# Linda Calvo Kimbell, LCSW – Life Transitions Counseling, LLC

**117 Harmony Crossing, Suite 1; Eatonton, GA 31024**
**706-485-4004, FAX 706-262-2986 Mylifestylemed.com**


## CLIENT INFORMATION FORM

**This Form is Confidential**

**Today's date:** _____

**Your name:** _____
**Last** **First** **Middle Initial**

**Date of birth:** _____ **Social Security #:** _____

**Home street address:** _____

**City:** _____ **State:** _____**Zip:**_____

**Name of Employer:**_____

**Address of Employer:** _____

**City:** _____ **State:** _____**Zip:**_____

**Home Phone:** _____ **Work Phone:** _____
**Cell Phone:** _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

**Referred by:** _____
- May I have your permission to thank this person for the referral?
  ☐ Yes ☐ No
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ Yes ☐ No

**Person(s) to notify in case of any emergency:** _____
**Name** **Phone**
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

**Please briefly describe your presenting concern(s):** _____
_____
_____
_____
_____
_____

**What are your goals for therapy?** _____
_____
_____
_____
_____

**How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?** _____

**The following information on this form will help guide your treatment.*
*Please try to fill out as much as you are comfortable disclosing.**

## MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

**Current Medications:**

| Name of Medication | Dosage | Purpose | Name of Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

## FAMILY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

_____

## RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

## EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

| DIFFICULTY WITH: | NOW | PAST | DIFFICULTY WITH: | NOW | PAST | DIFFICULTY WITH: | NOW | PAST |
|---|---|---|---|---|---|---|---|---|
| Anxiety → | | | People in General → | | | Nausea → | | |
| Depression | | | Parents | | | Abdominal Distress | | |
| Mood Changes | | | Children | | | Fainting | | |
| Anger or Temper | | | Marriage/Partnership | | | Dizziness | | |
| Panic | | | Friend(s) | | | Diarrhea | | |
| Fears | | | Co-Worker(s) | | | Shortness of Breath | | |
| Irritability | | | Employer | | | Chest Pain | | |
| Concentration | | | Finances | | | Lump in the Throat | | |
| Headaches | | | Legal Problems | | | Sweating | | |
| Loss of Memory | | | Sexual Concerns | | | Heart Palpitations | | |
| Excessive Worry | | | History of Child Abuse | | | Muscle Tension | | |
| Feeling Manic | | | History of Sexual Abuse | | | Pain in joints | | |
| Trusting Others | | | Domestic Violence | | | Allergies | | |
| Communicating with Others | | | Thoughts of Hurting Someone Else | | | Often Make Careless Mistakes | | |
| Drugs | | | Hurting Self | | | Fidget Frequently | | |
| Alcohol | | | Thoughts of Suicide | | | Speak Without Thinking | | |
| Caffeine | | | Sleeping Too Much | | | Waiting Your Turn | | |
| Frequent Vomiting | | | Sleeping Too Little | | | Completing Tasks | | |
| Eating Problems | | | Getting to Sleep | | | Paying Attention | | |
| Severe Weight Gain | | | Waking Too Early | | | Easily Distracted by Noises | | |
| Severe Weight Loss | | | Nightmares | | | Hyperactivity | | |
| Blackouts | | | Head Injury | | | Chills or Hot Flashes | | |

**FAMILY HISTORY OF (Check all that apply):**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Drug/Alcohol Problems | | | Physical Abuse | | | Depression | | |
| Legal Trouble | | | Sexual Abuse | | | Anxiety | | |
| Domestic Violence | | | Hyperactivity | | | Psychiatric Hospitalization | | |
| Suicide | | | Learning Disabilities | | | "Nervous Breakdown" | | |

**Any additional information you would like to include:**

_____

_____

*Linda Calvo Kimbell, LCSW*
*LIFE TRANSISTIONS COUNSELING, LLC*
*117 Harmony Crossing, #1; Eatonton, GA 31024*
*Phone*

# Health Insurance Portability and Accountability Act (HIPAA)

## NOTICE OF PRIVACY PRACTICES

**I. COMMITMENT TO YOUR PRIVACY:** *LIFE TRANSITIONS COUNSELING, LLC* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *LIFE TRANSITIONS COUNSELING, LLC* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

**II. LEGAL DUTY TO SAFEGUARD YOUR PHI:** By federal and state law, *LIFE TRANSITIONS COUNSELING, LLC* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *LIFE TRANSITIONS COUNSELING, LLC* would use and/or disclose your PHI. Use of PHI means when *LIFE TRANSITIONS COUNSELING, LLC* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *LIFE TRANSITIONS COUNSELING, LLC* releases, transfers, gives, or otherwise reveals it to a third party outside of the *LIFE TRANSITIONS COUNSELING, LLC* . With some exceptions, *LIFE TRANSITIONS COUNSELING, LLC* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *LIFE TRANSITIONS COUNSELING, LLC* is always legally required to follow the privacy practices described in this Notice.

**III. CHANGES TO THIS NOTICE:** The terms of this notice apply to all records containing your PHI that are created or retained by *LIFE TRANSITIONS COUNSELING, LLC* Please note that *LIFE TRANSITIONS COUNSELING, LLC* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *LIFE TRANSITIONS COUNSELING, LLC* has created or maintained in the past and for any of your records that *LIFE TRANSITIONS COUNSELING, LLC* may create or maintain in the future. *LIFE TRANSITIONS COUNSELING, LLC* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *LIFE TRANSITIONS COUNSELING, LLC 's* Notice of Privacy Practices.

**IV. HOW LIFE TRANSITIONS COUNSELING, LLC MAY USE AND DISCLOSE YOUR PHI:** *LIFE TRANSITIONS COUNSELING, LLC* will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

**1. For Treatment:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *LIFE TRANSITIONS COUNSELING, LLC* will always ask for your authorization in writing prior to any such consultation.

**2. For Health Care Operations:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

**3. To Obtain Payment for Treatment:** *LIFE TRANSITIONS COUNSELING, LLC* may use and disclose your PHI to bill and collect payment for the treatment and services *LIFE TRANSITIONS COUNSELING, LLC* provided to you. Example: *LIFE TRANSITIONS COUNSELING, LLC* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *LIFE TRANSITIONS COUNSELING, LLC* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *LIFE TRANSITIONS COUNSELING, LLC 's* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *LIFE TRANSITIONS COUNSELING, LLC* will

always do its best to reconcile this with you first prior to involving any outside agency.

**4. Employees and Business Associates:** There may be instances where services are provided to *LIFE TRANSITIONS COUNSELING, LLC* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *LIFE TRANSITIONS COUNSELING, LLC* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *LIFE TRANSITIONS COUNSELING, LLC* .

***Note:*** This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *LIFE TRANSITIONS COUNSELING, LLC* may disclose information about you to others.

**V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – LIFE TRANSITIONS COUNSELING, LLC may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. **Law Enforcement:** Subject to certain conditions, *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *LIFE TRANSITIONS COUNSELING, LLC* may make a disclosure to the appropriate officials when a law requires *LIFE TRANSITIONS COUNSELING, LLC* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose information about you to respond to a court or administrative order or a search warrant. *LIFE TRANSITIONS COUNSELING, LLC* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *LIFE TRANSITIONS COUNSELING, LLC* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *LIFE TRANSITIONS COUNSELING, LLC* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *LIFE TRANSITIONS COUNSELING, LLC* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *LIFE TRANSITIONS COUNSELING, LLC* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), *LIFE TRANSITIONS COUNSELING, LLC* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *LIFE TRANSITIONS COUNSELING, LLC* has a reasonable suspicion of child abuse or neglect, *LIFE TRANSITIONS COUNSELING, LLC* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *LIFE TRANSITIONS COUNSELING, LLC* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *LIFE TRANSITIONS COUNSELING, LLC* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *LIFE TRANSITIONS COUNSELING, LLC* may release your

PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *LIFE TRANSITIONS COUNSELING, LLC* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. **Military and Veterans:** If you are a member of the armed forces, *LIFE TRANSITIONS COUNSELING, LLC* may release PHI about you as required by military command authorities. *LIFE TRANSITIONS COUNSELING, LLC* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *LIFE TRANSITIONS COUNSELING, LLC* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *LIFE TRANSITIONS COUNSELING, LLC* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *LIFE TRANSITIONS COUNSELING, LLC* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *LIFE TRANSITIONS COUNSELING, LLC* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *LIFE TRANSITIONS COUNSELING, LLC* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *LIFE TRANSITIONS COUNSELING, LLC* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *LIFE TRANSITIONS COUNSELING, LLC* 's compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *LIFE TRANSITIONS COUNSELING, LLC* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

**VI. Other Uses and Disclosures Require Your Prior Written Authorization:** In any other situation not covered by this notice, *LIFE TRANSITIONS COUNSELING, LLC* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *LIFE TRANSITIONS COUNSELING, LLC* in writing of your decision. You understand that *LIFE TRANSITIONS COUNSELING, LLC* is unable to take back any disclosures it has already made with your permission, *LIFE TRANSITIONS COUNSELING, LLC* will continue to comply with laws that require certain disclosures, and *LIFE TRANSITIONS COUNSELING, LLC* is required to retain records of the care that its therapists have provided to you.

**VII. RIGHTS YOU HAVE REGARDING YOUR PHI:**

**1. The Right to See and Get Copies of Your PHI either in paper or electronic format:** In general, you have the right to see your PHI that is in *LIFE TRANSITIONS COUNSELING, LLC* 's possession, or to get copies of it; however, you must request it in writing. If *LIFE TRANSITIONS COUNSELING, LLC* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *LIFE TRANSITIONS COUNSELING, LLC* within 30 days of

receiving your written request. Under certain circumstances, *LIFE TRANSITIONS COUNSELING, LLC* may feel it must deny your request, but if it does, *LIFE TRANSITIONS COUNSELING, LLC* will give you, in writing, the reasons for the denial. *LIFE TRANSITIONS COUNSELING, LLC* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *LIFE TRANSITIONS COUNSELING, LLC* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**2. The Right to Request Limits on Uses and Disclosures of Your PHI:** You have the right to ask that *LIFE TRANSITIONS COUNSELING, LLC* limit how it uses and discloses your PHI. While *LIFE TRANSITIONS COUNSELING, LLC* will consider your request, it is not legally bound to agree. If *LIFE TRANSITIONS COUNSELING, LLC* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that *LIFE TRANSITIONS COUNSELING, LLC* is legally required or permitted to make.

**3. The Right to Choose How *LIFE TRANSITIONS COUNSELING, LLC* Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *LIFE TRANSITIONS COUNSELING, LLC* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

**4. The Right to Get a List of the Disclosures.** You are entitled to a list of disclosures of your PHI that *LIFE TRANSITIONS COUNSELING, LLC* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

*LIFE TRANSITIONS COUNSELING, LLC* will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *LIFE TRANSITIONS COUNSELING, LLC* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

**5. The Right to Choose Someone to Act for You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**6. The Right to Amend Your PHI:** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *LIFE TRANSITIONS COUNSELING, LLC* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *LIFE TRANSITIONS COUNSELING, LLC 's* receipt of your request. *LIFE TRANSITIONS COUNSELING, LLC* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *LIFE TRANSITIONS COUNSELING, LLC* . Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *LIFE TRANSITIONS COUNSELING, LLC 's* denial will be attached to any future disclosures of your PHI. If *LIFE TRANSITIONS COUNSELING, LLC* approves your request, it will make the change(s) to your PHI. Additionally, *LIFE TRANSITIONS COUNSELING, LLC* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

**6. The Right to Get This Notice by Email:** You have the right to get this notice by email. You have the right to request a paper copy of it as well.

**7. Submit all Written Requests:** Submit to *LIFE TRANSITIONS COUNSELING, LLC 's* Director and Privacy Officer, Linda Calvo Kimbell, at the address listed on top of page one of this document.

**VIII. COMPLAINTS:** If you are concerned your privacy rights may have been violated, or if you object to a decision *LIFE TRANSITIONS COUNSELING, LLC* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and

Human Services Office of Civil Rights. *LIFE TRANSITIONS COUNSELING, LLC* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

**Please discuss any questions or concerns with your therapist.**

Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

**IX.** *LIFE TRANSITIONS COUNSELING, LLC 's* **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

*Date of Last Revision: 2/15/16*

**Linda Calvo Kimbell, LCSW – Life Transitions Counseling, LLC**
**117 Harmony Crossing, Suite 1, Eatonton, GA 31024**
**706-485-4004, FAX 706-262-2986, WEB: Mylifestylemed.com**

# INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

## Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

*BA Psychology, University of South Florida*
*Masters of Social Work, University of Georgia*
*Licensed Clinical Social Worker, State of Georgia*
*Credentialed with Medicare, Medicaid and several insurance companies to provide psychotherapy and counseling*

*My professional experience is working with adults, who are dealing with chronic illness, and their caregivers. This has afforded me significant relevant experience in also addressing issues associated with every day stress, anxiety, depression, pain and grief. I have been certified as a facilitator with: the Agency on Aging's Chronic Disease Self-Management Program; The American Cancer Society's Fresh Start Tobacco Cessation Workshop; and North Georgia Heart Foundation Hands Only CPR. I have completed special training in Palliative Care through the End-of-Life Nursing Education Consortium. If desired I can incorporate a certified therapy dog for animal assisted therapy. I volunteer as a speaker for community support groups in the areas of Lifestyle Medicine, Advance Care Planning, Memory and Grief.*

## Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me

Please initial that you have read this page _____

know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

## Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with Care Cloud, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, Federally approved encryption. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

## Structure and Cost of Sessions

I agree to provide psychotherapy for the fee of $90 per 45-50 minute session, $110 per 50-60 minute session, and/or $90 per 90 minute group therapy session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and I will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $30 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Based on the insurance information you provide, I will attempt to file a claim on your behalf. Otherwise, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

## Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for a **$75.00 no show fee** for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

## In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

Please initial that you have read this page _____

- **Call Behavioral Health Link/GCAL: 800-715-4225 or other crisis hotline**
- **Call Suicide Prevention Lifeline at (800) 273-8255 (National Crisis Line)**
- **Call 911.**
- **Go to the emergency room of your choice.**
- **Wesley Woods Center (Emory) located in Atlanta 404-728-6222, or**
- **Vantage Point located in Athens 706-354-3978, or**
- **Recovery Center located in Macon 478-803-8617, or**
- **Serenity located in Augusta 706-836-6025,**

## Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. **For your confidentiality, I will not address you in public unless you speak to me first**. I must also decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

## Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the ***National Association of Social Workers.*** If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Please initial that you have read this page _____

## Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, I realize that most people have and utilize a cell phone. I may also use my personal cell phone to contact you. If so, there may be a message **"No Caller ID."** If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. I realize that many people prefer to text and/or email because it is a quick way to convey information. **However, please know that it is my policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy).** Therefore, please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that I will not respond. **You also need to know that I am required to keep a summary or copy of all emails and texts as part of your clinical record that address anything related to therapy.**

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc: It is my policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter Direct Message. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Google, Bing, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material and bring it to your session.

Faxing Medical Records:

If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine. However, my fax machine is kept behind locks in our office. And, when my fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to me if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

## Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please initial that you have read this page _____

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

_____ _____

**Client Name (Please Print)** **Date**

_____

**Client Signature**

**If Applicable:**

_____ _____

**Parent's or Legal Guardian's Name (Please Print)** **Date**

_____

**Parent's or Legal Guardian's Signature**

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

**Therapist's Signature** **Date**

Please initial that you have read this page _____