Client Information

Calli's Counseling and Consultation, LLC
At Cornerstone Family Services
2993 sandy Plains RD, Suite 110 Box 4
Marietta, GA, 30066

New Client Intake

Client Name(s) ____

Date of Birth ____________ **Sex** ______**Age** ____

Parents/Guardian's Name (if Applicable) ________________________**Relationship** _______

Mailing Address ____

City ____________________ **State** _______ **Zip**___________

Home Phone ________________________ May I contact you at this number? ____________

May I leave a voicemail at this number? ________

Work Phone ______________________May I contact you at this number? _____________

May I leave a voicemail at this number? ________

Cell Phone _________________________May I contact you at this number? ____________

May I leave a voicemail at this number? ________

Occupation: ____

Education Level Completed: ____

If you are a student what school do you attend? _________________________

Person to notify in case of an emergency_________________________ **Phone**____________

I will only contact this person if I believe it is a life or death emergency. Please provide your signature that I may do so. ____

Referred By: ____

Briefly describe your presenting concerns:

____

____

____

FAMILY INFORMATION

Are you currently in a relationship? Yes or No

If yes: Married or Partnered **How long in current relationship?** _________________

Any previous significant relationships? Yes or No

Please list all the people that live in your household and your relationship to them:

Name ____ Relationship __________________ Age _______ Occupation ________________________________ Education Completed _____________________

Name ____ Relationship __________________ Age _______ Occupation ________________________________ Education Completed _____________________

Name ____ Relationship __________________ Age _______ Occupation ________________________________ Education Completed _____________________

Name ____ Relationship __________________ Age _______ Occupation ________________________________ Education Completed _____________________

Please list any family members who do not live in your house, but are important to you:

Name _________________________Relationship _____________ Age _______

Where they live _____________________ Occupation ________________________________

Education Completed _______________________

Name _________________________Relationship _____________ Age _______

Where they live ______________________ Occupation _________________________

Education Completed _______________________

Name _________________________Relationship _____________ Age _______

Where they live ___________________ Occupation ____________________________

Education Completed _______________________

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered from the following:

Depression Who? ____

Anxiety Who? ____

ADHD Who? ____

Bipolar Disorder Who? ____

Schizophrenia Who? ____

Other Who/What? ____

MEDICAL HISTORY

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

____
____
____

Current Medications Indication Dosage Frequency Side Effects Please include over-the –counter medications and vitamins

____
____
____

Past Medications Date(s) Indication Dosage Side Effects

____
____
____

Do you smoke or use tobacco? Yes or No If yes, how much per day? _______________________
Do you consume caffeine? Yes or No If yes, how much per day? _______________________
Do you drink alcohol? Yes or No If yes, how much per day/week/month? _____________
Do you use any illicit drugs? Yes or No If yes, which? ____________________________________
Do you exercise? Yes or No If yes, how often?_________________________________

PSYCHIATRIC HISTORY

Have you ever talked with a mental health professional before today? Yes or No

If yes: Date(s) Type of Treatment Reason Professional Seen

____

____

____

Would you like me to contact any of your previous providers? Yes or No

If yes, please provide their contact information

____

____

____

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues? Yes or No

If yes, please describe briefly:

____

____

____

Are you currently involved in any lawsuits, custody battles, or other legal battles? Yes or No

Is therapy part of any court mandated requirement that you are required to complete? Yes or No

Informed Consent and Authorization

Calli's Counseling and Consultation, LLC
At Cornerstone Family Services
2993 Sandy Plains Rd, Suite 110, Box 4
Marietta, GA, 30066

Informed Consent:

I am so pleased to have the honor and privilege of working with you to meet your therapy needs. The following document is designed to inform you about the type of therapy I provide, what you can expect from treatment, policies regarding confidentiality, emergencies, and other information pertinent to our work together. It is my sincerest desire to provide the best treatment possible for your individual/family needs I welcome your feedback on how I can improve your therapy experience. By signing this document we enter into an agreement that allows me Calli Cruz, LMFT to provide therapeutic services to you.

Background Information:

I earned my Bachelor's Degree in Psychology from Kennesaw State University in 2010, then earned my Master of Arts in Marriage and Family Therapy with a specialization in child and adolescent therapy from Richmont Graduate University in 2014. I earned my license in the state of Georgia in Marriage and Family Therapy in 2016 (MFT001501). The majority of my experience has been working with children and adolescents in community mental health settings, in home, as well as private practice. I have had additional trauma training and worked for a child advocacy center as well and found great joy in celebrating the resiliency and healing of my clients. I have had 3 years of experience of crisis work including working on a locked unit for adults as well as completing behavioral assessments in the ER. I am currently contracted with Cornerstone Family services to provide outpatient mental health services through my own company, Calli's Counseling and Consultation Services, LLC.

Theoretical Views

It is my firm belief that your therapy experience should be as unique as you are and I work closely with each individual or family to tailor treatment specifically to their needs. I would consider the style of therapy that I provide to be integrative meaning that I carefully draw from different perspectives to meet your needs. However, I do tend to heavily utilize a family systems, solution focused, cognitive behavioral, and Christian perspectives during my sessions. Overall I believe in taking a holistic approach to treatment and recognizing individuals' as part of a larger system. Furthermore, I believe that clients are capable of creating the positive change they seek in their lives and often need a positive support system to walk alongside them in their journey. As a therapist I seek to provide support by offering a warm non-directional perspective, celebrating small changes that are made, affirming your autonomy, holding you accountable to the standards you have set for yourself, and encouraging you to fully engage in your growth process.

Participation

Because I believe you are capable of achieving the positive goals that you set for yourself the effectiveness of therapy will largely depend upon your willingness to participate in the process. Participation includes: showing up to your appointments on time and of sound mind (i.e. avoiding mind altering substances such as drugs or alcohol prior to sessions), engaging with me in session, providing feedback on how therapy is working for you, and applying insights gained from therapy to your everyday life. I reserve the right to end session early or reschedule sessions should you arrive to session intoxicated or unable to participate fully in session that day. This includes physical illness. In order to promote overall health and wellness for all the clients I ask that you call to reschedule should you or your child experience any cold, flu, viral, or symptoms of any other contagious illnesses. I ask that parents/ guardians of minor clients remain on the premises during session.

Confidentiality and Records:

Your communication with me both written (ex: intake paperwork) and verbal is considered Protected Health Information (PHI) and is considered confidential. A detailed portion of PHI is included in this packet. I will keep all information confidential and will not release your information to anyone including family or insurance companies if you are a legal adult without a signed release of information from you. If you are a minor, it is your parents' legal right to have access to the information discussed in our sessions. Prior to beginning therapy with any minor I will discuss with both the minor client and their parents expectations for communication. In order to foster a healthy therapeutic relationship it may be more beneficial not to reveal information disclosed in session to parents or guardians. For couples I will not keep secrets as I view the couple as my client and partner secrecy does not promote wellness in the relationship. If the need arises in couples' therapy for a partner to have individual sessions I will work with you to refer to an individual counselor to address those needs. There are legal limits to your confidentiality and it's important that you understand what those limits are.

1) If you express intent to harm yourself or others or are no longer to care for yourself. I may be required to break confidentiality in order to promote health and safety for all those involved.
2) Therapist are required by law to report all suspected child, elder, or abuse of disabled adults to the appropriate state authorities.
3) A judge orders me to release information. In which case you have a right to appeal, but I cannot guarantee that appeal will be upheld and will do what I can within my power not to disclose confidential information.
4) When homeland security requests information, according to the Patriot Act.

Confidentiality and Minors

As mentioned above parents/guardians have a legal right to information disclosed in session. Due to the importance of trust with a client and therapist I will offer general information about the therapeutic process and discuss ways in which parents/guardians can support the positive changes their child is making. But I will not provide details from the session. If at any time your

child is engaging in risky or dangerous behavior I will let you know of their behavior immediately. Risky or dangerous behaviors include but are not limited to: self-harm, suicidal ideation, homicidal threats, or threats of running away. If you need to speak with me about your child's behaviors please contact me prior to their session and will I be glad to set up a time to meet with you or discuss adding a family session to address concerns.

Structure and Cost of Session:

Sessions last between 45- 50 minutes and are face to face sessions only. The length of therapy will vary greatly for each client based on their level of need, some have benefitted and reached their goals in as little as a few sessions. Whereas others have benefitted more from long term therapy. I do not provide phone or internet based sessions, if this is a service you need please let me know and I will be happy to provide you with referrals. Phone calls exceeding 20 minutes, excessive paperwork, attending school meetings, or court appearances/ preparation will be billed will incur additional fees as listed below. At this time I do not bill insurance companies and full payment of $120 is due at the time of service. If you miss a payment for whatever reason therapy services maybe postponed until the full payment is rendered. I reserve the right to announce fee increases which upon effective date shall become current for all existing clients. I do reserve a limited number of spaces for reduced fee sessions, I cannot guarantee availability for these spaces and there may be a wait list. If you feel that you qualify for a reduced fee space please let me know at the *beginning of our first session* if I am unable to accommodate you I will be happy to provide you with referrals to other low cost or sliding scale providers. I can provide a copy of your receipt or a "superbill" for you to submit to your insurance company for reimbursement. I am able to accept cash, checks, and debit/credit cards as forms of payment with the exception of American Express. Please note there is a $25 fee for any returned checks.

Waive right to subpoena

In order to protect you and the information you and/or your child (ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by "a licensed…marriage and family therapist… during the psychotherapeutic relationship." If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs. If, for any reason, I am required to participate in court proceedings my regular hourly fee will be applied from door to door. In addition, I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at $120 per hour.

Cancellation Policy

You are expected to attend all scheduled sessions with your therapist. I do understand that unexpected life events and if you need to cancel your appointment please call **NO LATER**

THAN 24 HOURS PRIOR to your scheduled appointment. You will be charged $60.00 for appointments cancelled with less than 24 hours' notice. Cornerstone Family Services requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you "no show" or cancel your appointment without 24-hour notification the $60.00 cancellation charge will be charged to your card. Please note that insurance companies do not reimburse for missed appointments. Any files that have no activity for a period of 3 months will be considered closed.

In Case of an Emergency:

Our 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 pager or have an "on call system". Generally, I will return phone calls within 48 hours (excluding weekends). If at any time this does not feel like sufficient support, please inform me, and we can discuss referrals. If you have a mental health emergency, you agree that you will not to wait for me to call back. You agree to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567, Peachford Hospital at 770.454.5589, or the Georgia Crisis and Access Line at 1-800-715-4225. These facilities have 24 hour crisis lines, with trained, qualified mental health professionals available, any time, day or night.
- Call 911.
- Go to your nearest emergency room.

Correspondence:

If you have a question, or need to talk with me, please call my office during normal business hours. Due to security concerns, I do not use e-mail to correspond with clients. I am restricted by the code of ethics by which I abide to avoid engaging in "dual relationships", except in limited circumstances in which it would benefit you. A dual relationship is any relationship outside a therapeutic one. To abide by this code, I will not accept any requests or engage with you on any social media such as Facebook, Instagram, Linked In etc. In an effort to maintain confidentiality if we are to encounter each other outside the office I will not address you, unless you speak with me first.

Risks:

It is important that you understand there are some risks involved in receiving treatment. Some of those risks include discomfort when discussing difficult topics, as therapy can be emotionally painful at times. As your therapist it is my responsibility to provide support and a safe space for you throughout the therapeutic process and will work alongside you to ensure that the pace of therapy is appropriate for you. We are all part of a system whether it be a family, a friend group, church, team, and even at our jobs the positive changes you begin to make as a result of therapy will have an impact on the people in your life. It is important to understand that not all the positive changes you make will be welcomed by the systems you are a part of. While you are

working towards your goals we will not only explore how the changes you make will impact others, but also how you would like to respond to their reactions.

Ethical Considerations

If at any point and time you feel that services are delivered in a less than professional manner please let me know immediately so that we can work together to address your concerns. If we are unable to resolve your concerns I will be glad to provide you with contact information for the American Association of Marriage and Family Therapy and for the Georgia Association for Marriage and Family Therapy, both of which govern my profession. I make it a priority to provide services consistent with the AAMFT Code of Ethics and review those guidelines regularly to ensure I am practicing ethically. One way I maintain ethical compliance is through consultation with other professionals. During consultations, I do not reveal the identity of my client and only consult with professionals who are bound by their professional code of ethics.

Please keep the above records for your information and only return the signed page below.

Consent to Treatment

By signing below you agree that you have read (or have had read to you) all the above sections of the informed consent and you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time and can choose to end services at any time. You also agree to pay the disclosed fee for services and provide 24 hours' notice to cancel your appointment.

___________________________________ ________________

Signature Client (parent or guardian) Date

___________________________________ ________________

Minor's Name Date

___________________________________ ________________

Signature Date

___________________________________ ________________

Signature Date

Initial Here:

________ I have read and understand the working with children policy.

_________ I have read and agree to the "Waive the Right to Subpoena" policy.

_________ I have read and agree to the "No secrets" policy.

_________ I have read and understand the "Cancellation" policy.

Credit Card Policy

Calli's Counseling and Consultation Services, LLC
at Cornerstone Family Services, LLC
2993 Sandy Plains Rd
Marietta, GA, 30066

I am hereby entering into a contract for Calli Cruz, LMFT's professional time and services when I set an appointment. I understand that by entering into this contract that Ms. Cruz's that I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Ms. Cruz's cancellation policy requires 24 hours advance notice in order to be released from the contract for her time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24 hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of $60. I hereby authorize Calli Cruz, LMFT owner of Calli's counseling and Consultation Services to charge the following card:

Visa / MasterCard / Discover (please circle)

Credit card number_______________________________________

Expiration date_______________ CVV code (last 3 digits on the back of the card) __________

Zip code to which billing statement is mailed____

Name on credit card____

I have read and understand the above credit card policy for services provided by Calli Cruz, LMFT through Calli's Counseling and Consultation Services, LLC at Cornerstone Family Services. I understand that any credit card charges will read on my bill as Calli's Counseling and Consultation Services.

Please have all consenting adults sign below.

_____________________________ _____________

Signature Date

_____________________________ ______________

Signature Date

Calli's Counseling and Consultation Services, LLC
at Cornerstone Family Services, LLC
2993 Sandy Plains Rd, Suite 110, Box 4
Marietta, GA, 30066

Privacy Protection Notice

Please keep these pages for your records

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect April 15, 2011 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition. Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on a client's behalf. (Please note that we do not file insurance for clients at Cornerstone Family Services, LLC.)

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The use of your protected health information refers to activities my office conducts for scheduling appointments, keeping records and other tasks within my office related to your care.

Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care. Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

PHI(2) There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination,

your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as "Business Associates." I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your correspondence sent to your home address so I will send them to another location of your choosing;

• The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
•The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care; PHI(3)
•The right to an accounting of non-authorized disclosures of your protected health information;
•The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
• The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified.

VI. Complaints

Jennifer Vann, LMFT is the appointed "Privacy Officer" for Cornerstone Family Services, LLC per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 2993 Sandy Plains Road, Suite 110 Marietta, GA 30066 or by phone at 770-910- 2753. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In

mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Calli Cruz, LMFT

RECEIPT OF PRIVACY NOTICES

I, ____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

____ ______________

Client Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority:____

Calli's Counseling and Consultation Services, LLC
at Cornerstone Family Services, LLC
2993 Sandy Plains Road, Suite 110, Box 4,
Marietta, GA 30066
770-910-2753

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Phone Number:_____________________________

___OK to leave message with detailed information

___ Message with name & call back number only

___ Do not leave messages on home phone

___ Do not leave messages at home number

Written Communication

___ OK to mail to my home address

___ OK to mail to my work/office address

Work Phone Number:____________________________

___ Ok to leave messages with detailed information

_____ Message with name and call back number only

_____Do not leaves messages on work number

_____Do not call work number

Cell Phone Number:______________________

____Ok to leave detailed messages

____ Message with name & call back number only

____Do not leave messages on cell number

___ Do not call cell number

_____________________________________ _______________

Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY

DIRECTIONS

From I-75: Exit 267A. At first light you will turn right onto Sandy Plains Rd. Drive 3.9 miles and make a left Uturn at Bryant Lane. (The Harper Woods subdivision is on your right.) After making the U-turn, the office complex is immediately on your right, and the office complex sign says “2993” and you will see “Cornerstone Family Services” on the marquee. Suite 110 is the farthest door on your left on the building on the right as you face the buildings.

From Barrett Parkway: Travel southeast on Barrett. It will turn into East Piedmont. As you approach Sprayberry H.S. on your right you will turn left onto Sandy Plains Road. Drive 1.3 miles and make a left U-turn at Bryant Lane. (The Harper Woods subdivision is on your right.) After making the U-turn, the office complex is immediately on your right, and the office complex sign says “2993” and you will see “Cornerstone Family Services” on the marquee. Suite 110 is the farthest door on your left on the building on the right as you face the buildings.

From East Cobb: Travel 92 west/ Shallowford Road west until you turn left onto Sandy Plains Rd. From the Shallowford/Sandy Plains intersection the office complex is 1.5 miles on your Right just after Bryant Ln. (across from the Harper Woods subdivision), and the office complex sign says “2993” and you will see “Cornerstone Family Services” on the marquee. Suite 110 is the farthest door on your left on the building on the right as you face the buildings.

From Woodstock and Roswell: From Hwy 92 east turn south onto Sandy Plains Road. The office complex is 4.7 miles on your right, just after Bryant Ln (across from the Harper Woods subdivision), and the office complex sign says “2993” and you will see “Cornerstone Family Services” on the marquee. Suite 110 is the farthest door on your left on the building on the right as you face the buildings.

From West Cobb: From Marietta Square make your way toward Kennestone Hospital passing Kennestone on your left and crossing over I-75 on Canton Rd. At the first light on the “connector” you will turn right onto Sandy Plains Rd. Drive 3.9 miles and make a left U-turn at Bryant Lane. (The Harper Woods subdivision is on your right.) After making the U-turn, the office complex is immediately on your right, and the office complex sign says “2993” and you will see “Cornerstone Family Services” on the marquee. Suite 110 is the farthest door on your left on the building on the right as you face the buildings.