Hart Behavioral Health LLC

Client Information Form 1

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral

Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____ = _____

C. Your Medical Care

From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____ Fax: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

D. Your Current Employer

Employer: _____ Address: _____

_____ Work phone: _____

Calls will be discreet, but please indicate any restrictions: _____

E. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____ Phone: _____

F. Your Education and Training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.

I. Family-of-origin history

Relative	Name	Living/ Deceased	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father						
Mother:						
Brothers						
Sisters						
Stepparents						
Grandparents						
Uncles/aunts						
Others						

J. Marital/relationship history

	Spouse's name	Spouse's age when married	Your age when married	Year Married	Year Divorced	Has spouse remarried?
1ST						
2ND						
3RD						

K. Significant nonmarital relationships

	Name of other person	Person's age when began	Your age when began	Your age when ended	Reasons for ending
1ST					
2ND					
3RD					
CURRENT					

L. Children

Indicate those from a previous marriage or relationship with "P" in the last column.

	Name	Current age	Sex	School	Grade	Adjustment problems?
1ST						
2nd						
3rd						
4th						

M. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ Other _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____

or other similar way you identify yourself and consider important: _____

M. Is there any other information you think we should know?

Jane Hart Lewis, MS

Licensed Professional Counselor
Supervisor for Professional Counselor
National Certified Counselor

503 Ridgewood Drive Florence, SC 29501 843-679-9200

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

◊ I have no problem or concern bringing me here
◊ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
◊ Aggression, violence
◊ Alcohol use
◊ Anger, hostility, arguing, irritability
◊ Anxiety, nervousness
◊ Attention, concentration, distractibility
◊ Career concerns, goals, and choices
◊ Childhood issues (your own childhood)
◊ Children, child management, child care, parenting
◊ Codependence
◊ Confusion
◊ Compulsions
◊ Custody of children
◊ Decision making, indecision, mixed feelings, putting off decisions
◊ Delusions (false ideas)
◊ Dependence
◊ Depression, low mood, sadness, crying
◊ Divorce, separation
◊ Drug use—prescription medications, over-the-counter medications, street drugs
◊ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
◊ Emptiness
◊ Failure
◊ Fatigue, tiredness, low energy
◊ Fears, phobias
◊ Financial or money troubles, debt, impulsive spending, low income
◊ Friendships
◊ Gambling
◊ Grieving, mourning, deaths, losses, divorce
◊ Guilt
◊ Headaches, other kinds of pains

(cont.)

◊ Health, illness, medical concerns, physical problems
◊ Inferiority feelings
◊ Interpersonal conflicts
◊ Impulsiveness, loss of control, outbursts
◊ Irresponsibility
◊ Judgment problems, risk taking
◊ Legal matters, charges, suits
◊ Loneliness
◊ Marital conflict, distance/coldness, infidelity/affairs, remarriage
◊ Memory problems
◊ Menstrual problems, PMS, menopause
◊ Mood swings
◊ Motivation, laziness
◊ Nervousness, tension
◊ Obsessions, compulsions (thoughts or actions that repeat themselves)
◊ Oversensitivity to rejection
◊ Panic or anxiety attacks
◊ Perfectionism
◊ Pessimism
◊ Procrastination, work inhibitions, laziness
◊ Relationship problems
◊ School problems (see also "Career concerns . . .")
◊ Self-centeredness
◊ Self-esteem
◊ Self-neglect, poor self-care
◊ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
◊ Shyness, oversensitivity to criticism
◊ Sleep problems—too much, too little, insomnia, nightmares
◊ Smoking and tobacco use
◊ Stress, relaxation, stress management, stress disorders, tension
◊ Suspiciousness
◊ Suicidal thoughts
◊ Temper problems, self-control, low frustration tolerance
◊ Thought disorganization and confusion
◊ Threats, violence
◊ Weight and diet issues
◊ Withdrawal, isolating
◊ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

◊ _____
◊ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

Hart Behavioral Health LLC

Jane Hart Lewis, MS

Licensed Professional Counselor
Supervisor for Professional Counselors
National Certified Counselor
Certified Dialectical Behavior Therapist

503 Ridgewood Drive Florence, SC 29501 843-679-9200

INFORMATION AND CONSENT

For best results and your own welfare, it is important that you understand what it means to be in counseling. Please read the brief description below. If you understand it and you choose to be in counseling as described here, sign and date this form. If you have any questions or concerns, you are urged to talk about them.

1. Counseling is a special kind of health care service. The goals of counseling are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feelings and challenges that you encounter in your daily life.

2. The most common form of counseling involves your talking about your feelings, problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home.

3. To better understand you, many counselors use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are also helpful in estimating your progress.

4. The length of counseling often depends upon your individual needs and the rate of your progress. Many counselors use periodic reviews as a means of evaluating your needs, progress, and satisfaction.

5. Most people benefit from counseling. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood,

relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in counseling. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your counselor). Psychological damage caused by counseling is rare, but you should be aware that it could happen. The most common causes of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in counseling, you should discuss this with your counselor. If you feel that your therapist has attempted to violate you in any way -- financially, physically, sexually, or otherwise -- you should so inform the state agency responsible for professional licensing.

6. You always have the right to choose whether or not to continue in counseling. If you feel that you might work better with a different counselor, your present counselor should be able to offer you information on possible referrals. Local mental health agencies are listed online and they may also offer helpful information. The most common alternatives to counseling are self-help and support groups, bibliotherapy (therapeutic reading), and different forms or religious counseling.

7. Communication is essential to successful counseling. You are urged to ask questions, express concerns, and share information about your personal life with your counselor. This information must be kept confidential by your counselor unless you grant permission to release it. State and federal laws dictate the only exceptions to this protection of your privacy. Some limits of confidentiality include: a) if you threaten harm to yourself or others; b) there is suspected child abuse or neglect; c) in various types of legal proceedings whereby records are court-ordered; or d) you use insurance to reimburse for fees. It is important for you to know that communicating by email and text are NOT always confidential. Therefore, I use the telephone for communicating with clients.

8. Telehealth is a service that I use. If you wish to access your appointment virtually, please let me know. My virtual visits meet all the necessary requirements and are HIPAA and HITECH compliant. I will provide virtual visits from my home. You will be expected to download the Thera-link.com.

Your signature below indicates that you have read and understood the above description of counseling. Your signature also indicates that you are now consenting to be in counseling with the understanding that you retain the right to review and revise this decision at later points in time.

_____ _____

Signature of Client or Parent/Guardian Date

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialists. Board offices may be reached at: South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialists, PO Box 11329, Columbia, SC 29211-1329.

Hart Behavioral Health, LLC

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above. **I also acknowledge that I have received or have been offered and refused a copy of the HIPAA Notice of Privacy Practices.**

Signature of Patient: _____
(Or Parent)

Date: _____

Health Insurance Portability and Accountability Act (HIPAA) - PRIVACY NOTICE

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

In this Privacy Notice, "medical information" and "psychological information" mean the same as "health information." Health information includes any information that relates to:

1) your past, present, or future physical or mental health or condition;
2) providing health care to you; or
3) the past, present, or future payment for your health care.

Protecting Your Privacy:

Counselors must always manage psychological records with great concern for privacy and confidentiality. I am required by law to protect the privacy of your health information. This means that I will not use or disclose your health information without your authorization except in the ways I tell you in this notice. If I wish to use or disclose your health information in ways other than those stated in this notice, I will ask you for your written authorization. If you give such an authorization, you may revoke it at any time, but I will not be liable for uses or disclosures made before you revoked your authorization.

Although the security of psychological records has continuously been addressed by Counseling Codes of Ethics as well as by State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

In my practice, the following individuals are required by HIPAA to comply with the privacy rules:

- Me and any practice staff such as office manager/scheduler, etc..
- Any billing agency or collection agency that handles information about you (name and address, diagnostic codes, treatment codes, and consultation dates...but not actual clinical records)

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU:

1. The Right to Inspect and Obtain a Copy of Your Psychological Record

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your consultations are documented in two ways: 1) The Clinical Record (required), which includes the date of your consultations, your reasons for seeking therapy, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, and any reports to your insurance carrier; and 2) Psychotherapy Notes (optional), which consist of specific content or analyses of therapy conversations (some of which may include sensitive information you have revealed that is not required to be included in your Clinical Record) and therapist's notes that may assist in treatment. Psychotherapy Notes, if created, are never disclosed to third parties, HMOs, insurance companies, billing agencies, patients, or anyone else. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (signing a Release of Information form) or denying access to them. If you refuse, it will not affect your coverage or reimbursement in any way, and your insurance company or HMO is obliged to provide payment, as usual.

2. The Right to Request a Correction or Add an Addendum to Your Psychological Record Correction
3. The Right to an Accounting of Disclosures of Your Psychological Information to Third Parties
4. The Right to Request Restrictions on How Your Information is Used
5. The Right to Request Confidential Communications
6. The Right to a Copy of This Notice upon Request
7. The Right to Withdraw Permission to Disclose Health Information
8. The Right to File a Complaint You have the right to file a complaint if you believe your privacy rights have been violated. Complaints must be filed in writing, and may be addressed directly to your therapist, or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W. Washington, DC 20201). If you have any questions or concerns about this notice or your health information privacy, please do not hesitate to address them during session or contact my office by telephone.
9. The Right to be Notified in There is a Breach of Your Unsecured PHI You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.
10. The Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket -

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for services.

_____ _____

My signature above represents that I have read and understand my rights under HIPAA. Date

Hart Behavioral Health, LLC

Jane Hart Lewis, MS, LPC, LPCS, NCC, DBTC
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INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here: _____.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Hart Behavioral Health LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Hart Behavioral Health LLC at any time. I understand Hart Behavioral Health LLC will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____

Patient/Client Signature

_____

Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

_____

Date

Hart Behavioral Health, LLC

Jane Hart Lewis, MS, LPC, LPCS, NCC, DBTC
503 Ridgewood Drive Florence, SC 29501
843 679 9200 (telephone) 843 667-6840 (fax)
hartbehavioral@protonmail.com

Service code (CPT Code)	Description	Fee for Service
90791	Initial Diagnostic Evaluation	135.00
90837	Psychotherapy ≥ 53 minutes	135.00
90846	Family Psychotherapy without Patient Present, 50 minutes	135.00
90847	Family Psychotherapy with Patient Present, 50 minutes	135.00
90853	Group Psychotherapy	70.00
Telephone Assessment/ Management	Telephone calls from the patient, telephone calls made or taken on patient behalf	Prorated based on amount of time spent at hourly rate
Electronic Communi-cations	Responding to Email & Text Messages	Prorated based on amount of time spent at hourly rate
Cancellation Fee	If client does not cancel 24 hours in advance or does not come for appointment	You are responsible for the full fee of the missed appointment
Production of records	Medical records requests	Prorated based on amount of time spent at hourly rate
Correspondence and Reports	Time to complete reports or requested correspondence	Prorated based on amount of time spent at hourly rate
Legal Fees	Depositions and Court Appearances	$200.00/hour including travel time and mileage

Signature Date

Jane Hart Lewis, MS, LPC, LPCS
Hart Behavioral Health, LLC

Agreement to Pay for Professional Services

I, the client (or person acting for the client), request that Jane Hart Lewis, MS, LPC, LPCS provide professional services to me or to _____, who is my _____ and I agree to pay Ms. Lewis' current hourly rate of $135.00 (See Fee Schedule). I agree that I am responsible for the charges for services provided by Ms. Lewis to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. Prior to my first appointment, I will be responsible for contacting my insurance company to determine whether preauthorization is needed and my benefits are for outpatient mental health treatment. I understand that I will be financially responsible for all appointments and that if I / the client miss / misses an appointment with less than 24-hour notice (except in the case of sickness or emergency), I will be expected to pay $135.00 at my next session (or whatever is the current rate for services.)

Insurance Company: _____

Copayment: _____

I agree that this financial relationship with Ms. Lewis will continue as long as she provides services or until I inform her in person, that I wish to discontinue treatment. I agree to meet with Ms. Lewis at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship. Should I miss two consecutive appointments, I agree that Ms. Lewis may terminate therapy with me and refer me to another provider.

I have also read Ms Lewis' Consent for Treatment and agree to act according to everything stated there, as shown by my signature below.

_____

Signature of client (or person acting for client) Date

_____

Printed name

I, Jane Hart Lewis, MS, LPC, LPCS, NCC, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of therapist Date

503 Ridgewood Drive Florence, SC 29501
Phone: 843-679-9200
Fax: 843-667-6840

Hart Behavioral Health, LLC

ELECTRONIC COMMUNICATIONS AND SOCIAL MEDIA POLICY

This document outlines my office policies related to the use of social media and electronic communications. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

ELECTRONIC COMMUNICATIONS

It is important to know that no electronic communications are confidential. Therefore, I do not conduct therapeutic business via email or text. Thera-LINK does provide a messaging function that is HIPAA and HITECH compliant. Additionally, you may open a free proton.me mail account abd contact me at hartbehavioral@proton.me. This communication will then be encypted according to regulations. Should you choose to contact me by other providers or by text, please realize that I cannot guarantee your confidentiality and you should only share information that you would not mind the public knowing. I prefer to use email and texts only to communicate about appointment times. Remember that emails and texts are stored in the logs of Internet providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the systems administrators of the Internet service provider. You should also know that any emails that I receive from you will become part of your legal record.

Through thera-LINK, you will receive an email reminder of your appointment from Hart Behavioral Health 48 hours prior. This contains the link for your session. If you accidentally delete this email, you may sign onto thera-LINK and there will be another link to your appointment. **Please remember, these reminders are a courtesy and not receiving an appointment reminder may not be used as a reason for missing a session.**

SOCIAL MEDIA

I do not accept friend requests from clients or former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up with me when we meet so we may discuss them.

Hart Behavioral Health does have a Facebook page where I sometimes post information. While you may certainly visit this page, remember that liking a post or liking the page will allow others to see your name, thus compromising your confidentiality.

I do not use any other social media sites at this time but should I start, I will conduct myself as previously outlined.

BUSINESS REVIEW SITES

You may find my counseling practice on sites such as Healthgrades or other places that list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites employ search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial rating or endorsement from you as my client.

The ethics of my profession say that it is unethical for me to solicit testimonials from current clients or others who, because of their particular circumstances, are vulnerable to undue influence.

Of course, you have the right to express yourself on any site you wish. However, due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

As we work together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you wish. Confidentiality means that I cannot tell people that you are my client and my Code of Ethics prohibits me from requesting testimonials. You are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provide to you, in any forum you choose.

If you do choose to write something on a social media site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

LOCATION BASED SERVICES

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular visits to my office. Please be aware of this risk if you are intentionally 'checking in' from my office.

USE OF SEARCH ENGINES

It is NOT a regular part of my practice to search for clients on Google of Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, someone close to you, or to check on your recent status updates) becomes necessary as part of insuring your welfare. These are unusual situations and if I ever resort to such means, I will document this fully and discuss it with you when we next meet.

My first concern is for your welfare. Thank you for reading this policy and sign below to indicate that you are familiar with these positions. If you have any questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

_____ _____

Signature Date

HART BEHAVIORAL HEALTH

Medication List

NAME DOB DATE

REVIEWED ON:

Medication Name	Dosage	Instructions	Prescribed By	Prescribed For (condition)