1 | Client information

Please complete this packet before your first visit. You may discuss sensitive questions privately with your counselor. Optional service consents apply only when that service is offered.

Legal name

Preferred name / pronouns

Date of birth

Date completed

Street address, city, state, ZIP

Mobile / preferred telephone

Other telephone

Email address

Employment / student status

Relationship status

Emergency contact / relationship

Emergency contact telephone

Listing an emergency contact does not authorize routine sharing of treatment information. Emergency disclosures follow applicable law. Use the separate release form for ongoing communication.

Responsible payer / relationship

Payer contact information

Insurance company / plan (if used)

Member ID / group number

Subscriber name / date of birth

Relationship to subscriber

Referral source / how you heard about us

2 | Counseling services & informed consent

Practice: Sound Mind Counseling, Inc., 3060 Alt. 19 N., Suite B17, Palm Harbor, FL 34683. Telephone: 727-647-1546. Email: nkcounseling@hotmail.com. Website: soundmindcounselingnk.com. Routine messages are not emergency services.

Practice owner: Dr. Nicole Kratimenos, LMHC, NCC, CRC, QS, C-DBT, BC-TMH, CVE. Your actual treating clinician and any applicable supervisor will be identified below before treatment begins.

Treating clinician / credentials (staff completes)

FL license / registration number

Supervisor, if applicable

Supervisor license / contact

Treatment, benefits, risks, and choices

Counseling is collaborative. Your counselor will discuss your concerns, goals, clinical impressions or diagnosis when applicable, recommended methods, expected frequency, and progress. Approaches may include cognitive-behavioral, family-systems, behavioral, trauma-informed, relationship-focused, or other appropriate interventions. The plan may change as your needs change.

Possible benefits include improved coping, functioning, understanding, and relationships. Discussing difficult experiences may cause temporary distress, and changes can affect relationships or daily life. No outcome is guaranteed. Alternatives may include another provider or approach, medication evaluation with a qualified prescriber, a higher level of care, or declining treatment. Ask about material risks and alternatives specific to your plan.

Participation is voluntary except where legal requirements independently apply. You may ask questions, decline an intervention, request a second opinion or referral, or withdraw consent at any time. If care is court-ordered, your counselor will explain known reporting obligations and the possible consequences of stopping; the practice does not decide legal consequences.

Professional boundaries and consultation

Counselors avoid overlapping relationships that may impair judgment, increase exploitation risk, or harm clients. Unavoidable community contacts will be addressed with appropriate boundaries. The counselor will generally not initiate acknowledgment in public. Social-media connections and personal relationships may be declined to protect your care.

Qualified consultation or supervision may support care. Identifying information is shared only with authorization or other lawful authority, and only as appropriate to the purpose. Registered interns work under identified supervision. Recording, outside observation, and identifiable teaching use require the separate permissions described in this packet when applicable.

Ending treatment

You may end treatment. The counselor may recommend a transition or discharge if needs exceed available services, treatment is no longer appropriate, or other clinical or administrative circumstances require it. When practicable, the counselor will discuss transition planning, referrals, and immediate safety needs. Financial disputes do not eliminate your lawful record-access rights.

Client / legal representative signature

Date

3 | Confidentiality, safety & communication

Confidentiality and its limits

Counseling communications and records are confidential. They are released only with valid authorization or another applicable legal basis. HIPAA permissions do not override more protective Florida law or other applicable confidentiality rules. Disclosures are limited as required by law; only information appropriate to the lawful purpose is shared.

Exceptions may include mandatory reports of suspected child abuse, abandonment, or neglect and abuse, neglect, or exploitation of a vulnerable adult; disclosures necessary for emergency evaluation or serious self-harm risk when permitted or required by law; and other disclosures required by law.

Florida law requires notification to law enforcement when a client communicates a specific threat of serious bodily injury or death to an identified or readily available person and the clinician judges that the client has the apparent intent and ability to imminently or immediately carry it out. The law also permits communication of the qualifying threat to the potential victim.

A subpoena or attorney request does not automatically waive confidentiality or privilege. The practice reviews legal authority, applicable privilege, authorizations, and any required court procedures before responding. A client-initiated civil, criminal, or disciplinary complaint may permit a limited defensive disclosure in that action. A valid court order or another legal requirement may require disclosure, subject to applicable protections.

Emergencies and routine contact

The practice does not provide 24-hour crisis coverage. If you are in immediate danger, call 911 or go to the nearest emergency department. For crisis support, call or text 988. Outside the United States, use local emergency services. Do not rely on email, text, voicemail, or the portal for urgent safety needs.

Routine messages are answered as soon as reasonably possible during practice operations; counselor schedules vary. You and your counselor will discuss expected response times and absences. If you do not receive a response, call again or use emergency resources when needed.

Email, text messages, voicemail, devices, and notifications may be accessed by others or carry privacy risks. Reasonable safeguards do not guarantee absolute security. Use the secure portal for sensitive material when available and limit routine email/text to scheduling or brief administrative matters. You may change contact preferences at any time.

- ☐ Phone calls permitted
- ☐ Voicemail with practice name permitted
- ☐ Text reminders permitted
- ☐ Email reminders permitted
- ☐ Secure portal preferred
- ☐ No appointment reminders requested

Safe numbers / addresses, message limits, and alternate mailing address

Reminders are a convenience. You remain responsible for attending or canceling scheduled appointments even if no reminder arrives. Listing a preference does not authorize disclosure of your chart to another person.

Client / legal representative signature

Date

4 | Fees, appointments & client paperwork

Session fees: The usual fee range is $125-$150 for a 45-50-minute session, unless a different fee or service is agreed in writing. Your exact fee and session duration are documented below before services. Insurance cost-sharing follows your plan and applicable agreements. Fee changes will be disclosed before the affected service.

Agreed session fee / service

Session length / frequency

Payment: The agreed fee or applicable copayment is due before the session unless another arrangement is documented. You are responsible only for amounts lawfully billable to you under applicable law, your insurance plan, and provider agreements. A denial does not automatically make the entire claim your responsibility. We cannot guarantee insurance reimbursement.

Cancellations: Give at least 24 hours notice. A missed appointment or cancellation with less than 24 hours notice is subject to a $100 fee where legally and contractually permitted. Insurance generally does not pay this fee. Arriving more than 15 minutes late may be treated as a missed appointment if the session cannot be held; contact the office if you are delayed. Exceptions may be considered for emergencies.

More than two missed appointments or late cancellations may require a $100 scheduling deposit where permitted. The deposit is applied to the next attended session or an applicable missed-appointment charge. Any unused balance will be returned if services end, less lawful agreed charges. Any effect on scheduling and transition needs will be discussed.

Forms, certifications, and other paperwork - $50 per set

There is a $50 fee per set of client paperwork completed each time. This includes medical leave of absence, FMLA, disability, workplace or school accommodation forms, and similar requested certifications or paperwork. Each new set, renewal, or requested update constitutes a separate completion request and carries a separate $50 fee. Corrections of a practice error are not charged again.

Submit the complete forms, instructions, recipient details, and deadline. The counselor must have sufficient clinical information and may require an appointment at the agreed session fee. Paperwork must be clinically supportable and within the counselor's scope; requests may be declined or referred. Completion does not guarantee approval, leave, benefits, or an accommodation. Turnaround will be agreed before work begins. Required authorization must be obtained before sending information to an employer, school, insurer, or other third party.

The $50 fee applies to completion of requested forms, not access to existing records, routine billing documents, privacy-rights requests, or services for which law or a payer agreement prohibits a separate charge. It will be disclosed and accepted before work begins and is payable when the agreed paperwork is completed, unless a different lawful arrangement is documented.

Other services: Extended calls, specialized reports, evaluations, and additional care coordination may carry separate charges disclosed and agreed in advance. Do not assume these services are included in the session fee. No undisclosed additional fee will be charged.

Client / legal representative signature

Date

5 | Financial authorizations & legal requests

Records and legal services

Copies of existing records furnished to you or another treating provider at your written request are provided at no charge under this practice policy, subject to any required authorization. Other requests are evaluated under applicable law. Any permitted fee will be disclosed in advance. Fees for individual access must comply with HIPAA's cost-based limits, and electronic copies of electronically maintained records do not carry per-page fees.

Routine therapy is not a forensic evaluation, custody evaluation, or expert-witness service. The practice does not voluntarily undertake testimony as part of routine treatment. If testimony is legally compelled or a separate legal service is expressly accepted, the stated rate is $250 per hour for lawful preparation, attendance, and travel time. A $1,880 advance retainer may be requested where lawful and applicable. Unused funds are refunded; only lawful, agreed charges are assessed. A fee dispute does not excuse compliance with a court order or restrict lawful record access.

Insurance billing instructions

- ☐ Use my insurance and direct applicable benefit payments to Sound Mind Counseling. I authorize necessary claims disclosures as allowed by applicable law.
- ☐ I will self-pay; do not submit claims for these services unless I later direct otherwise.
- ☐ I request the legally required insurer restriction for services I pay out of pocket in full; discuss the covered service with me.

Select the applicable instruction; staff will clarify an incomplete or conflicting selection. Insurance may require a diagnosis and treatment information. Insurance disclosures remain subject to applicable privacy law. This agreement does not waive privacy rights or release the practice from responsibility for its obligations.

Required card-on-file authorization

A valid card on file is required, subject to applicable law and payer agreements. Complete the full credit card number, expiration date, and CVV below. Do not send this completed page by ordinary email or text.

Cardholder name / relationship to client

Full credit card number (required)

Expiration date - MM/YY (required)

CVV / security code (required)

- ☐ I authorize agreed session fees, lawful copayments, and other amounts I expressly approve.
- ☐ I also authorize lawful $100 late-cancellation / missed-appointment charges under the stated policy.
- ☐ I authorize $50 paperwork charges when I request a set and accept the fee for that request.

Agreed charges may be processed when due, with a receipt or itemized statement available. Ask promptly about errors. Revoke authorization for future charges by written notice and arrange another payment method; this does not cancel lawful amounts already owed. Charges must comply with payer agreements and law. The statement descriptor is Sound Mind Counseling, Inc.

Cardholder signature (if authorized)

Date

Client / legal representative signature

Date

6 | Client records: retention & destruction

Seven years after last session contact

Sound Mind Counseling maintains a full record of services for 7 years after the last session contact.

When charts may be destroyed

After the applicable retention period expires, records may be securely destroyed under documented records-management procedures. Deletion is not automatic at seven years. Records are retained longer when required by applicable law, a court order, a preservation duty, or an applicable contract. Minor-client records are reviewed for any longer requirement before disposal.

Destruction is suspended for relevant records subject to an unresolved access request, pending or reasonably anticipated litigation, an investigation, an audit, or another preservation hold. Records are destroyed only after the practice has reviewed applicable retention and preservation obligations.

Secure disposal and continued confidentiality

Paper records are shredded or destroyed so identifying information cannot reasonably be reconstructed. Electronic records are securely deleted or disposed of through methods appropriate to the storage medium and privacy/security requirements. Inactive or archived status alone is not destruction. Vendor-held copies and backups are addressed through documented retention, preservation, and secure-disposal procedures. Confidentiality continues throughout retention and disposal.

Requesting access before disposal

You may request access to or copies of retained records, subject to applicable law. Send requests to the practice or its privacy contact using the information in this packet. Once lawfully destroyed, records may no longer be available. This notice does not waive your access, privacy, complaint, or other legal rights.

Custody when a clinician becomes unavailable

If practice termination, relocation resulting in unavailability, or a clinician's death affects records, applicable notice, custody, access, and retention requirements under Rule 64B4-9.001 will be followed. The practice arranges record custodianship and required notices. This intake acknowledgment does not replace a legally required closure or death-related notice.

Client / legal representative signature

Date

7 | Notice of Privacy Practices: your rights

Applies to Sound Mind Counseling, Inc. and its workforce in providing practice services.

Notice effective date (practice completes before use)

This notice explains how health information about you may be used or disclosed and how you may obtain access. Please read it carefully. Florida confidentiality and privilege rules and any other more protective laws remain applicable.

Privacy contact: Dr. Nicole Kratimenos, Practice Owner / Privacy Contact, 727-647-1546, nkcounseling@hotmail.com; 3060 Alt. 19 N., Suite B17, Palm Harbor, FL 34683. You may use telephone or mail to avoid sending sensitive information by ordinary email.

Access, corrections, and communication

You may inspect or receive paper or electronic copies of information in your designated record set, including ordinary progress and billing records. Requests may be made in writing through the practice. We act within 30 calendar days unless a lawful extension applies; any permitted extension is explained in writing. A summary is provided instead of records only if you agree. Existing copies for clients are free under our policy. Any legally permitted denial is explained in writing, including available review and complaint rights. Unpaid bills alone do not justify withholding access.

Separately maintained psychotherapy notes and information prepared for certain legal proceedings are excluded from HIPAA's access right; ordinary treatment notes do not become psychotherapy notes merely because they are counseling notes. Other applicable rights are considered.

You may request amendment of inaccurate or incomplete information. We generally respond within 60 days, subject to a permitted extension. A denial is explained in writing, with your right to submit a statement of disagreement. You may ask for confidential communication by a reasonable alternate method or address, and we will accommodate reasonable requests.

Restrictions, disclosure accounting, and representatives

You may request restrictions on uses and disclosures. We need not agree to every request, except restrictions required by law. If you pay for a service out of pocket in full and request it, we will not disclose that service to your health plan for payment or health-care operations unless disclosure is required by law. Tell us before claim submission so we can apply the restriction.

You may request an accounting of disclosures covered by HIPAA for the preceding six years. Certain disclosures, including most treatment, payment, operations, and authorized disclosures, are excluded. One accounting in 12 months is free; we disclose any permitted fee for additional requests. We respond within applicable legal deadlines.

You may obtain a paper copy of this notice even if you receive it electronically. A legally authorized personal representative may exercise applicable rights after authority is verified; exceptions under law may apply, including some safety, abuse, and minor-treatment situations.

Complaints without retaliation

Contact our privacy contact with concerns. You may also complain to HHS Office for Civil Rights at hhs.gov/hipaa/filing-a-complaint/index.html, 1-877-696-6775, or 200 Independence Avenue, S.W., Washington, DC 20201. Professional complaints may be submitted to Florida Department of Health at online-complaint.mqa.flhealthsource.gov/practitioner or 850-245-4339. You need not complain to us first. We will not retaliate for exercising your rights or filing a complaint.

Client / representative signature acknowledging receipt

Date

8 | Notice of Privacy Practices: information use

Care, payment, and practice operations

Subject to Florida law and required consent, information may be used for care, claims, scheduling, quality review, compliance, and secure record services. Workforce access is limited by role. Vendors must meet applicable confidentiality and security duties.

HIPAA permissions do not override more protective Florida or federal laws. Additional permission is obtained when required. General intake consent is not blanket disclosure authority.

Other lawful disclosures

Information may be disclosed when legally required or permitted and applicable conditions are met: abuse/neglect reporting; serious health or safety threats; health oversight; public health; workers' compensation; certain government, military, or national-security functions; appropriate coroner, medical-examiner, funeral-director, or donation functions; and legal proceedings. Florida privilege and any additional protections govern whether a particular disclosure is allowed. A subpoena alone is not treated as an automatic waiver.

Family, friends, and others involved in care receive information with your permission or another lawful basis. If you cannot express a preference, limited best-interest or emergency disclosures may be made only where applicable law permits. Listing an emergency contact does not authorize routine disclosure. Research disclosures, if proposed, require the applicable permission or other legally approved basis and any additional Florida protections.

Authorization and specially protected information

Uses outside this notice require your written authorization unless law permits or requires otherwise. Most disclosures of separately maintained psychotherapy notes require a separate specific authorization. Marketing and sale of protected information require authorization when the law requires it. You may revoke an authorization in writing through our privacy contact, except to the extent already relied upon or another lawful exception applies. Refusal does not waive your rights.

If we receive or maintain substance use disorder records protected by 42 CFR Part 2, applicable Part 2 restrictions also apply. Such records cannot be used or disclosed in civil, criminal, administrative, or legislative investigations or proceedings against you without your specific written consent or a qualifying court order and subpoena or similar legal mandate. Ordinary consent for treatment, payment, and operations does not authorize that use. Separately maintained SUD counseling notes have additional consent protections.

If fundraising communications are offered, you may opt out of further contact. Any use of Part 2 information for fundraising requires advance clear notice and an opportunity to choose whether to receive those communications. Treatment or payment is not conditioned on that choice.

Our duties and changes to this notice

We safeguard protected information, provide this notice, follow the notice in effect, and notify affected individuals of breaches when required by law. We disclose only as authorized, permitted, or required. You may request clarification of any privacy practice.

We may revise this notice for existing and future information. Revisions will show an effective date and be available in the office, on our website, and upon request. We provide the notice at first service and seek acknowledgment of receipt; declining acknowledgment does not waive your rights.

Client / representative signature acknowledging receipt

Date

9 | Your right to a Good Faith Estimate

You have the right to receive a Good Faith Estimate explaining expected charges when you do not have insurance or are not using insurance for the services. An estimate is separate from your general fee agreement. You may request one before scheduling.

If care is scheduled 3-9 business days in advance, the estimate is generally provided within 1 business day after scheduling. If scheduled at least 10 business days in advance, or if you request an estimate without scheduling, it is generally provided within 3 business days. Emergency care is not subject to these scheduling requirements. Estimates for recurring care describe the expected frequency, charges, and period covered; updated estimates are provided when required.

If a provider bills you at least $400 more than that provider's estimate, you may qualify for the federal patient-provider dispute process. You generally must initiate it within 120 calendar days of receiving the initial bill. Visit cms.gov/nosurprises or call 1-800-985-3059 for information. Starting a dispute does not reduce the quality of your care. Keep a copy of the estimate.

Individualized estimate - staff completes for applicable clients

Client name / date of birth

Estimate date / requested or scheduled date

Treating provider / NPI

Tax ID / service location

Expected diagnosis / code, if known

Estimated period / number of sessions

Expected service(s), service/CPT code(s), frequency, and dates

Session fee x expected sessions

Forms: $50 x expected sets, if requested

Other expected services / itemized charges

Total estimated charges

Other expected providers / facilities, charges, and separate estimates, if applicable

This is an estimate, not a contract or guarantee of final charges, and does not require you to obtain care here. Unexpected or separately scheduled services may require another estimate. The practice will explain anticipated changes and supply an updated estimate when required. Contact us to correct incomplete information; staff must complete applicable identifying and itemized information before issuing this estimate.

Client / representative signature acknowledging estimate

Date

10 | Consent & acknowledgment of receipt

Read sections 1-9 and ask questions before signing. Optional sections later in this packet apply only to the selected service or permission; a general signature does not activate them.

- [ ] I consent to counseling services and have had the opportunity to discuss benefits, risks, alternatives, and the treatment plan.
- [ ] I understand confidentiality and its exceptions, professional boundaries, emergency limits, and communication preferences.
- [ ] I understand the fees and appointment policies, including the $50 fee for each set of requested paperwork completed each time.
- [ ] I understand the record-retention and secure-destruction policy, including at least seven years after last session contact and any longer obligations.

Signing documents consent and acknowledgment. It does not waive legal rights, excuse the practice's legal duties, or guarantee a clinical, insurance, employment, or legal outcome. Questions, changes to the agreed fee, and additional arrangements should be documented below.

Questions discussed / individualized arrangements / relevant limitations

Client / legal representative signature

Date

If representative: printed name, relationship, and authority

Treating clinician signature

Date

Separate acknowledgment: Notice of Privacy Practices

I acknowledge actual receipt of the Notice of Privacy Practices (sections 7-8 of this packet), with the effective date shown on the notice. This receipt is not authorization for uses or disclosures beyond applicable law.

Client / representative signature acknowledging receipt

Date received

For staff: if acknowledgment was not obtained

- [ ] Notice delivered on the date below; client declined acknowledgment
- [ ] Notice delivered; acknowledgment could not be obtained for the reason below

Delivery date / method

Reason / staff name

11 | Telehealth consent - when applicable

Complete this section only if telehealth is offered. Telehealth uses remote audio/video technology. It may improve access but can limit nonverbal information, fail technically, or expose information through devices, networks, or the surroundings. In-person care or another provider may be an alternative.

The clinician must be authorized to provide services where you are physically located. State your location at each session and notify us before traveling. Sessions may need to be rescheduled or referred if lawful practice or safe treatment cannot be arranged. You must be in a private, safe location and may not participate while driving. Identify anyone else present; their participation requires agreement.

Use a secure device and private connection where possible. Avoid shared devices and public networks. Protect passwords and prevent others from overhearing. The practice uses appropriate safeguards, but no system is completely risk-free. Recording is not authorized by this consent; a separate specific agreement and applicable law govern recording.

At each encounter, we confirm location, callback information, and emergency arrangements as appropriate. If connection fails, attempt to reconnect and use the agreed backup method below. If an emergency occurs, the clinician may contact local emergency services or your emergency contact when permitted or required. The practice does not monitor your location or messages continuously.

Typical session address / city / state / ZIP

Client callback number

Local emergency contact / telephone

Nearest emergency facility / local emergency resources

Agreed technology / backup plan / reconnection instructions

- [ ] I consent to telehealth using the agreed audio/video platform.
- [ ] I consent to telephone backup when clinically appropriate and lawful if video fails.
- [ ] I prefer in-person services; discuss available alternatives.

The same clinical, privacy, billing, and cancellation policies apply unless otherwise documented. You may withdraw telehealth consent and discuss alternatives. The clinician may recommend a different level or format of care when remote care is unsuitable.

Client / legal representative signature

Date

Clinician signature

Date

12 | Couples, family & group services

Complete applicable portions before joint or group treatment. Joint therapy can improve communication but can also increase conflict or distress. The clinician will assess safety and suitability, including concerns about coercion or violence. Joint therapy may be paused or referred when unsafe or unsuitable.

Participants / client(s) receiving treatment; identify any visitor or collateral participant

Treatment focus, record arrangement, and any individual identified for insurance billing

Privacy within couples or family treatment

Information material to shared treatment may need to be addressed in joint sessions. If you privately disclose something affecting joint work, the clinician will discuss safe and appropriate sharing with you. The clinician may pause joint treatment or refer rather than continue under a secrecy arrangement that undermines treatment. This policy does not promise immediate disclosure without considering safety, does not waive privilege, and does not authorize outside releases. Agree on any different policy before treatment.

Each person receiving family therapy has confidentiality rights under applicable law. Written waiver by each family member receiving therapy is obtained when required by Florida law. Records may include information about several people; requests for access or release are evaluated for each person's rights. One participant's signature is not assumed to authorize release of everyone's information. Relevant individual permissions and legal authority are obtained before outside disclosures.

The clinician is providing treatment, not deciding custody, blame, legal credibility, or who is the primary aggressor. Treatment records may nevertheless be sought in legal proceedings. Discuss any pending litigation or reporting requirement before joint work begins.

Groups - confidentiality expectations

For group services, participants agree not to identify other members or disclose their personal information outside the group. Do not record, photograph, or screenshot sessions. The practice can control its own disclosures but cannot guarantee that other participants will keep information private. Group-specific rules, fees, and expectations will be discussed before participation.

Any additional joint/group privacy policy or safety arrangement agreed before care

Participant 1 signature	Date	Participant 2 signature	Date

Participant 3 signature	Date	Participant 4 signature	Date

Use extra copies for additional signers. Complete minor consent when applicable.

13 | Minor clients & legal authority

Complete only for a minor client or other client requiring legally authorized consent. Provide current parenting plans, custody/guardianship orders, and any relevant amendments. Report changes promptly. The practice verifies authority and follows controlling law and court orders; it does not resolve custody disputes.

Client name / date of birth

Parent / guardian authorizing care

Relationship / legal authority

Telephone / email

Other parent / guardian: name, contact, and relevant decision-making authority

Applicable court orders, restrictions, or documents provided

When a court orders shared parental responsibility over health-care decisions, either parent may generally consent to mental-health treatment unless the parenting plan states otherwise. The practice reviews the specific order and any applicable legal exception; it does not assume every minor may be treated based solely on this general rule.

Privacy and parental involvement

The counselor explains privacy in developmentally appropriate language and discusses parent involvement and progress/safety updates. Absolute secrecy is not promised. Parental access, exceptions, and independently authorized minor treatment follow applicable law and court orders.

A parent's payment does not by itself resolve access rights. The clinician may need to share safety information or make legally required reports. The practice will not provide a custody opinion as part of routine care or allow requests from competing adults to substitute for legal authority.

Agreed parent involvement / routine updates / limits on sharing

- [ ] I affirm that I have authority to consent and have disclosed relevant orders or restrictions.
- [ ] I consent to counseling for the client identified above, subject to applicable law and the disclosed treatment plan.

Authorized parent / guardian signature

Date

Additional guardian signature, if required

Date

Minor assent (not legal consent)

Clinician verification / date

14 | Authorization to release information

OPTIONAL. Complete all applicable fields for a specific release. A blank or unsigned form authorizes nothing.

Client name

Date of birth

Person / organization authorized to disclose (name and contact)

Recipient authorized to receive (name and contact)

- [ ] Sound Mind Counseling may disclose to the named recipient.
- [ ] The named outside provider may disclose to Sound Mind Counseling (identify it as recipient above).

For a two-way exchange, identify both disclosers and recipients specifically; use another copy if needed. The exclusions below apply to each direction of this exchange.

Specific information to disclose; date range and any exclusions

Purpose (for example coordination of care, employer paperwork, or at my request)

Expiration date OR expiration event related to this client or purpose

Preferred delivery method / verified destination

This optional authorization excludes all progress notes, separately maintained psychotherapy notes, and SUD counseling notes, even if "all records" is requested. Ordinary progress notes remain part of the medical record; this exclusion does not limit the client's lawful access rights or disclosures required by law. Release of progress notes to a third party requires a separate valid authorization or other lawful basis. This form is not a Part 2 consent or consent for legal proceedings against the client. Obtain separate permission for specially protected information when required.

I may revoke this authorization in writing to the practice privacy contact or named discloser, except to the extent already relied upon or another lawful exception applies. Recipients may redisclose information that may no longer have HIPAA protection; other laws may still restrict redisclosure. I may receive a copy of this signed form. Routine treatment, payment, enrollment, or eligibility for benefits is not conditioned on this optional release. Any lawful exception must be separately explained before signing.

Client / authorized representative signature

Date

Representative name / relationship / legal authority, if applicable

Witness signature

Date

15 | Optional recording & observation permission

No recording, outside observer, or use of identifiable material for teaching is authorized by the general treatment consent. Complete this page only for the specific activity described below. Do not use it for research consent or authorization to disclose separately maintained psychotherapy notes or Part 2-protected records; those require separate appropriate documents.

- ☐ Audio recording
- ☐ Video recording
- ☐ Live observation
- ☐ Identifiable teaching presentation limited to the audience below

Clinician / person authorized to record, use, or disclose information

Specific session(s), dates, information, and purpose

Named observers / recipients or specifically described audience

Storage location / access limits / agreed deletion or retention date

Authorization expiration date or event

Discuss foreseeable privacy risks, alternatives, and how participation can be stopped. Material must be handled with appropriate safeguards. Any recording retained as a clinical record must also satisfy applicable record-retention duties; the stated disposal date cannot override them. No public posting, social-media use, or further distribution is permitted by this authorization.

Participation is voluntary. Declining does not affect ordinary treatment, payment, enrollment, or eligibility for benefits. You may revoke authorization in writing to the practice privacy contact; revocation does not undo lawful prior reliance, but future uses will stop unless another legal obligation applies. Recipients may redisclose information, and it may no longer be protected by HIPAA; other legal duties may continue. You may receive a copy of this authorization.

- ☐ I consent only to the activity, information, audience, and period specified above.
- ☐ I decline recording, observation, and identifiable teaching use.

Client / legal representative signature

Date

All participants whose consent is required must sign. Obtain additional copies or separate authorizations as needed. A permission with missing essential details is not valid.

16 | Presenting concerns & current symptoms

What brings you to counseling? When did the concern begin?

Goals for counseling / what would improvement look like?

Current stressors, recent changes, and effect on daily functioning

Identify current symptoms and their severity, frequency, and duration. You may explain privately rather than writing details here.

- ☐ Low mood, reduced pleasure, low energy, guilt, or hopelessness
- ☐ Anxiety, panic, excessive worry, avoidance, or irritability
- ☐ Sleep or appetite changes; concentration or memory concerns
- ☐ Racing thoughts, unusual energy, reduced need for sleep, or impulsive behavior
- ☐ Unusual perceptions, voices, suspiciousness, or beliefs that concern you
- ☐ Trauma reminders, nightmares, dissociation, or difficulty feeling safe

Describe symptoms / other symptoms / approximate duration

Safety - tell the clinician promptly

Current thoughts of suicide / self-harm? Yes / No / Unsure

Current thoughts of harming another? Yes / No / Unsure

Any plan, intent, access to means (including firearms), or recent action?

Past attempts or self-harm, most recent thoughts, and what helps you stay safe

This questionnaire is not a complete risk assessment. If immediate danger exists, call 911 or go to an emergency department; call/text 988 for crisis support. Do not wait for the practice to review this form.

17 | Medical & mental-health history

Primary care clinician / contact

Last physical examination / location

Current diagnoses, allergies, weight/height if relevant, and health concerns

Past illness, hospitalizations, surgeries, head injury, chronic pain, seizures, or cardiac concerns

ALL current prescription medications: name, dose, frequency, prescriber, and start date

Over-the-counter medications / supplements / side effects or adherence concerns

Prior counseling or psychiatric treatment: reasons, dates, clinician, and response

Past psychiatric medications: dates/doses if known, benefit, and side effects

Psychiatric hospitalizations, emergency visits, or other higher-level care: dates and reasons

Family medical / mental-health history, substance concerns, suicide, or violence

Exercise, sleep, nutrition, and pregnancy/reproductive considerations if relevant to care

Provider updates require lawful permission. Prescribing requires separate qualifications and legal authority.

18 | Substance use & health habits

These questions help us understand health, safety, and treatment needs. Discuss concerns without judgment. Substance use alone does not establish a diagnosis. You may answer privately with your counselor.

Alcohol: days per week, typical drinks, highest drinks in a day in the past 3 months, and last use

Cannabis: form, amount, frequency, reason for use, prescription status if applicable, and last use

Other substances: stimulants, opioids, sedatives, hallucinogens, or other drugs; frequency and last use

Prescription medication used differently than prescribed: type, amount, and timing

Past or current substance treatment: substance(s), dates, setting, and outcome

- [ ] I have wondered whether I should cut down.
- [ ] Others have expressed concerns about my use.
- [ ] I have felt guilty or worried about my use.
- [ ] I have used a substance in the morning to relieve discomfort or steady myself.
- [ ] Use has affected relationships, work/school, health, finances, driving, or caregiving.
- [ ] I have experienced withdrawal, overdose, blackouts, or inability to stop.

Details, current concerns, periods of nonuse, and changes you would like to make

Nicotine / tobacco: form, amount, years, quit attempts

Caffeine: type and daily amount

Safety concerns, use while caring for others, or concerns about another person's use

19 | Family, relationships & life context

Childhood / upbringing, caregivers, adoption or foster care, siblings, and important transitions

Relationships with parents/caregivers; family losses or separation

Trauma, abuse, neglect, coercion, or violence you want us to know about (may discuss privately)

Education, occupation, disability/retirement, military service, or career concerns

Current / prior intimate relationships, children, household members, and concerns

Gender identity (optional)

Sexual orientation (optional)

Cultural identities, preferred language, religion/spirituality, and their importance to you

Legal concerns, arrests, pending matters, court-ordered treatment, or reporting expectations

Supports, strengths, interests, coping resources, and accessibility/accommodation needs

Anything else you would like your counselor to know?

Client / guardian signature

Date

Reviewed by clinician

Date / follow-up needed