BULL CITY
SAFE SPACE
COUNSELING

Lauren K. Dawood, MA, LPC, NCC
P: 919.887.9502 F: 919.882.0980
www.bullcitysafespace.com
Lauren@bullcitysafespace.com

Client Information

Name:	Date of Birth:
Guardian Name(s) if Applicable:	
Martial Status:	Gender Identity/Sexual Orientation:

Address:	Email:			
	Phone #	cell	home	work
	Phone #	cell	home	work

Insurance Type	Insurance ID #:
Policy Holder Name:	Policy Holder DOB:

Primary Care Doctor (Name & Contact Info)	Prescribing Physician (Name & Contact Info)

Emergency Contact (Name, Relation, Contact Info)

Therapy Information

Reason for seeking therapy, goals, etc.

Best time for appointments:

Other Information:

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Client / Therapist Agreement

Please take a moment to read this overview of mental health services and indicate that you understand our policies by checking each box as you read it.

▫ **Confidentiality:** Under state and federal law, your or your child's counseling records are protected. Thus, the content of our sessions is strictly confidential. Information about you or your child cannot be released without your written consent. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. This right of confidentiality belongs to you, and you are free to discuss your therapy with whomever you choose. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email or text message at some point in our work together, please be aware that email or text message is not completely confidential.

However, under mandated law, there are exceptions to this confidentiality.

The following are legal exceptions to your or your child's right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately. Once such a report is filed, I may be required to provide additional information.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. If a judge orders the release of client records or compels me to testify in court, therapists are required to do so. This does not include subpoena requests from attorneys, but does include validly executed search warrants signed by a judge.
5. If, at any time, I have concerns about a particular issue, I may discuss that issue with a qualified and trustworthy attorney, but the privilege extends to that attorney who must also maintain this confidentiality and may only discuss the issue with me.
6. Certain pieces of confidential information must be discussed with staff and services used to obtain payment through insurance and authorizations, in which I will only release as much information as is necessary to complete these required tasks. Though the staff and services must maintain confidentiality, I do not have control what these services do once the information is in their hands.

Additionally, insurance carriers often request and require oral or written case summaries as a condition of reimbursement. Also, if you were referred to me by another professional, I would like to notify them of your contact with me, unless you instruct me otherwise.

▫ **Record Keeping** I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location that cannot be accessed by anyone else. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. You have the right to a copy of your file unless of an unusual circumstances that may involve danger to yourself. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. In most cases, I am allowed to charge a copying and processing fee of $0.50 per page (and for certain other expenses).

▫ **Fees and Billing Policy** All fees are due at the time services are provided. In general, all sessions are billed at $100 per 52 minute (“clinical hour”) session. Different fee schedules exist based on varying circumstances. You may pay by cash, check, credit card. Upon payment of cash, you will receive a receipt to keep for your own records. In the event that a check should be returned, you will be responsible for paying any fees that are charged to me by my banking company, in addition to the original amount owed. (This payment may be made by cash only) Non-payment of copay, coinsurance, or agreed rate will prevent any follow-up appointments from being scheduled. Account balances must be paid in full prior to scheduling next appointment.

▫ **Insurance Billing Policy** If you choose to use your insurance plan, you will be encouraged to pay for services rendered at the time of service. If you are unable to pay the full amount, review your financial concerns with your therapist. Please be aware that if you do elect to use your health benefits, your insurance company will require that I submit diagnostic and clinical information. All of the diagnoses come from a book titled the DSM-IV; I have a copy in my office and will be happy to review it with you to help learn more about what it says about your diagnosis. While such information is very sensitive and generally treated as such by insurance carriers, I cannot guarantee how any particular insurance carrier or employer will respect the information. Additionally, there may be times that your insurance company will seek more information before giving further authorizations for reimbursement. At those times, it will be necessary to use part of your clinical sessions completing the necessary paperwork and providing them with the requested information.

▫ **Authorization to Release Information and to Pay Benefits**
By signing below, I agree to authorize Bull City Safe Space Counseling, PLLC, to release any of my behavioral health information, including any drug and alcohol history, to my insurance company, as needed to process my insurance claim. In addition, I authorize my insurance company to make payments directly to Bull City Safe Space Counseling, PLLC, for covered behavioral health services.

▫ **Appointments** My services are provided by appointment only. The length of the appointment is generally scheduled for 45-52 minutes, allowing 10-15 minutes of the hourly charge for preparation and record keeping. I require a 24-hour notice for cancellations, otherwise you will be charged a No Show/Late Cancellation fee of $50. I know that unpredictable circumstances do arise and will allow one emergency cancellation for which you will not be charged, upon my discretion. Please be aware that insurance carriers do not reimburse for missed appointments. If you know that you will need to cancel an appointment, please contact me and we will work together on rescheduling your session at a more convenient time and date. In the event that you arrive late for an appointment, only the remainder of that appointment time can be carried out, appointments cannot be extended. With this policy, it is intended that you, as well, will not be inconvenienced and seen later than scheduled by a previous client’s late arrival.

▫ **Therapy Approaches and Risks** Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

▫ **Court/Custody:** Please be aware that I am not a custody evaluator or mediator. I have no training in either, it is unethical for me to be in that role as your or your child's personal therapist. I maintain these ethical boundaries for everyone's safety, and well-being. I am happy to provide resources to outside evaluators/mediators if needed.

▫ **Messages** You will find that I do not accept calls while I am in session with you, or while I am with other clients. During those times, or when I am out of the office, messages can be left on my voicemail. I will make every effort to return your call as soon as possible. Please note, Bull City Safe Space Counseling does not use email or text to convey or receive clinical information, anything shared via email or text is not guaranteed to be confidential and secure, so share at your own discretion.

▫ **Termination** The client will normally be the one who decides when therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not, in my judgment able to help you, because of the specific diagnosis you have and/or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you become violent, threaten violence, harass (physically or verbally) myself, the office, any of my staff or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

▫ **Confirmation of Appointments** By signing below, I agree for Bull City Safe Space, PLLC to contact me at the following number(s) to confirm, make, or change appointments:

Phone #'s: _____
Email address(s): _____

I also ▫ **agree /** ▫ **don't agree (please check one)** to allow Bull City Safe Space Counseling, PLLC, to leave a message regarding our appointment, if I am not available at the time of the call.

Please go to next page for signature

Consent for Treatment

By signing below, I acknowledge that I have read this Agreement and the Notice of Privacy Practices and agree to their terms. If you have any questions or concerns regarding any of this material, please contact your therapist.

_____
Patient Name

_____ _____
Patient Signature Date

_____
Printed Name of Responsible Party if Applicable

_____ _____
Responsible Party's Signature (if patient's under 18) Date

_____
Printed Name of Responsible Party if Applicable

_____ _____
Responsible Party's Signature (if patient's under 18) Date

_____ _____
Lauren K. Dawood, MA, LPC, NCC Date
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Child/Adolescent Informed Consent Form

The purpose of meeting with a therapist is to get help with the areas of your life that are bothering you or interfering with being successful. You may have asked to meet with and talk to a therapist or this could have occurred because your parents, teachers, doctor or someone else has concerns about you. The process of therapy involves getting to know your perspective on these difficulties and developing an understanding of what you are experiencing. Then working together to find better ways to cope with or manage those difficulties.

Sometimes these difficulties will include topics you do not want your parents or guardian to know about. For most people, knowing that what they say will be kept private helps with sharing thoughts, feelings, and perceptions and to have more trust in their therapist. *As a general rule, information you share in therapy sessions is confidential, unless you give consent to disclose certain information.*

However, there are exceptions to this rule that are important to understand prior to starting with the therapy process. In some situations it is required by law or professional guidelines that information discussed in therapy has to be disclosed. Some of those situations are described below. Most involve your protection and the protection of others from the potential to be hurt or harmed. I will inform you if I am going to have to share.

1. If you report having a plan to harm yourself, based on the evaluation of that plan, confidentiality can be broken in order to protect you from harming yourself.

2. If you report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person you intend to harm.

3. If you are involved in activities that could cause harm to yourself or someone else, even if you do not *intend* to harm yourself or someone else, based on the evaluation of that behavior, confidentiality can be broken.

4. If you report that you are being abused - physically, emotionally or sexually – or that you have been abused in the past, the law requires that this be reported.

5. If you are involved in a court case and a request is made for information about your therapy, information will be disclosed with your written consent unless the court *requires* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you.

6. If you agree that information can be shared with a specific person or entity, then we will discuss the limits of what will be shared, and how that information will be shared.
Except for situations as described above, your parents/guardians will not be told of *specific information* you disclose in therapy. This includes activities and behavior that your parents/guardians would not approve of or be upset by, but that do not put you or others at risk for immediate harm. It may be important to let your parents know some information that is

protected by confidentiality and you may be encouraged to share that information. Part of the therapist's job is to discuss this with you and to decide together the best way to communicate the information.

Also, parents and guardians may be able to be more helpful if they have general ideas about themes of therapy (such as diagnosis, treatment techniques, special needs, the status of symptoms, etc.) and the therapist may have specific suggestions for parents that do not involve breaking your privacy. **Parents are strongly urged to respect the privacy of your treatment and the related records.**

Schools and Teachers Information will not be shared with your school, including that you are even seeing a therapist, unless you and your parents/guardians give permission. If someone from your school wants to talk about your treatment, or if it is decided that talking to someone at your school would be beneficial, then you and your parents will be asked to give permission for that and sign a release of information form. If your parents or school want information about the treatment, and you do not want to give permission, then that will be discussed in a session.

Physicians/Doctor's Offices Your medical doctor may have been involved in referring you for therapy, may have prescribed medication for you, or may be considering prescribing medication.Thus, it may be important to coordinate with your doctor or doctor's office regarding your progress or status, especially when medication is involved or there are other health issues. Again, your permission will be required for such a consultation to occur and it will be important to discuss in therapy what information will be disclosed, especially since some information can be disclosed to a doctor that is not disclosed to your parents. The only time information can be shared with your medical doctor without your permission is if you are engaged in harmful or risky behavior that creates a concern about safety.

By signing below, I acknowledge that I have read this Agreement and the Notice of Privacy Practices and agree to their terms. If you have any questions or concerns regarding any of this material, please contact your therapist.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date

_____ _____

Lauren K. Dawood, MA, LPC, NCC Date

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Professional Disclosure Statement

Below you will find my credentials, background, training, and information about by treatment and policies. Please read and sign below once you have reviewed and/or recieved a copy for your records.

Education and Credentials
I hold a Master of Arts in Mental Health Counseling from Campbell University (2013), as well as a Bachelor of Science in Psychology from Campbell University (2011). I have gained a vast amount of experience through my Master's program, and Supervised Professional Practice and have been practicing for nearly 5 years now. I am Licensed Professional Counselor (#10647) in North Carolina, as well as a National Certified Counselor.

Counseling Background
I have experience working with a variety of populations including children, teenagers, adults, families and couples, facing a variety of issues. Some areas that I have experience with are Academic Concerns, Anger Management, Anxiety,Behavioral Issues, Bipolar Disorder/Mood Disorders, Borderline Personality Disorder, Career Counseling, Codependency, Coping Skills, Communication Issues, Depression, Emotional Disturbances, Family Conflict, Grief, OCD, Relationship Distress, Parenting Skills, Self-Esteem Issues, Self-Harm, Sleep Concerns, Spirituality, Suicidal Ideation, etc. My counseling philosophy includes an integrative approach based on Person-Centered, Cognitive-Behavioral, Dialectical-Behavioral, Solution-Focused, and Creative/Expressive Theories.

Use of Diagnosis
In diagnosing clients, I refer to the Diagnostic and Statistical Manual, Volume 5; this diagnosis becomes part of your permanent record, and will serve as a guide to how we go about treatment. It is beneficial for the client to understand that a diagnosis is usually required for insurance billing purposes. Insurance companies may also ask for copies of the current treatment plan based on client's diagnosis.

Confidentiality
Your care and confidentiality are always my top priority. I am legally obligated to keep our communications in the strictest of confidence. I highly respect the sharing of your emotions and personal concerns, and will uphold your privacy. Please do note that any and all of our communication may become part of your clinical record.
1) Clients or legally appointed representatives have signed a Release of Information allowing specific information to be exchanged with an identified third party.
2) In the case of clinical supervision, with a counseling supervisor.
3) Clients have revealed and have intent of suicidal/homicidal thought and/or behaviors.
4) A court has ordered the release of confidential information without client consent, at which request the counselor is ethically bound to ask the court to disallow disclosure due to potential harm for a client or counseling relationship.
5) The counselor has legitimate reason to suspect or believe that a child (or elder) is being abused, at which time it is my ethical and civic duty to report such abuse to the proper authorities.

Length of Sessions
Each session will last approximately 45-60 minutes (depending on your insurance) and cannot be extended. It is important that the sessions begin and end at the scheduled time because there will be others waiting to be seen at their scheduled time. Please note that if you are late, the session will not be extended, and you will be responsible for the full payment. It is important that you are on time and consistent with appointments in order to work together successfully.

Cancellations
If you must cancel or reschedule an appointment please do so 24 hours in advance otherwise, you will be charged a $65 cancellation or no-show fee for the session. Repeated cancellations in less then 24 hours may result in discontinuation of therapy services. Your therapist will consider personal emergency circumstances.

Fees/Methods of Payment
All services provided will be reimbursed through Blue Cross, various third party insurances and Out of Network, at defined Rates of $100-$120 per hour for Individual sessions, $50 per group session, $130 per assessment. If you are not using insurance we will work out an out of pocket arrangement. Client is responsible for co-pay, and/or co-insurance based on Insurance benefits. A Sliding Scale rate is also available at defined rates of $35-$85 depending upon of household income and number of dependents. The agreed upon rate will be _____ per session. Payment is accepted in the form of Cash, Credit/Debit Card or Check.

Complaints
I abide by the ACA Code of Ethics http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf . Should you feel I am in violation of any of these codes of ethics, you are encouraged to discuss any concerns with me, however, you may file a complaint against me with the North Carolina Board of Licensed Professional Counselors, contact information below:

Acceptance of Terms: We/I agree to these terms and will abide by these guidelines.

_____
Patient Name

_____ _____
Patient Signature Date

_____
Printed Name of Responsible Party if Applicable

_____ _____
Responsible Party's Signature (if patient's under 18) Date

_____
Printed Name of Responsible Party if Applicable

_____ _____
Responsible Party's Signature (if patient's under 18) Date

_____ _____
Lauren K. Dawood, MA, LPC, NCC Date
Bull City Safe Space Counseling, PLLC

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Financial Agreement

I _____(parent/client), agree to pay the co-pay, deductibles, co-insurance, and any past-due balance that may occur on my/my child's account that are not covered by my/their insurance benefits. I will be expected to pay by check, cash, or credit card. I further understand that if I want Bull City Safe Space, PLLC to file claims with my/my child's insurance company, that I am responsible for providing accurate insurance information, verifying my/my child's benefits with the insurance company, and understanding the limits of my/my child's coverage.

I agree to get preauthorization if it is required by my/my child's insurance company. I understand that I am expected to notify Bull City Safe Space Counseling, PLLC of any changes in insurance coverage. I agree that I will be responsible for any services and charges that are not covered in my/my child's insurance plan. I understand that any checks returned to Bull City Safe Space Counseling, PLLC are subject to an additional fee up to $25 to cover bank fees that are incurred.

In order to file your/your child's insurance for you/your child, please review the following items and check that you agree with each one:

- ▢ I authorize the use of this form on all my/my child's insurance submissions and permit a copy to be used in place of the original.
- ▢ I authorize release of information to all my/my child's insurance carriers.
- ▢ I understand that I am responsible for my/child's bill and that any outstanding bills will be sent to the billing address I have provided.
- ▢ I authorize Bull City Safe Space Counseling PLLC to act as my/my child's agent in helping me/my child obtain payment from my/my child's insurance carriers.
- ▢ I authorize payment directly to Bull City Safe Space Counseling PLLC and hereby assign my right to reimbursement for the services rendered to this practice.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date
_____		_____
Lauren K. Dawood, MA, LPC, NCC		Date

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Electronic Communication Contract

As a client at Bull City Safe Space Counseling, PLLC, I understand that I have access to my therapist's e-mail address & phone number; however, I understand that my therapist will only respond to e-mails and/or text messages regarding appointments, scheduling, & billing/payment. All other topics shall be discussed ***in-session*** only. Therapy is most effective when done face-to-face, therefore your therapist will not respond through email or text-message with any clinical advice, therapeutic suggestions, or engage in any other type of dialogue. I also understand and agree that I will not report any kind of emergency situation through e-mail or text-message, as this is not an appropriate way to report time-sensitive information.

As a client, you are welcome to send information to your therapist through e-mail or text message; however, this is your choice, as your therapist will not provide response electronically, but through a phone call or in person at a session. E-mails and text messages are not confidential, therefore, sharing personal details, and engaging in therapeutic conversation is unethical based on the American Counseling Association's Code of Ethics. Please understand that this contract is composed and used, for your safety, as a client.

By signing below, I **agree to**, and **understand** the purpose of this contract and how it benefits my care coordination, overall well-being and safety, as recommended by my therapist.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date
_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date

_____ _____

Lauren K. Dawood, MA, LPC, NCC — Date

Bull City Safe Space Counseling, PLLC

BULL CITY
SAFE SPACE
COUNSELING

Child/Adolescent History
18 years and under

Parent and/or child/adolescent, please fill this out to the best of your knowledge and/or fill this out with your child, to gain the most accurate answers.
Client Name: _____ Age: _____ Gender Identity/Sexual Identity _____
School Grade: _____ Name of Current School: _____

Please check if you experience any of the following:

▢ Feeling sad, blue, depressed	▢ Poor concentration	▢ Gained/lost weight
▢ Change of appetite	▢ Crying spells	▢ Feel tired a lot
▢ Don't enjoy things	▢ Problems with sleeping	▢ More irritated than usual
▢ Feel bad about self	▢ Hyperactivity	▢ Self-Injury
▢ Headaches	▢ Seizure	▢ Stomach Problems
▢ Dizziness	▢ Sweating	▢ Backache
▢ Shortness of Breath	▢ Pins and Needles/Tingling	▢ Vomiting/Diarrhea

Check the Appropriate Answer:

▢ Yes ▢ No Do you think about hurting or killing yourself?

▢ Yes ▢ No Do you think about hurting or killing anyone else?

▢ Yes ▢ No Do you feel anxious, nervous or stressed?

▢ Yes ▢ No Have you ever been so anxious that you had trouble breathing?

▢ Yes ▢ No Are you deathly afraid of anything?

▢ Yes ▢ No Is there anything that you think about a lot of the time?

▢ Yes ▢ No Is there anything that you do (checking locks, washing hands, cleaning things, etc.) a lot more than others?

▢ Yes ▢ No Are there times when your mind races and you feel out of control?

▢ Yes ▢ No Do you smoke? (marijuana, cigarettes, other)

▢ Yes ▢ No Do you drink alcohol?

▢ Yes ▢ No Do you use recreational drugs?

▢ Yes ▢ No Has your family ever been upset because of your drinking or use of drugs?

▢ Yes ▢ No Have you ever been in trouble with school officials or the police because of your drinking or use of drugs?

▢ Yes ▢ No Have you ever run away from home?

▢ Yes ▢ No Have you ever been picked up by the police?

▢ Yes ▢ No Have you ever been or are you currently sexually active?

▢ Yes ▢ No Have you ever experienced any type of abuse?

▢ Yes ▢ No Do you have any health problems?

▢ Yes ▢ No Are you having trouble getting along with your parents?

▢ Yes ▢ No Have you ever experienced any type of unexpected traumatic event?

▢ Yes ▢ No Have you lost a parent through death?

▢ Yes ▢ No Would you like to include religious beliefs and thoughts in the counseling process?

▢ Yes ▢ No Are there relationship matters that concern you?

▢ Yes ▢ No Are there any sexual matters that concern you?

▢ Yes ▢ No Do you have difficulty with grades or school?

▢ Yes ▢ No Do you have any concerns about friends or classmates?

When was your last physical? _____

List any health problems you have: _____
_____
_____

List medications/dosage/frequency: _____
_____
_____

Any previous mental health diagnosis?
_____
_____

Any previous therapy experience? If yes, please explain reason for treatment and outcome.
_____
_____

Any prior hospitalizations for psychiatric reasons?
_____
_____

Other information you would like to share:
_____
_____

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Authorization for Release of Information

I, _____ (client/guardian), hereby authorize the release and exchange of information specified below between Bull City Safe Space Counseling, PLLC and:

Name of Person and/or Organization to share information with:

_____

Phone #: _____ Fax #: _____ Email: _____
Address: _____

Client Name:_____ DOB: _____

Purpose of the disclosure authorized (as specific as possible):
▢Coordination of Care ▢ Referral ▢ Payment ▢ Utilization Management ▢ Other _____

Data may be released in written, verbal, or electronic form and may include copies of the following information:
(Please check all applicable information, enter NA if not requested)

▢ Psychiatric Evaluation
▢ General Progress in Treatment
▢ Service Plan/PCP
▢ Discharge/Transfer Summary
▢ Presence/Participation in TX
▢ Alcohol or Substance Abuse History and TX
▢ Diagnosis
▢ Psychological/Educational Testing
▢ HIV/AIDS History and TX
▢ Labs and Special Tests as Indicated
▢ Collection of Fees/Payment
▢ Continuing Care Plan
▢ Medication History/Physician Orders
▢ Other: _____

This Authorization For Release Of Information has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is voluntary, and I have the right to have this Release reviewed by a third party or independent counsel. Further, I understand that this consent shall expire twelve (12) months from the date below and must be reauthorized at that time. I understand that I have the right to revoke this authorization at any time by sending written notice to Bull City Safe Space Counseling, PLLC..

_____ _____
Client Name & Signature Date

_____ _____
Name & Signature of Parent/Legal Guardian or Personal Representative Date

_____ _____
Therapist Name & Contact Info: Lauren K. Dawood, MA, LPC, NCC Date
P: 919.887.9502 F: 919.882.0980 Lauren@bullcitysafespace.com