ Female □ Other: _____

Sexual Orientation: □ Bisexual □ Gay □ Hetero □ Lesbian □ Other: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Mailing Address or Post Office Box (if different from above): _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Email Address: _____ May I send a message here? □ Yes □ No

Home Phone: (____)_____ May I leave a message here? □ Yes □ No

Cell Phone: (____)_____ May I leave a message here? □ Yes □ No Work

Phone: (____)_____ May I leave a message here? □ Yes □ No

Emergancy Contact: Name_____Phone (____)_____

EDUCATION/EMPLOYMENT INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ AA □ BA/BS □ Post-Grad or Professional

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____ Combined household annual income range:

□ Below $25,000 □$25,001-$45,000 □Above $45,000

RELATIONAL INFORMATION

Current Romantic Relationship Status:

□ Single □ Partner (boy/girlfriend) □ Married □ Separated/Divorced □ Widowed □Engaged □ Polyamorous □ Other

Are You Content with Your Current Status? □ Yes □ No. If No, Briefly Explain: _____

_____

If Partnered/Married, How Long: _____ If Separated or Divorced, How Long: _____

With Whom Do You Currently Live? *(Check all that apply)*

□ Alone □ Spouse/Partner □ Children (#___) □ Parent(s) □ Sibling(s) □ Boyfriend/girlfriend

□ Other: _____

PARTNER INFORMATION

Full Name: _____

How Long Have You Known Your Partner? _____ Age: _____

Race: □ White □ Black □ Latino/Hispanic □ Asian □ Other: _____

Gender Identity: □ Male □ Female □ Other: _____

Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ AA □ BA/BS □ Post-Grad or Professional

How Would You Describe this Person? _____

_____

CHILDREN

List Your Children (Living or Deceased) as well as Children You Have Placed for Adoption:

Name: Current Age: Relationship (biological/step/adopted): Living with you?

_____

_____

_____

Have You or Your Partner Ever Had a Miscarriage or Medical Abortion? □ Yes □ No. If yes, When: _____

FAMILY OF ORIGIN (FOO) - (Who you grew up with)

Please list family members and describe your relationship with them.

Name: Gender: Age: Relationship to you: Description:

_____

_____

_____

_____

_____

_____

_____

PRESENTING ISSUES

Please tell me why you are seeking counseling: _____

_____

_____

_____

How long have these concerns been causing you distress? _____

Please check the boxes below if you've had problems or concerns with any of the following:

Aggressiveness	□ Past □ Present	Loneliness	□ Past □ Present
Alcohol Abuse	□ Past □ Present	Loss of Control	□ Past □ Present
Anger	□ Past □ Present	Making Decisions	□ Past □ Present
Anxiety	□ Past □ Present	Memory	□ Past □ Present
Apathy	□ Past □ Present	Nervousness	□ Past □ Present
Bad Dreams	□ Past □ Present	Pain	□ Past □ Present
Change in Appetite	□ Past □ Present	Panic	□ Past □ Present
Compulsivity	□ Past □ Present	Physical Abuse	□ Past □ Present
Depression	□ Past □ Present	Racing Thoughts	□ Past □ Present
Difficulty Breathing	□ Past □ Present	Rapid Heart Rate	□ Past □ Present
Digestive Upset	□ Past □ Present	Seeing Things	□ Past □ Present
Dizziness	□ Past □ Present	Serious Illness	□ Past □ Present
Drug Abuse	□ Past □ Present	Sexual Abuse	□ Past □ Present
Eating Problems	□ Past □ Present	Sexual Problems	□ Past □ Present
Emotional Abuse	□ Past □ Present	Sleep Trouble	□ Past □ Present
Fatigue	□ Past □ Present	Social Anxiety	□ Past □ Present
Fears	□ Past □ Present	Stress	□ Past □ Present
Finances	□ Past □ Present	Trauma	□ Past □ Present
Grief/Loss	□ Past □ Present	Trouble Focusing	□ Past □ Present
Guilt	□ Past □ Present	Trouble Relaxing	□ Past □ Present
Headaches	□ Past □ Present	Unhappiness	□ Past □ Present
Hearing Noises/Voices	□ Past □ Present	Unwanted Thoughts	□ Past □ Present
Hopelessness	□ Past □ Present	Verbal Abuse	□ Past □ Present
Impulsive Behavior	□ Past □ Present	Weakness	□ Past □ Present
Legal Matters	□ Past □ Present	Work Problems	□ Past □ Present

Are You Currently Experiencing Any Suicidal Thoughts? □ Yes □ No

Have You Experienced Them in the Past? □ Yes □ No ---- Have You Ever Attempted Suicide? □ Yes □ No

If Yes, When and How: _____

Have you had any previous psychiatric hospitalizations? □ Yes □ No

If Yes, When and where: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide? □ Yes □ No

If Yes, When and Who: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____)_____

Address: _____ City: _____ Zip: _____

Would you like to sign a release of information (ROI) for use between me and your doctor? □ Yes □ No □ Unsure

If Yes would you like any specific information restricted? □ Yes □ No □ N/A

Please indicate on the following scale how comfortable you are with revealing personal information to this doctor:

Not at all 1 - - - - - - 2- - - - - - - 3 - - - - - - - 4 - - - - - - -5 - - - - - - 6 - - - - - -7 - - - - - 8 - - - - - - - 9 - - - - - - -10 Completely

Are You Currently Receiving Medical Treatment For A Specific Concern? □ Yes □ No □ Unsure

If Yes or Unsure, Please Specify: _____

List any Previous Conditions, Illnesses, Surgeries, Hospitalizations, or Injuries you've had:

_____

Current Medications: Dosage: Taking for:

_____

_____

_____

_____

SOCIAL SUPPORTS

Do You Have a Personal Support System? □ Yes □ No □ Unsure

If Yes, Who: _____

Do You Regularly Attend a Place of Worship? □ Yes □ No □ Unsure

If Yes, Where: _____

How important are spiritual matters to you? □ Not at all □ Somewhat □ Very much

Would you like your spiritual/religious beliefs to be included in your counseling? □ Yes □ No □ Unsure

How or from whom did you hear about my services? Specificity is preferred:_____

If referred by a friend or acquaintance, may I tell them thank you?_____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

John Hammack, MA, LMHC
Hammack Counseling, PLLC
425-870-5142

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or "PHI"). I must follow the privacy practices described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal and State law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in supervision and consultation so that I may provide high quality services for your benefit.

2. Health care operations: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing or credentialing activities. I will notify you in advance of any such disclosure.

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:
a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.
b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.
c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).
d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.
e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.
f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying

information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization:
1. Psychotherapy notes: Notes recorded by me documenting the contents of a counseling session with you ("Psychotherapy notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.
2. Marketing communications: I will not use your health information for marketing communications without your written authorization.
3. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.
4. Other Uses and Disclosures: Uses and disclosures other than those described in Section I-A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, to your attorney, or to your health care providers. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.

B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer," as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement," based upon your proposed amendment, must be added to your record.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, John Hammack, MA LMHC, by telephone at (425) 870-5142, or in writing at 7304 10th St SE #B201 Lake Stevens, WA 98258. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360) 236-4900, P.O. Box 47869, Olympia, WA 98504.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on August 24, 2015.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will inform you, and you may obtain any revised notice by contacting me.

Acknowledgement of Receipt of Notice of Privacy Practices

John Hammack, MA, LMHC

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for John Hammack, MA, LMHC.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of John Hammack, MA, LMHC with respect to my protected health information.

_____ _____

Signature of Client Date

This form will be retained in the mental health record.

* * * FOR OFFICE USE ONLY * * *

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the Acknowledgment
☐ An emergency situation prevented me from obtaining Acknowledgment
☐ Other: _____

_____

THERAPIST DISCLOSURE STATEMENT & CLIENT INFORMED CONSENT

John Hammack, MA, LMHC
Hammack Counseling, PLLC
425-870-5142

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully.

I. THERAPIST DISCLOSURE TO CLIENT

■ **Credentials**: I am a Licensed Mental Health Counselor in Washington State (#LH60536005).
■ **Education, Training, and Experience:** I received a Bachelor of Arts in Psychology from the University of Utah. I completed my Master of Arts in Psychology from Washington School of Professional Psychology, Argosy University, Seattle, WA. I completed my internship hours at Catholic Community Services in Everett, WA. I have also worked for a wilderness program with troubled teens and done work with Autistic children.
■ **Services Provided:** I provide psychotherapy for individuals (adolescents aged 13 and older, and adults), couples, and families.

II. WORKING RELATIONSHIP

■ Confidentiality: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. I may be required to disclose information under the following circumstances:

1. where there is reason to suspect the occurrence of abuse or neglect of a child, dependent adult, or a developmentally disabled person;
2. where there is a clear threat to do serious bodily harm to yourself or others;
3. in response to a subpoena issued by the Secretary of Health that is associated with a regulatory complaint,
4. or if you are involved in some legal action, it is possible that a court order might require that I provide the court with evidence relating to your sessions. If this should occur, I would prefer to work with you to prevent or limit such action. Before releasing any information I will do my best to let you know and attempt to discuss the material with you.

■ Risks and Benefits: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Counseling is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is very likely you will see improvements throughout our work and in the future.

■ Appointments: Please notify me via phone, at (425) 870-5142, at least 24 hours in advance if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Likewise, I will notify

you via phone if I should need to cancel our appointment. Please do not send cancelation notices through email or text messages as I cannot guarantee I will receive them.

When you arrive for an appointment, please make yourself comfortable in the waiting room. Our sessions will be about 50 minutes long (standard for therapy appointments), and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

Please note that you are responsible for the full session fee if you miss an appointment without 24 hours notice of any cancellations. You will not be charged if I cancel our appointment. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment. Also, please note that most insurance companies will not reimburse in any case for a late cancelled or missed session.

■ Fee for Services: My standard fee is $150 per 50-55 minute individual session and $180 for a couples session. If the session is scheduled to be longer in length the fee will be adjusted accordingly. This is the same fee charged for any missed or late canceled appointments. In very rare circumstances, I may agree to arrange a reduced fee for you based on my availability of reduced fee slots and your income and family size. Additional fees might include: preparation of requested documents, or copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services.

I do not practice as an expert witness in court proceedings. If I am subpoenaed for court testimony my fee is $350 an hour with a minimum of four hours, payment is due before court appearance. I will not respond to communication from legal counsel without written consent from you.

■ Payment for Services: I accept cash or personal check payments made payable to **John Hammack or Hammack Counseling** and credit or debit card payments. Payments are due directly to me at the time of service (at the beginning of each session) unless we make arrangements otherwise. If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I will charge a $30 fee for any returned checks.

■ Insurance: I am a preferred provider with some insurance companies, it is your responsibility to check with your carrier for your specific plan details and ask them if I am in their network and what your copay is. If you do decide to use insurance, you are still responsible for your copay at the beginning of each session and ultimately could be responsible for the full fee if your insurance does not cover mental health counseling with me. There are benefits and drawbacks to using insurance and we can discuss these at our first session.

■ Using PIP Insurance: PIP or personal injury protection is an insurance available to you through your auto insurance. If you have pip insurance and wish to use it for counseling due to mental or emotional trauma sustained from an automobile accident and I agree to bill your pip insurance, you are still ultimately responsible for payment if your pip is unable to pay for your counseling. I may also agree to put a lien on any payment received from a third party due to the accident but again, if no payment or settlement is reached you will ultimately be responsible for payment.

■ Record-keeping: I will keep a confidential file containing your private health information (PHI) in my office. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part

define as recording “what happens in a session.” I make an effort to summarize what we discuss in each session (capture the essence), but I make no effort to record sessions verbatim. Washington State law requires the retention of records for five years after last contact. In some cases I may also keep your records on a secure database to aid in the reduction of paper waste.

■ Emergency, Urgent, or Other Contacts: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within one business day. If you need to cancel or reschedule an appointment, please do so via phone at least 24 hours in advance. Emails and text messages will not be accepted for this purpose.

Please note that anything you send over email is not confidential. Once we have begun our counseling relationship please bring up important information during our sessions. I will not be able to respond to emails as I have no way to insure my response is confidential.

If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or the Snohomish County Care Crisis Line at (425) 258-4357. The Crisis Line has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information. I am not able to provide on-call crisis or emergency services.

If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.

■ Therapy Relationship and Professional Boundaries: It is my intention to maintain a relatively comfortable, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship; this includes contact on social networking sites, like Facebook. I do have a Facebook business page on which I sometimes post but I will not respond to comments or “likes” you may offer on the page. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care, but part of the basic structure for a therapeutic relationship.
2) Because my business does have an internet presence, it is possible for you to place unsolicited reviews on sites of me and my business if you wish. It is important to your treatment that you communicate your intent to do so prior to actually doing it. This is to keep communication flowing between us. In other words, if you have feedback for me (positive, negative, or ambivalent) it is best for us to discuss them in person as they are likely very important for your treatment.
3) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting, or an occasional hug if you initiate it.
4) I will not, at any time, accept any gifts from you. I may accept a card or note from you, but this is not a required or expected gesture on your or my part.
5) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate a visible or audible greeting, I will reciprocate, but I will not attempt further communication unless you request it.

6) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any business and financial relationships. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement, specifically as these are not where my extensive training lies.

7) I will only provide appropriate referrals to other health professionals with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.
8) I will uphold confidentiality standards pertaining to Federal and State of law during the course of therapy and thereafter. By law, our sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

■ Therapeutic Work, Duration, and Termination: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions as I believe doing so is part of the healing process in therapy.
Though if you would like to end therapy, I do ask that we first discuss this in person. This is due to the fact that often the reason for wanting to end therapy is because an old wound has been opened and past responses to that wound have informed you that it is best to leave (when your best interests might actually be to stay). Part of the therapeutic relationship between you and me is looking at these wounds safely and attempting to find ways to heal them. The very notion that you might want to leave abruptly might be an indication that we are making great progress!

If more than 30 days have passed since our last contact, we have no scheduled sessions on the calendar, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

■ Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, you may contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

John Hammack, MA, LMHC

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for John Hammack, MA, LMHC and I understand it.

_____ I agree to follow the terms in the Disclosure Statement.

_____ I give my consent for treatment as outlined in this Disclosure Statement.

_____ I received a copy of this Disclosure Statement.

_____ I understand that my therapeutic relationship with John Hammack, MA, LMHC may be discontinued if the terms in this agreement are not fulfilled by either of us.

_____
Client Name (please print)

_____ _____
Client Signature Date

This form will be retained in the mental health record.