Jennifer Farmer, L.P.C.
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jennifer@jenniferfarmerlpc.com

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ **Date of birth:** _____

Your name: _____
Last **First** **Middle Initial**

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work Phone:** _____
Home Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions: _____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

****

I, _____ (client), hereby authorize _____ (therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

(1) _____
(2) _____
(3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____
_____

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at Therapist's Address to be effective.

Client's Signature:_____ Date: _____

Parent's/Legal Guardian's Signature:_____ Date: _____

Therapist's Signature:____ Date: _________

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office and will be kept on my password protected computer in an encrypted file format. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. Georgia and Florida have a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private

information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Professional Relationship

Our relationship must be different from most other relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. To offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

There is another dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. My passion is not in forensic work but in providing you with the best therapeutic care possible. Therefore, by signing this document, you acknowledge that I will be providing therapy only and not forensic services. You also understand that this means I will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities. However, if for some reason I am compelled to testify to a court of law, I will require an upfront retainer of $3,000.00, and my billing rate will be $500.00 per hour, plus you agree to be responsible for the reasonable attorney fees I am charged by my counsel. Additionally, if I receive a valid subpoena to produce or a valid request for production of documents, I will need to charge you reasonable and customary fees based on state and Federal guidelines of $1.00 per page or maximum allowed by law to produce those records. If a summary of treatment is accepted instead of the entire set of records, I charge my prorated hourly rate for the time to produce this summary. I will also need to charge you the reasonable attorney fees associated with that production, which will take place by and through my counsel's office to preserve your confidentiality.

Additionally, since therapists are required to keep the identity of their clients confidential, for your confidentiality, I will not address you in public unless you speak to me first. I must also decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the ***American Mental Health Association***. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For

example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

For the safety of all my clients, their accompanying family members and children, I maintain a zero tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates my weapons policy.

TeleMental Health Statement

TeleMental Health is defined as follows:

> "TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health (certification on file). I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Please initial that you have read this page _____

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize HIPPA-compliant Zoom Professional. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Zoom is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize IvyPay or Square as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or

the credit cardholder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Jennifer Farmer.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number.

If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

- ☐ Texting
- ☐ Email
- ☐ Video Conferencing
- ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Communication Response Time

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls, texts, or email within 24 hours. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call Ridgeview Institute at 770.434.4567 or local hospital

Please initial that you have read this page _____

- Call Peachford Hospital at 770.454.5589 or local hospital
- Call or text 988 Suicide Prevention & Crisis Line
- Call 911.
- Go to the emergency room of your choice.

If we decide to include TeleMental Health as part of your treatment, there are additional procedures that we need to have in place specific to TeleMental health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform me of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

Structure and Cost of Sessions

Based on your treatment needs, I may provide face-to-face, phone, text, email, or video conferencing). The structure and cost of both in-person sessions and TeleMental Health is $150 per 50 minute session, and $200 per 75 minute session, unless otherwise negotiated by your insurance carrier. The fee for each session will be due at the conclusion of the session. Cash, Visa, MasterCard, Discover, American Express, FHA, HSA or Zelle are acceptable for payment, and I will provide you with a detailed receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you.

Your credit card will be charged at the conclusion of each TeleMental Health interaction. **Again, this includes any therapeutic interaction other than setting up appointments.**

Insurance is not accepted, but I will provide a superbill that you may file on your own.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Our Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you. Please note that this updated "Information, Authorization & Consent to Treatment" replaces any previously signed informed consents.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please initial that you have read this page _____

Client Name (Please Print)	**Date**

Client Signature

For minors, if applicable:

Parent's or Legal Guardian's Name (Please Print)	**Date**

Parent's or Legal Guardian's Signature

Parent's or Legal Guardian's Name (Please Print)	**Date**

Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that they have discussed this form with you and has answered any questions you have regarding this information.

Therapist's Signature	**Date**

Please initial that you have read this page _____

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Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: *JENNIFER FARMER, L.P.C.* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *JENNIFER FARMER, L.P.C.* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *JENNIFER FARMER, L.P.C.* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *JENNIFER FARMER, L.P.C.* would use and/or disclose your PHI. Use of PHI means when *JENNIFER FARMER, L.P.C.* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *JENNIFER FARMER, L.P.C.* releases, transfers, gives, or otherwise reveals it to a third party outside of the *JENNIFER FARMER, L.P.C.*. With some exceptions, *JENNIFER FARMER, L.P.C.* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *JENNIFER FARMER, L.P.C.* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *JENNIFER FARMER, L.P.C.* Please note that *JENNIFER FARMER, L.P.C.* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *JENNIFER FARMER, L.P.C.* has created or maintained in the past and for any of your records that *JENNIFER FARMER, L.P.C.* may create or maintain in the future. *JENNIFER FARMER, L.P.C.* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *JENNIFER FARMER, L.P.C.'s* Notice of Privacy Practices.

IV. HOW JENNIFER FARMER, L.P.C. MAY USE AND DISCLOSE YOUR PHI: *JENNIFER FARMER, L.P.C.* will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *JENNIFER FARMER, L.P.C.* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *JENNIFER FARMER, L.P.C.* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *JENNIFER FARMER, L.P.C.* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *JENNIFER FARMER, L.P.C.* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: *JENNIFER FARMER, L.P.C.* may use and disclose your PHI to bill and collect payment for the treatment and services *JENNIFER FARMER, L.P.C.* provided to you. Example: *JENNIFER FARMER, L.P.C.* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *JENNIFER FARMER, L.P.C.* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *JENNIFER FARMER, L.P.C.'s* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *JENNIFER FARMER, L.P.C.* will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are

provided to *JENNIFER FARMER, L.P.C.* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *JENNIFER FARMER, L.P.C.* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *JENNIFER FARMER, L.P.C.*.

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *JENNIFER FARMER, L.P.C.* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – JENNIFER FARMER, L.P.C. may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *JENNIFER FARMER, L.P.C.* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *JENNIFER FARMER, L.P.C.* may make a disclosure to the appropriate officials when a law requires *JENNIFER FARMER, L.P.C.* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *JENNIFER FARMER, L.P.C.* may disclose information about you to respond to a court or administrative order or a search warrant. *JENNIFER FARMER, L.P.C.* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *JENNIFER FARMER, L.P.C.* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *JENNIFER FARMER, L.P.C.* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *JENNIFER FARMER, L.P.C.* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *JENNIFER FARMER, L.P.C.* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *JENNIFER FARMER, L.P.C.* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *JENNIFER FARMER, L.P.C.* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), *JENNIFER FARMER, L.P.C.* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *JENNIFER FARMER, L.P.C.* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *JENNIFER FARMER, L.P.C.* has a reasonable suspicion of child abuse or neglect, *JENNIFER FARMER, L.P.C.* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *JENNIFER FARMER, L.P.C.* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *JENNIFER FARMER, L.P.C.* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *JENNIFER FARMER, L.P.C.* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related

decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *JENNIFER FARMER, L.P.C.* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. **Military and Veterans:** If you are a member of the armed forces, *JENNIFER FARMER, L.P.C.* may release PHI about you as required by military command authorities. *JENNIFER FARMER, L.P.C.* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *JENNIFER FARMER, L.P.C.* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *JENNIFER FARMER, L.P.C.* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *JENNIFER FARMER, L.P.C.* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *JENNIFER FARMER, L.P.C.* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *JENNIFER FARMER, L.P.C.* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *JENNIFER FARMER, L.P.C.* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *JENNIFER FARMER, L.P.C.*'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *JENNIFER FARMER, L.P.C.* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *JENNIFER FARMER, L.P.C.* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *JENNIFER FARMER, L.P.C.* in writing of your decision. You understand that *JENNIFER FARMER, L.P.C.* is unable to take back any disclosures it has already made with your permission, *JENNIFER FARMER, L.P.C.* will continue to comply with laws that require certain disclosures, and *JENNIFER FARMER, L.P.C.* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *JENNIFER FARMER, L.P.C.*'s possession, or to get copies of it; however, you must request it in writing. If *JENNIFER FARMER, L.P.C.* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *JENNIFER FARMER, L.P.C.* within 30 days of receiving your written request. Under certain circumstances, *JENNIFER*

FARMER, L.P.C. may feel it must deny your request, but if it does, *JENNIFER FARMER, L.P.C.* will give you, in writing, the reasons for the denial. *JENNIFER FARMER, L.P.C.* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *JENNIFER FARMER, L.P.C.* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *JENNIFER FARMER, L.P.C.* limit how it uses and discloses your PHI. While *JENNIFER FARMER, L.P.C.* will consider your request, it is not legally bound to agree. If *JENNIFER FARMER, L.P.C.* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that *JENNIFER FARMER, L.P.C.* is legally required or permitted to make.

3. The Right to Choose How *JENNIFER FARMER, L.P.C.* Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *JENNIFER FARMER, L.P.C.* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *JENNIFER FARMER, L.P.C.* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

JENNIFER FARMER, L.P.C. will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *JENNIFER FARMER, L.P.C.* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *JENNIFER FARMER, L.P.C.* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *JENNIFER FARMER, L.P.C.'s* receipt of your request. *JENNIFER FARMER, L.P.C.* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *JENNIFER FARMER, L.P.C.*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *JENNIFER FARMER, L.P.C.'s* denial will be attached to any future disclosures of your PHI. If *JENNIFER FARMER, L.P.C.* approves your request, it will make the change(s) to your PHI. Additionally, *JENNIFER FARMER, L.P.C.* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *JENNIFER FARMER, L.P.C.'s* Director and Privacy Officer,

_____, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *JENNIFER FARMER, L.P.C.* made about access to your PHI, you are

entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *JENNIFER FARMER, L.P.C.* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. ***JENNIFER FARMER, L.P.C.'s*** **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 06/16/2025