CATALYST
321 Ringgold Road
Somerset, KY 42503
Phone: (606) 451-1936 Fax: (606) 451-9713

CONSENTS AND AUTHORIZATIONS

GENERAL CLIENT INFORMATION

DATE: ______________________________

Full Name: ____
First MI Last Maiden/Alias

DOB: ______ /______ /______ **Social Security #:**________---________--- ________

Street Address: ____
(House/Apt #) (City/ST) (ZIP) (County)

Mailing Address: ____
(House/Apt #) (City/ST) (ZIP) (County)

Phone #:________________________ **Alternate Phone #:** ________________________

Emergency Contact Name: ________________________**Relationship:**________________

Emergency Phone #:____________________**Alternate Phone #:** ________________________

CONSENT FOR TREATMENT & SERVICE FEE AGREEMENT
FREEDOM OF CHOICE OF PROVIDERS

Please indicate the services you are requesting for yourself or the person for whom you are guardian. Please note that you are afforded Freedom of Choice of Providers and may select any provider for any service and you may choose to modify your provider selection by notifying your case manager or therapist. Your signature below indicates your acknowledgment of freedom of choice of providers and services fees, as well as my agreement to pay set fees at the time services are rendered. You acknowledge that fees are subject to change and that you will receive written notification of any applicable changes to fees of services provided to them. You also understand and agree to abide by the agency's Payment Policies.

- ☐ Initial Assessment (intake/screening) ($250.00/occasion)
- ☐ Group counseling ($60.00/session)
- ☐ Case Management (inquire for rate)
- ☐ Consultation (inquire for rate)
- ☐ Individual counseling ($187.00/session)
- ☐ Psychological evaluation ($275.00 per evaluation)

My signature below acknowledges my consent for treatment by Catalyst for any of the services indicated above. Permission is granted to the staff of Catalyst to render treatment and/or services to me (or the individual I represent) as outlined in my treatment plan and/or per order of the court systems and/or medical professionals. I understand that I may terminate this authorization by changing providers, with 30 days advance notice. Permission is given to seek emergency medical treatment by calling 911 or emergency services if necessary. I understand that Catalyst personnel are not responsible for my medical treatment and will not provide transportation to hospitals, etc.

My signature below also serves as acknowledgment that I have received, reviewed, and understood the Informed Consent form for treatment.

CLIENT SIGNATURE		DATE	
CATALYST REPRESENTATIVE/TITLE		DATE	

Client Name: ________________________
Insurance Member ID:__________________

Revised 6/13/16

CATALYST
321 Ringgold Road
Somerset, KY 42503
Phone: (606) 451-1936 Fax: (606) 451-9713

CONSENTS AND AUTHORIZATIONS

INFORMED CONSENT FOR BEHAVIORAL HEALTH SERVICES

Full Name: ____
First MI Last Maiden/Alias

INTRODUCTION
We welcome you as a new or returning client receiving services from Catalyst. This informed consent document is intended to give you general information about the services that we offer. This is a legal document, so we ask that you please read it carefully before signing. We welcome any questions, comments, or concerns about this document. If you would like a copy of this document, please ask your counselor.

NON-DISCRIMINATION
Catalyst Behavioral Health shall provide comprehensive clinical services without discrimination. The agency shall not discriminate based upon an individual's: race, color, national origin, or ethnicity; sex, gender identity, or sexual orientation; religion; disability; age; socioeconomic status and/or inability to pay.

NATURE AND PROVISION OF SERVICES
Catalyst offers a variety of clinical services to clients including: assessment, consultation, case management, individual counseling, group counseling, and psychological evaluation. We will also assist with aftercare and referral. During the initial assessment, you and the clinician will work together to determine how to best serve your needs. Furthermore, understand that appropriate referrals will be provided to you if it is determined that you would be best serviced by a community resource. The approach, goals, and duration of services will be discussed with you individually by your specific therapist, assessor, and/or instructor.

POTENTIAL CONSEQUENCES OF TREATMENT
It is important that you realize that working with a therapist may sometimes lead to unexpected consequences. In general, exploring problems may uncover painful feelings and it is important to know that this is a normal part of the growth process. One goal of therapy is to work through and resolve these underlying issues and this requires your ongoing commitment to therapy. Counseling may result in making major life-changing decisions, including decisions that affect your lifestyle, which may involve separation within families, development of other types of relationships, or changing employment settings. The decisions are a legitimate outcome of the counseling experience as a result of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. Your therapist will be available to discuss any of your assumptions or possible negative side effects in your work together.

ATTENDANCE POLICY
Catalyst expects clients to agree that while they are seeing a counselor or participating in a group, whenever possible, they will notify agency personnel at least 24 hours in advance of intent to miss or cancel a session. Extenuating circumstances such as a personal emergency, illness, accident, etc. in which 24 hours notice is not possible must be documented in writing from an authorized source. As a client, you agree that if you cancel or miss an appointment without 24 hours advance notice, you will be billed and responsible for paying the full amount of your session fee. Furthermore, clients who cancel or miss ("no show") three appointments will be considered to have chosen to discontinue services and will no longer be accepted as clients of Catalyst Behavioral Health. The agency will strictly enforce its Non-compliance Reporting policy, with regards to failure to attend for court-mandated counseling.

RULES OF CONDUCT

You are expected to follow all rules of the agency while receiving services. Refusal or noncompliance with these rules may result in immediate discharge from the program. The rules of conduct for clients of Catalyst include:

- Treating staff, volunteers, and other clients (i.e. group members) with mutual respect, honesty, and dignity
- Informing staff of needs and changes in circumstances in order to receive relevant services
- Maintaining the confidentiality of other clients and staff
- Being punctual, sober, and ready to participate for all sessions
- Avoiding advice-giving, cross-talk, overpowering/domineering, and/or demeaning language
- Listening to the opinions of others
- Actively participating in sessions
- Refraining from:
    - Use, abuse, or intoxication of drugs and/or alcohol while on agency premises
    - Possessing drugs and/or alcohol while on agency premises
    - Physical, emotional, sexual and/or verbal aggression to other clients, staff, volunteers, and/or self on agency premises
    - Harassing, threatening, intimidating, or manipulating any other person
    - Bringing or possessing any sort of weapon on agency premises
    - Acting out your feelings in group, whether upon yourself or another member. The way we most respect ourselves and others is by experiencing our feelings and then talking about them
    - Unauthorized photography in the lobby/waiting room or in session

RIGHTS/RESPONSIBILITIES

As a recipient of services from Catalyst, you are awarded many rights, along with your responsibilities. You will not be unlawfully discriminated against in determining eligibility for the program. You also have the rights to:

- Have input into your treatment and case management plans and be informed of their consent
- Give informed consent to receive services and/or to participate in research studies
- Receive individualized treatment from competent professionals
- File a grievance, recommendation, or opinion on the services you receive
- Confidentiality according to HIPAA and all applicable regulations;
- Request a written statement of the charge for a service;
- Be informed of the policy for services and payment of fees;
- Be informed of the rules of client conduct, including the consequences for the use of alcohol and other drugs or other infractions that may result in disciplinary action or discharge
- Be treated with consideration, respect, and personal dignity
- Request records
- Receive services that are non-discriminatory, regardless of race, ethnicity, religion, disability, gender identity, sexual orientation, etc.

RECORDS

Our agency is required by law and regulation to maintain records of services provided to you. These records include a brief summary of our conversations along with any observations or plans for future sessions. These may also include notes regarding progress to goals that you have self-identified. A judge can subpoena your records for a variety of reasons, and if this happens, our agency must comply. Staff persons can be called to testify about the contents of the records and we must comply with this as well. If you have any questions about this, please let a staff person know.

Catalyst Behavioral Health uses a HIPAA-compliant electronic health records system to manage client records, schedule and manage appointments, create reminder calls and e-mails, bill insurance for services rendered, and manage client accounts. In addition you may opt in for access to the online Patient Portal by making your therapist or service provider aware of your confidential e-mail address. As with any electronic service, there are inherent risks. In very rare instances, security protocols could fail, causing a breach of privacy of personal information.

FEES
Payment is expected at the time services are rendered. Fees charged will not exceed the maximum fee published by this agency. Clients will not be permitted to attend additional sessions without payment for previous sessions. At the time of this publication (6/13/2016), the following fees are established:

- Initial Assessment (intake, screening) - $250.00/occasion
- Individual Counseling - $187.00/session
- Group Counseling - $60.00/session
- Psychological Evaluation - $275.00/evaluation
- Consultation – Inquire for rates
- Case Management – Inquire for rates.

Fees are non-refundable and non-transferrable.

Catalyst does offer a sliding fee discount program for individuals who may qualify based on household income and family size. Clients will not be turned away due to inability to pay.

INSURANCE
If you have insurance through a company with which Catalyst is a provider, we will attempt to bill the company for your services, if you desire. You may be required to pay any co-payments, co-insurance, deductibles, or denied claims at the time services are rendered.

It should be noted that as part of requesting services in this manner, it is necessary for the therapist to assign an appropriate diagnosis from the Diagnostic and Statistical Manual (DSM), which is the approved reference manual for mental health professionals. The diagnosis assigned, along with all other information obtained, will become part of your permanent medical record.

CONFIDENTIALITY
All employees of Catalyst maintain confidentiality with the ethical guidelines and legal requirements of their professions and licensure boards. Effective counseling and treatment sometimes requires that staff members share confidential information with other staff members in consultation and staffing. This collaboration may also include trainees and practicum/internship students, whose work is supervised by Catalyst. Records are kept for the period required by ethical and legal guidelines. That period is currently 7 years.

Your treatment will not be discussed with anyone identifiable about your situation with anyone other than to those persons authorized by yourself. No records or information about you will be released by Catalyst without your permission, except under the following circumstances (please initial understanding of each bullet point below):

- __________If you present a serious danger to yourself or another person.
- __________If you disclose current or prior abuse, neglect, or exploitation of yourself or of another person to your counselor or a staff person (or if there is reasonable suspicion that these are occurring), whether it was done by yourself or another person
- __________If you disclose that you have abused, neglected, or exploited another person
- __________If a valid subpoena is issued for your records, or your records are otherwise subject to a court order other legal process requiring disclosure
- __________If you request that your services be billed to an insurance company or third-party payer
- __________If you are under 18 years old, please be aware that while the specific communication and content of sessions will remain confidential, your legal guardian(s) have the right to receive general information on how your treatment is proceeding

Confidentiality is a particularly important consideration where group work is concerned. Group work is based on mutual trust, and violations of that trust can be detrimental to the group as a whole.

CUSTODIAL RIGHTS
When requesting services for a minor of divorced or separated parents, documentation of custodial rights must be received at the onset of treatment. Please be advised that unless a parent's rights have been legally terminated, he/she has the right to request information and records about the treatment of the minor child, even in situations in which one parent has full custody.

Client Name: ___________________________________ *Revised 6/13/16*
Insurance Member ID:_________________________

USE OF TOUCH

When appropriate and according to the therapist's clinical judgment, the clinician may use therapeutic touch in sessions, especially with clients who are children. In the context of this document, touch refers to any physical contact occurring between persons in the course of the psychotherapy session. In its most positive form, touch is nurturing and supportive and may include a pat, high-five, or a hug. There is also fairly neutral touch, such as holding a young child's hand on the way to the playroom to prevent the child wandering off. There is touch that the child may experience as unpleasant, such as taking a child's hand to stop him or her from hitting in session. When a child experiences touch from a loving, safe caregiver many things happen to promote healthy growth. Children develop a sense of self and the ability to relate to others; they learn to modulate affect; and develop a belief in his or her own self-worth and ability to master their environment. Research indicates that touch is essential in forming healthy parent/child attachments, promotes physiological development, reduces the effect of stress on an infant, and promotes positive body image. As such, touch is considered essential to the human experience and is a powerful form of communication. Touch, when used appropriately, can promote growth and provide healing. When misused, touch can impede healthy development and cause harm. Because touch is such a complex, powerful form of communication that is highly debated in today's psychotherapeutic world and also in society, the clinician may carefully evaluate and understand their own motivations for using or not using touch, and whether or not this decision meets the needs of the child. The use of touch is driven strictly by the needs of the child, and any sexual or erotic touch is strictly forbidden between the child and clinician. It is equally important to be informed and understand that the therapist may need to use touch (i.e., guiding your child by the hand or carrying your child out of the room, to enforce ending the end of session, etc.). With this said, the therapist will assure you that every incident of touch will be explained to you after the session (or soon thereafter, depending upon time constraints), including how the touch was initiated and addressed, and the subsequent consequence or reaction of the child. If you ever have any questions or concerns regarding this, please direct them toward the therapist so that he/she may help explain and/or address any such issues.

USE OF PHOTOGRAPHY

Photographs, videotapes and other recordings of a patient can contain protected health information (PHI), and any use or disclosure must be HIPAA compliant. Photographs, videotapes and other recordings of a patient, when they include full face images and/or voices or other identifying information, are considered PHI

Photographs, videotapes and other recordings may be used and disclosed as follows and if in compliance with applicable state laws:

- Treatment – The agency may photograph, videotape or make other recordings of clients for treatment purposes only and with your consent. When used for treatment purposes, they will be considered part of your medical record and stored in accordance with the agency's records policies. A photograph, videotape or other recording of a patient taken for treatment purposes may not be used or disclosed for any other purpose unless such disclosure is pursuant to this Policy and consistent with applicable state laws. In some situations, clients may give consent for their photograph or video recording to be used by interns and practicum students in the course of their study. These images will be restricted to use by the agency, the student, and the college/university according to their own policy and shall comply with all HIPAA guidelines and policies.
- Health Care Operations – Catalyst may photograph, videotape or make other similar visual images of you for purposes of health care operations. For example, we may take a photo of you for your intake sheet on your record. The agency must use and disclose only the minimum amount necessary for health care operations purposes in accordance with HIPAA.
- Security Cameras – Catalyst may use security cameras on the premises. The images of clients from such cameras will be considered part of health care operations. Use and disclosure of patient-related security camera photography or video will be restricted to the minimum necessary to accomplish the purpose and be HIPAA-compliant.
- Disclosures to Law Enforcement – Facilities may disclose photographs, videotapes or other recordings to law enforcement officials if and to the extent the disclosures are made in accordance with state and federal law.
- Authorization – In addition to the other situations described in this Policy, Facilities may take, use and disclose photographs, videotapes or other recordings of a client pursuant to a valid authorization that explicitly permits the taking, use and disclosure. Using and disclosing on this basis will be limited to those uses and disclosures specified in the authorization.
- Marketing – Catalyst will not use a photograph, videotape or other image of a client for marketing efforts without express authorization from the client.
- Images made by Others – Catalyst will not be responsible for obtaining authorization from the client for photographs, videotapes or other recordings taken of the client by him or herself, the client's family, and/or others visiting the client who are not employed by the agency. Catalyst will attempt to limit taking of photographs, videotapes or other

recordings by a client, a client's family or others visiting the client by prohibiting the use of cameras or recording devices by clients on agency premises.

TEXT MESSAGING

The use of text messaging with clients is at the discretion of each client and clinician of Catalyst Behavioral Health. Some therapists may opt not to provide clients with their personal cell phone number due to a desire to maintain boundaries of privacy and confidentiality. If you and your therapist agree that texting is agreeable, it should only be used in order to send quick messages on scheduling and not for the use of significant issues, which should be discussed in sessions. If you feel the need to text clinical information, you should instead text to schedule an appointment. Be advised that texting is not a secure medium and could compromise privacy. Further, text messages become part of your legal medical record. If you do not wish to receive text messages from Catalyst, please let your therapist know.

VOICEMAIL

Your therapist may often be unavailable to take phone calls. You may leave a voicemail message for non-urgent situations at our office by calling (606) 451-1936. Your message will be returned at the earliest convenience. Catalyst may also leave voicemail messages for you as appointment reminders. Be advised that while all possible safeguards are taken to ensure your privacy, voicemail messages run the risk of being intercepted by unintended parties. If you wish to restrict Catalyst from leaving a voicemail message for you, please inform your therapist.

E-MAIL

E-mails with your therapist should only be used to arrange or modify appointments, to discuss billing information, or for the clinician to check in on you if you we have not heard from you as suspected. Please do not e-mail content related to therapy sessions, as e-mail does have the potential for not being entirely secure or confidential and may not be immediately checked in a time of crisis. Please be advised that any e-mail from you or response from your therapist is considered part of your legal health record and could be subpoenaed.

Catalyst cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any email sent to agency staff via a computer in a work-place environment is legally accessible by an employer.

SOCIAL MEDIA AND INTERNET CONSIDERATIONS

Clinicians and support staff do not accept friend or contact requests from current or former clients on any social networking site (i.e., Facebook, Twitter, Instagram, Pinterest, Tumblr, LinkedIn, Snapchat, etc.), as these forms of media can blur the boundaries of the therapeutic relationship, compromise your confidentiality, and violate your privacy (and ours). Please be advised that, while Catalyst may have its own accounts as business pages or profiles on various social media platforms, you follow or like those at the risk of your own confidentiality. Similarly, any messaging on those platforms may not be immediately answered and should be limited to general questions about services offered and not about your specific treatment.

Similarly, it is our stance that clients' online presence or personal information should not be entered into search engines (i.e. "Googled") by our clinicians or support staff. Extremely rare exceptions may be made during times of crisis. For example, in situations in which there is suspicion that you are in danger and contact by usual means has not been successful, the therapist or staff may feel the need to search for an alternative method of contacting you, someone close to you, etc., in order to ensure your welfare.

Please be aware that if you use location-based services on your mobile phone, you may compromise your privacy while attending sessions at the office of Catalyst. Our office is not a "check-in" location on various sites like Foursquare; however it can be found as a Google location or from Facebook. Enabling GPS tracking makes it possible for others to surmise that you are a client at Catalyst due to your regular presence at our offices. As such, you may choose to disable location-based services while on our premises.

Client Name: ________________________________

Insurance Member ID:________________________

CONTACTING YOU

In order to keep your relationship with Catalyst confidential, the best way to contact you, should the need arise, is noted below. You should note that information exchanged over a cell phone and e-mail could be intercepted by a third party.

CONTACT BY:		METHOD	CONTACT	MESSAGE OK?	
YES	*NO*			*YES*	*NO*
☐	☐	*Cell phone*		☐	☐
☐	☐	*Home phone*		☐	☐
☐	☐	*Work phone*		☐	☐
☐	☐	*E-mail*		☐	☐
☐	☐	*Other*		☐	☐

TRANSPORTATION

In general, the agency will not provide transportation to clients without a notarized waiver limiting any sort of liability. In cases wherein transportation may be necessary, the agency will maintain on file verification of the employee's automobile insurance and active driver's license.

EMERGENCY SERVICES

Catalyst does not offer emergency services. If you have an emergency, go to the nearest hospital emergency room or call local law enforcement. Do not leave a voicemail message in an emergency, as there is no assurance that your call will be received and returned in a timely manner.

TERMINATION OF SERVICES

Therapy and/or treatment services will discontinue when the therapeutic relationship is no longer needed by the client, if the client becomes a threat to the counselor, if the counselor/treatment team assists with a referral to another mental health professional that seems more qualified to meet the needs of the individual, and/or if the family chooses to discontinue services. Furthermore, therapy and treatment shall be considered discontinued by the client if he/she misses or cancels three appointments.

COMPLAINTS

It is our hope that, should any misunderstandings arise, they may be resolved by discussing them with you. We welcome your questions, comments, and concerns and are more than willing to discuss any issues you have with your services in a calm, constructive manner. Our policy requests that you address any complaints about clinicians to our Clinical Director, Justin Smith. Nevertheless, should you have a complaint that you cannot resolve by talking with your therapist or the supervisor or that you do not wish to discuss with him/her, you have the right to notify the Division of Mental Health and Substance Abuse at (502) 564-9208 or the person's professional licensing board. Licensure board information is as follows:

- Board of Examiners of Psychology: (502) 782-8812
- Board of Social Workers: (502) 564-2350
- Board of Licensure for Marriage & Family Therapists: (502) 782-8809
- Board of Licensed Professional Counselors: (502) 782-8803

Client Name: ______________________________ *Revised 6/13/16*
Insurance Member ID:______________________

THERAPIST SPECIFIC INFORMATION

The therapist assigned to you at the time of intake is:

- **Name:** ______________________________
- **License Type & Number:** ______________________________
- **Other Credentials/Experience:** ______________________________
- **Educational Background:**______________________________
- **Theoretical Orientation/Specialization(s):**______________________________
- **Agency Supervisor/Contact Info:** ______________________________
- **Licensing Board:**______________________________

CONSENT

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of services provided by Catalyst. I hereby give my consent to authorize Catalyst to evaluate/assess, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information and have had all questions answered accordingly.

______________________________ ______________________________

CLIENT SIGNATURE/TITLE **DATE**

______________________________ ______________________________

WITNESSED BY: (CLINICIAN SIGNATURE/TITLE) **DATE**

CONSENT TO BILL INSURANCE

CLIENT NAME: ______________________________**INSURANCE COMPANY:** ______________________________

GROUP NAME: ______________________________**POLICY #:**______________________________

I, the undersigned, authorize the above named agency's office to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my therapist/provider may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his/her doing so is a necessity in his effort to secure ongoing care. I also authorize payment of benefits to the Catalyst, Inc. for services provided.

I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill.

I certify the above information is true and correct to the best of my knowledge and will notify Catalyst, Inc. of any changes of the above stated information.

______________________________ ______________________________

CLIENT/PATIENT SIGNATURE **DATE**

______________________________ ______________________________

INSURED SIGNATURE **DATE**

CATALYST
321 Ringgold Road
Somerset, KY 42503
Phone: (606) 451-1936 Fax: (606) 451-9713

CONSENTS AND AUTHORIZATIONS

HEALTH SCREENING FORM

DATE: ______________________________

Full Name: ____
First MI Last Maiden/Alias

DOB: ______ /______ /______ **Social Security #:**________---________--- ________

Primary Care Physician: ______________________**Phone:**______________________
May we thank this person for referring you? Y / N

Psychiatrist/Counselor: ______________________**Phone:**______________________
May we thank this person for referring you? Y / N

List any allergies you have (including medication allergies): ______________________

____

Do you have any advance directives/DNR/living will/Power of Attorney, etc.? If so, please explain:

____

MEDICAL HISTORY		
Have you ever been treated for or had any known indications of the following disorders, diseases, or issues? If yes, please explain the nature of the problem, dates, and treatment in the spaces provided.		
☐	*Eyes/Vision*	
☐	*Ear, Nose, Throat*	
☐	*Chest pains*	
☐	*High blood pressure*	
☐	*Heart attack*	
☐	*Stroke*	
☐	*Other heart disease, etc.*	
☐	*Cough, Shortness of breath, Asthma, COPD, or other respiratory problems*	
☐	*Seizures/Fainting*	
☐	*Anemia*	
☐	*Brain/head injury*	
☐	*Thyroid, pancreas, liver, or jaundice problems*	
☐	*Diabetes or hypoglycemia*	
☐	*Disorders of muscles, bones, back or joints/arthritis*	
☐	*Bowel or urinary problems*	

☐	*GERD, ulcers, or other stomach problems*	
☐	*Genetic disorders or birth defects*	
☐	*Disorders of the skin, tumors, cancer, or severe infections*	
☐	*Problems with sex organs*	
☐	*Tuberculosis*	
☐	*Hepatitis*	
☐	*HIV/AIDS*	
☐	*Other sexually-transmitted diseases*	
☐	*Are you currently pregnant?*	
☐	*Sleep disturbances*	
☐	*Unexplained weight loss/gain*	
☐	*Changes in appetite*	

CURRENT MEDICATIONS

Please list the names/doses/purpose of all medications that you are currently taking.
(Please include non-prescription over-the-counter medications, such as Tylenol, etc.).

Medication Name	Dosage/Frequency	Purpose	Prescriber

PREVIOUS TREATMENT

Please describe any previous health problems, surgeries, operations, medical hospitalizations, psychiatric/behavioral hospitalizations, counseling, addictions treatment, rehabilitative treatments, or other mental health services.

Place/Provider	Treatment/Procedure	Length of Time	Dates

Date of Last Physical Exam: ____________________________ **Date of Last Tetanus Shot:** ________________________

Please identify any other medical condition(s) that may affect your participation in treatment:

____

____

_______________________________________ **CLIENT SIGNATURE/DATE**

_______________________________________ **CLINICIAN SIGNATURE/TITLE/DATE**