

**ANGELA S. McLEAN**  
*Licensed Marriage and Family Counselor*

(Please Print)

**PATIENT REGISTRATION SHEET**

Today's Date:		
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**PATIENT INFORMATION**

Last Name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Street Address:	City:	State:	ZIP Code:
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Home phone no.: (    )	Cell/Other contact no.: (    )	Social Security no.:	Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Employer:	Occupation:	Work phone no.: (    )
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Street Address:	City:	State:	ZIP Code:
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Referring Doctor (if required by insurance):	
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Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Primary Care Physician	Contact no.: (    )
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**IN CASE OF EMERGENCY**

Emergency Contact Name:	Home phone no.: (    )	Cell phone no.: (    )
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**INSURANCE INFORMATION**

Insured's Last Name (if different):	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Home phone no.: (if different) (    )	Cell/Other contact no.: (    )	Social Security no.:	Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Insurance Company:	Insurance Billing Address:	Insurance phone no.: (    )
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Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
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**SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**

Insurance Company:	Insurance Billing Address:	Insurance phone no.: (    )
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Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also Angela S. McLean, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

**\* PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Client History and Consent for Treatment**

Has your child ever had counseling before? <input type="checkbox"/> yes <input type="checkbox"/> no	How long ago and with whom? <input type="checkbox"/> n/a
Current mental health medication(s): <input type="checkbox"/> n/a	Dosage(s): <input type="checkbox"/> n/a
Any family history of mental health challenges <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	Please explain:
Have your child ever attempted suicide or tried to seriously harm someone else? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you concerned about your child harming him/herself or someone else? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure
Do you suspect alcohol or non-prescription drug use? <input type="checkbox"/> yes <input type="checkbox"/> no	What type of use do you suspect?
Has your child ever been physically or sexually abused? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Age:
Does your child have any significant medical conditions? <input type="checkbox"/> yes <input type="checkbox"/> no	Describe:
Has your child's eating/sleeping changed in the past six months? <input type="checkbox"/> yes <input type="checkbox"/> no	Describe:
What are some of your ideas/your child's ideas of goals for counseling? (list below)	
1.	
2.	
3.	

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**CHILDREN/TEEN Symptom Checklist**

<input type="checkbox"/> Headaches	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Heart beats fast	<input type="checkbox"/> Sweaty/clammy hands
<input type="checkbox"/> Unattractive	<input type="checkbox"/> Nervous	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Fearful
<input type="checkbox"/> Bored	<input type="checkbox"/> Want to hurt self	<input type="checkbox"/> Eating problems	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Restless	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Depressed/low mood	<input type="checkbox"/> Naïve
<input type="checkbox"/> Timid	<input type="checkbox"/> Sexual problems	<input type="checkbox"/> Boyfriend/girlfriend partner problems	<input type="checkbox"/> Can't concentrate
<input type="checkbox"/> Nightmares/Terrors	<input type="checkbox"/> Financial stress	<input type="checkbox"/> Empty feelings	<input type="checkbox"/> Regrets over past
<input type="checkbox"/> Very tired	<input type="checkbox"/> Sleeping too much	<input type="checkbox"/> Shy	<input type="checkbox"/> Low grades in school
<input type="checkbox"/> Can't finish things	<input type="checkbox"/> Stressed	<input type="checkbox"/> Others cause me problems	<input type="checkbox"/> Worthless
<input type="checkbox"/> Confused	<input type="checkbox"/> Fainting/dizziness	<input type="checkbox"/> Stupid	<input type="checkbox"/> Evil
<input type="checkbox"/> Developmental Challenges	<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Drug use	<input type="checkbox"/> Controlling
<input type="checkbox"/> Few/no friends	<input type="checkbox"/> Disturbing or violent thoughts/ideas	<input type="checkbox"/> Stomach aches	<input type="checkbox"/> Feel Guilty
<input type="checkbox"/> Lonely	<input type="checkbox"/> Panic	<input type="checkbox"/> Mean toward others	<input type="checkbox"/> Not loved
<input type="checkbox"/> Trembling/Shaking	<input type="checkbox"/> No one understands me	<input type="checkbox"/> Not as good as others	<input type="checkbox"/> Can't relax
<input type="checkbox"/> Stressful home	<input type="checkbox"/> Fighting	<input type="checkbox"/> Mind won't relax	<input type="checkbox"/> Trauma/Scary event
<input type="checkbox"/> Have to count/repeat things	<input type="checkbox"/> Want to hurt others/someone else	<input type="checkbox"/> Divorce/separation	<input type="checkbox"/> Bullied at school
<input type="checkbox"/> Family problems	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Criticize too much	<input type="checkbox"/> Spiritual concerns
<input type="checkbox"/> Spending problems	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Running away	<input type="checkbox"/> Anger
<input type="checkbox"/> Pornography	<input type="checkbox"/> Gambling	<input type="checkbox"/> Gang involvement	<input type="checkbox"/>
<input type="checkbox"/> Health concerns	<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Gifted	<input type="checkbox"/> Gay/Lesbian/Gender challenges
Other concerns:			

By checking the boxes and signing below, I agree to the following:

- I choose to receive a Clinical Assessment and/or outpatient therapy from Angela S. McLean, LMFT and consent to treatment.  
 The information above is accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Admin: \_\_\_\_\_ Date: \_\_\_\_\_

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Client Name:

DOB:

FINANCIAL AGREEMENT

	Client Billing Address	Guarantor Name/Address, if different
Street:		
City:		
State/Zip:		
County:		
Phone:		
Insurance:	Name	Policy #
Insurance:	Name	Policy #

For Medicaid/Health Choice clients: My child has not seen another outpatient therapist in the last year. (initial)\_\_\_\_\_

For Medicaid/Health Choice clients: I or my child do not have any other insurance besides Medicaid/Health Choice. (initial)\_\_\_\_\_

TERMS

1. I, \_\_\_\_\_, certify that the above information is correct and complete.

2. FEES FOR SERVICES: **I AM RESPONSIBLE FOR THE FULL COST OF THE SERVICES.** I understand that the amount I actually pay may be reduced by the amount paid by insurance. My per session cost will be \$ \_\_\_\_\_. I understand that when using insurance, the initial payment agreement is an estimate based on benefits information provided by my insurance company and is subject to change.

3. CHANGES: I agree to notify Angela S. McLean, LMFT of changes in my insurance or Medicaid coverage or county of residence.

4. ASSIGNMENT OF INSURANCE:

- I understand that if my insurance/third party listed does not assign benefits to Angela S. McLean, LMFT, I will be responsible for filing my own insurance. In this case, I am responsible for the full cost of services.
- I understand that if my insurance company requires that a doctor supervise services I receive, this may prevent payment for certain services.
- I understand that if Angela S. McLean, LMFT is not a listed provider of services for my insurance/third party, a claim may not be paid.
- If my insurance/third party requires pre-certification, I am responsible for obtaining authorization prior to or at the time of services. Failure to do so will result in benefits being reduced or denied.

5. AUTHORIZATIONS:

- I authorize use of this form on all my insurance submissions. I authorize release of any information from my medical record to my insurance company and authorize Angela S. McLean, LMFT to act as my agent to obtain payment from my insurance company.
- I authorize payment directly to Angela S. McLean, LMFT and hereby assign right to reimbursement for services rendered by Angela S. McLean, LMFT.
- I permit a copy of this authorization to be used in place of the original.

6. APPOINTMENTS: I agree to notify my service provider at least 24 hours in advance if I cannot make a schedule appointment. If I fail to do so, a charge may be applied.

7. REFUSAL TO PAY: I understand that if I am able to pay for services either in full or through payments, but refuse to do so, my account may be turned over to a collection agency and/or the courts.

8. I understand that fees for services and/or fee policies are subject to change.

BY SIGNING THIS DOCUMENT, I FULLY ACCEPT AND UNDERSTAND THAT  
 THE ABOVE TERMS OF PAYMENT ARE MY RESPONSIBILITY.

Client/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

# **ANGELA S. McLEAN**

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## **Professional Disclosure Information**

I am pleased you are coming to me for professional counseling. The following information is to orient you to my counseling practice and to assist you with understanding my policies and procedures. *Please read this document closely. If you have any questions or need clarification on anything you find here, please let me know.*

**Education and credentials:** I am a Licensed Marriage and Family Therapist. I have been working in the social work/mental health field for over 12 years. I received a Bachelor's of Science in Social Work from Trevecca Nazarene University. In addition, I also obtained a Masters in Marriage and Family Therapy from Trevecca Nazarene University in 2005 and received my license in 2008. I am a member of the American Association of Marriage and Family Therapists and adhere to their ethical standards.

**Services offered:** My practice serves adults, adolescents, and children. I offer clinical assessment, individual and group counseling services, marital/couples counseling, family counseling, and parenting consultation/education. If the problems you or your family experience is outside of my expertise, I will assist you with appropriate referrals to other professionals.

**Counseling process:** The first step in the counseling process involves a thorough assessment and evaluation. This is achieved by asking detailed questions about presenting problems and occasional completion of a symptom checklist. Additionally, questions are asked about family history. Screening devices may be used to assist me with obtaining an accurate assessment. The second step is the development of a treatment plan. The treatment plan is based on the assessment data gathered in step one as well as your input. Agreed upon goals and interventions are then established. The third step is putting the plan into action. We will work collaboratively to reach the agreed upon goals of treatment.

**Counseling approach:** As a marriage and family therapist I work with clients individually as well as with couples and families. Whenever possible, all family members living in the home and/or those concerned with the problem are invited to sessions to better assess each individual's perspective on the problem. After the initial assessment is complete, a decision will be made with you as to whether individual or family treatment will best serve your needs. All treatment will be strength based and focus on obtainable goals. Family therapy often focuses on solving family problems and building stronger relationships. Individual therapy may include skills building and will typically operate using a solution-focused model. Parenting consultation is also a common approach and often focuses on effective behavioral techniques.

I only provide treatment that is voluntary and with your consent, and you have the right to refuse any service. Although I engage in treatment that is research based and practiced, please note that I cannot guarantee specific treatment results. The counseling relationship is one that requires time, motivation, and dedication. The duration of counseling services is dependent primarily on the presenting issues. In addition, counseling is most effective when sessions take place on a consistent basis. I generally meet with clients once weekly, but other arrangements may be made if necessary. I treat many clients on a short-term basis, yet I also service clients who have more chronic mental health issues that require longer term therapy.

**A Note About My Colleagues in This Office:** Please be aware that I work closely with two colleagues Bonnie Fitts, LPC of Wake Counseling Associates, PLLC and Jessica Waugaman, LCSW of Capital Counseling & Consulting, PLLC. We share office space and administrative staff as well as the responsibility of getting the word out to the community about the services that each of us provide. Additionally, because of our confidence in one another and the convenience to our clients, we often work together on cases and refer to one another. However, Angela S. McLean, LMFT operates as an independent business owner and has no legal or business relationship with the other therapists operating out of this location.

**Counseling fee and insurance reimbursement:** Should you wish to use an insurance policy for counseling services, I ask that you contact your insurance company to inquire about specific policies and procedures for mental health services. I am a provider for *some* insurance and managed care companies. I will gladly provide a receipt for you should you wish to obtain reimbursement from insurance companies I do not contract with. You

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should understand that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. This diagnosis, once established, will become part of your permanent record (see confidentiality below). Should you wish to pay out-of-pocket for treatment, my counseling fee is \$95.00 per 50 minute session, payable at each visit, with the exception of the initial session fee, which is \$120.00 and generally 75 minutes in length. Please see my Financial Agreement Form and attached schedule of fees for more information about fees and insurance.

**Office Hours, Appointment Scheduling, and Cancellation policy:**

Sessions are scheduled on an appointment basis only Tuesdays - Fridays between the hours of 11:00 am and 7:00 pm. These nontraditional business hours are designed to better meet the needs of my clients. Please be aware that every effort is made to accommodate all client schedules. However, certain scheduling constraints outside of my control and the needs of other clients are also a factor in scheduling, so I ask clients to be as flexible as possible. After each appointment your next appointment will be scheduled. Please take time to review your schedule and be sure that you reserve a time specifically for your therapy. You may choose to schedule your therapy at the same time every week so that a specific slot is held for you weekly unless otherwise discussed. If you choose this option, your appointment is scheduled unless you call to cancel. Appointment confirmation calls are given as a courtesy when you first start therapy but not typically given for established clients. Please make arrangements for yourself to assure you will not forget your scheduled appointment.

As part of my effort to accommodate the schedules of all my clients, I provide evening appointments scheduled between the hours of 4:00-7:00. These appointments are in high demand, and I generally have a waiting list for these slots. Therefore, clients that are holding these slots are asked to be especially vigilant about keeping their appointments. If clients holding an evening slot misses/cancels more than 2 appointments in a 6 week period, they may be asked to move up to a daytime slot and be placed on the waiting list until another evening slot becomes available.

I will always strive to be on time for your appointment, but as with any medical office there will be circumstances that will on occasion prevent this from happening. There are many crises that can occur in a therapy office that are unpredictable and often of an emergency nature, therefore we respectfully request your patience and understanding if such a situation affects your appointment time. If for some unforeseen reason you cannot be on time for your appointment, please advise the office as soon as possible and we will attempt to accommodate you or reschedule you appointment. If you are going to be only 10-15 minutes late due to traffic or that type of delay we understand that those things are unavoidable.

With the exception of a life threatening emergency, I ask that you give at least a 24-hour notice should you need to cancel or reschedule an appointment. Please understand that when you fail to show for an appointment, or cancel at the last minute, you are taking away valuable time that could be used for another client in need. \$ 50 is due per broken appointment visit. This applies to private pay patients, patients with traditional insurance, and those with managed care who failed to keep an appointment or who wish to change an appointment with less than 24 hour notice. Although the Broken Appointment fee does not apply at this time for Medicaid and Health Choice clients, please be aware that a 24 hour notice for cancelations is still required. Please keep in mind the importance of this policy in order for the office to continue to run and help yourself as well as others. Remember that this policy is not meant to antagonize or upset patients, nor is it designed to be a hardship or burden on them. Its purpose is to minimize our unproductive time and to develop responsible patients for whom it is our pleasure to serve.

**Confidentiality:** Upon opening your case, I will create a file that contains all information provided by you, as well as my own documentation. This file will be kept in strict confidence, and you have the right to review your file with me if you so choose. Should I wish to obtain or share information with other professionals about you for treatment purposes, I will discuss this with you and ask for your written consent to do so. Please note that you have the right to full confidentiality with exception of the following circumstances:

\_ Confidentiality will be broken if disclosure is necessary to prevent clear and imminent danger to yourself or another.

**ANGELA S. McLEAN**  
*Licensed Marriage and Family Counselor*

This includes verbal statements that you may make to seriously harm yourself or another person.

\_ Confidentiality will be broken if I suspect child neglect or abuse.

\_ Confidentiality will be broken if I am made aware that you have a communicable and fatal disease and that you have willfully exposed an identified third party to it.

\_ Confidentiality may be broken should I feel it would be helpful for me to obtain consultation or supervision with another licensed mental health professional about your case. The purpose of clinical consultation is to provide you with the best quality care by consulting with other experts in the field. If this occurs every effort will be made to not give identifying information and the other professional is also bound by confidentiality.

\_ Confidentiality may be broken in a court of law. If information is requested in a court of law and you do *not* wish for me to release information, I will request to the court that confidentiality be maintained to protect your right to privacy. If I am *ordered by a judge* to release information, then I am legally bound to release information and will only release the *minimal* amount of information required in order to protect your privacy.

\_ Confidentiality may not be maintained if you are using an insurance company to pay for services, as explained above. I will be as brief as possible with giving your insurance company information about you in order to protect your privacy.

\_ Confidentiality may not be maintained should you become delinquent with payment owed for services. The services of a collection agency and/or small claims court may be used to collect delinquent fees. Only the *minimal* amount of information about you would be released in this case, including your name, service dates and amount due.

\_ Administrative and billing/accounting staff will have access to your information as needed to complete their assigned tasks. All staff members have signed confidentiality agreements.

\_ In group counseling services facilitated by me, the importance of confidentiality will be discussed in the first group session with all group members. It is important for you to understand, however, that although I will maintain your confidentiality, I cannot guarantee all members of the group will do so.

**CLIENT RIGHTS:** HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and the attached Notice form.

**PROFESSIONAL RECORDS:** You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in your Clinical Record and I will keep this record secured for seven years. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them

**ANGELA S. McLEAN**

*Licensed Marriage and Family Counselor*

in my presence. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

**Emergencies:** Should you have a mental health emergency and are not able to reach me, please go to your closest hospital emergency room, contact your primary care physician, or contact Holly Hill / Respond Hospital at (919) 250-7000, 3019 Falstaff Road, Raleigh, NC 27610. Crisis staff at Holly Hill is available 24 hours a day to assist you by telephone or at the facility. For life threatening emergencies please call 911.

**Comments about service:** Your comments about your experience in counseling are very important to me. I encourage you to immediately speak with me about any concerns or grievances you may have regarding your experience in counseling. If we cannot resolve the issue to your satisfaction, you may express your concerns to my licensing board at:

**NC Marriage & Family Licensure Board (NCMFTLB)**  
**PO Box 37669**  
**Raleigh, NC 27627**

**Schedule of Fees**  
**(Current as of February 1, 2010)**

Service	Fee
New Client-Intake session (Adult)	120.00
New Client-Intake session (Child or Teen)	120.00
Established Client-Psychotherapy-50 minute session	95.00
Established Client-Psychotherapy-75 minute session	120.00
Established Client-Psychotherapy-90 minute session	140.00
Couple/Family Therapy with child present – 50 minute session	95.00
Couple/Family Therapy without child present – 50 minute session	95.00
Group Therapy-60 minute session	40.00
Comprehensive Mental Health Assessment	350.00
Computer Testing and Interpretation-per hour	75.00
School or other out-of-office visit (+25.00 travel)	115.00
Team Conference-School or Clinician (+25.00 travel)	115.00
Telephone Consultations (greater than five minutes)	75.00
Missed Appointment	50.00
Court-related services (charged in increments of 4 hours, as well as portal to portal)	350.00
Returned check fee	20.00
Outstanding balance/late fee (per month; over 45 days)	35.00

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**Agreement Regarding Child Psychotherapy**

This agreement is made between the client's parents and Angela S. McLean, LMFT. We, the parents of:

\_\_\_\_\_ (print child's name) understand and agree to the following:

We understand that communications between the child and the therapist are confidential, subject to the limitations specified below. We understand that certain limitations to confidentiality will apply according to North Carolina State Law in which the therapist has the duty to report information concerning suspected child abuse, which include sexual abuse, physical abuse and neglect. The clients and the therapist acknowledge that once such allegations are reported, the therapy can still continue if all parties agree. We agree to fill out all client forms provided prior to the intake appointment as well as this form before meeting with Angela S. McLean, LMFT so that we are clear about client confidentiality and guidelines. We understand that Angela S. McLean, LMFT will inform the parents of the general goals and progress of treatment, either by a brief summary to all parents or through a parent-therapist session and that parents will be provided with a general understanding of the main content issues of the therapy. However, the child is given the right to confidentiality, in that, specific issues discussed may not be communicated to the parents if it is deemed best to maintain the child's privacy or if the therapist is requested by the child to do so (that remains under Angela S. McLean, LMFT's discretion). The exception would be if I believe that the child is in danger or is a danger to someone else. In such a case, I will notify the parents of my concern and the law requires me to report this to the proper authorities. Before giving parents any information, I will discuss the matter with the child or teen, if possible, and do my best to handle any objections he/she may have. Communication about therapy other than scheduling can only take place in Angela S. McLean, LMFT's office, not through phone calls, texts, or emails unless an exception is specifically discussed in session.

Therapy with children of divorced families requires consent from one or both parents depending on the terms of the custody agreement. A copy of this agreement may be required in order to insure that the proper consents needed according to law have been obtained. If I am the noncustodial parent, I will respect the therapeutic relationship between my child and Angela S. McLean, LMFT, and will accept reasonable recommendations about family sessions, waiting for my child's readiness to engage in therapeutic conversation as directed by Angela S. McLean, LMFT. We agree that we will not call Angela S. McLean, LMFT as a witness in any legal action having to do with the issues discussed in this treatment. However, Angela S. McLean, LMFT may be willing to discuss the therapy with a court ordered Special Master, Parent Coordinator or court ordered Custody Evaluator, to provide information and opinions which might be helpful to such a professional in determining the best interests of the child. We understand and agree that although any previously completed evaluations, psychological summaries or reports may have been the subject of testimony or court proceedings, the psychotherapy sessions now being agreed upon shall be confidential and not made subject of testimony or of a subpoena for court purposes to produce any written documents which may be prepared during the course of psychotherapy. We agree to this to protect the confidential nature of our child's therapy sessions and help our child progress and resolve conflicts.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Angela S. McLean, LMFT

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**Health Insurance Portability and Accountability Act (HIPPA)  
Consent to Disclose Information for Treatment, Payment, or Health Care Operations  
& Acknowledgement of Privacy Practices**

I hereby consent to the use or disclosure of my individually identifiable health information (“protected health information” or PHI), excluding psychotherapy notes, by provider Angela McLean, LMFT in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except on special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my mental health records, although I understand that the provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a “reviewing official.” A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my mental health record, although I understand the provider has the right to deny such a request. I have the right to request an accounting of disclosures of my PHI for purposes other than TPO and those for which I provided authorization. I may submit a written privacy complaint to the address below or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the provider against me and without any change in my treatment.

The provider reserves the right to change the terms of its Notice of Privacy Practices at may time. If the terms are changed, I may obtain a copy of the revisions by requesting a copy.

I retain the right to request that the provider further restrict how my PHI is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required to agree to such requested restrictions; however, if the provider does agree to by requested restriction(s), such restrictions are then binding on the provider.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to the provider in writing. The revocation shall be effective except to the extent that the provider has already taken action in reliance on the Consent.

The provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the provider is required by law to treat individuals). If I (or authorized representative) sign the consent portion and then revoke consent, the provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the provider is required by law to treat individuals).

I:                   \_\_\_ CONSENT \_\_\_ DO NOT CONSENT  
TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH  
CARE OPERATIONS.

I:                   \_\_\_ HAVE                   \_\_\_ HAVE NOT  
HAD THE OPPORTUNITY TO REVIEW THE PROVIDERS NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
Signature of Client (or authorized representative)

\_\_\_\_\_  
Please print name of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider, Angela McLean, LMFT

\_\_\_\_\_  
CLIENT