Practical Recovery Psychology Group, Inc.
8950 Villa La Jolla Drive, Suite B214
La Jolla, CA 92037

Practice Policies and Fees

Client Name: _____

Financially Responsible Party Name: _____

I UNDERSTAND THAT 48 HOURS NOTICE FOR AN APPOINTMENT CANCELLATION IS REQUIRED OR I WILL BE BILLED AT THAT SERVICE'S REGULAR FEE. EMAIL AND TEXT ARE NOT ACCEPTABLE METHODS OF CANCELLATION. PHONING AND VOICEMAIL ARE THE ONLY ACCEPTABLE METHODS OF CANCELLATION.

Payment for services is due at time of service unless other arrangements have been made. Practical Recovery Psychology Group, Inc. does not guarantee benefits and/or payment from any insurance company. I, the undersigned, request that payment of authorized benefits by my insurance company be made on my behalf to Practical Recovery Psychology Group, Inc. for services that have been provided for me. Reimbursement that is sent from the insurance company directly to the sponsor must be signed over to Practical Recovery Psychology Group, Inc. the day received. Daily finance charge of the maximum allowed by law will be added to client's bill if checks are not sent to Practical Recovery Psychology Group, Inc. immediately. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits are compliant with current healthcare standards. Please make checks payable to PRPG.

Any dispute as to malpractice will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Agreeing to arbitrate all disputes that are connected with this treatment is not necessary in order to be treated. If the client or the undersigned does not want to agree to arbitration, he/she should initial here _____ now or send a written notice within 30 days from today saying that he/she no longer agrees to arbitration.

Our email communication to you is secure (HIPAA compliant). However, any responses back from you may not be secure, depending on your email situation. Texting is **not** secure. We recommend you not text or email us with sensitive information. Individual providers may elect not to communicate by email or text. Communication through our client portal **is** secure for both parties.

Fees listed are for one hour sessions. Fees for other lengths of service are proportionate. Specialized services, such as forensic services, have a separate fee schedule.

Direct payment fee (discounted fee if paid at time of service)

Horvath, $330 ($300)
Galant, Shapiro, Kost, Neurofeedback, $220 ($200)
Camlin, Lewis, Pyrke, Gobar, Khalsa, Hricko, $180 ($160)
IIOP clients, also have Clinical Coordination fees, typically $200 - $400 total
IOP clients, $350 per day ($290 at time of service)
New client evaluations, all providers, $200 at time of service

_____

Client Print Name Signature Date

_____

Financially Responsible Party Print Name Signature Date

UNDERSTANDING PSYCHOTHERAPY AND CONSENT TO TREATMENT

Consent to Treatment

The success of psychotherapy depends upon a high degree of trust between us. We therefore want you to be fully informed about what to expect from us and from your sessions here.

Our Staff

All staff work under the supervision of Dr. Horvath (PSY7732). In addition to other psychologists and postdoctoral psychology fellows, the staff at Practical Recovery Psychology Group, Inc. includes counselors and specialists in holistic health (yoga, bodywork, meditation, etc.).

Understanding Psychotherapy

During initial visits the emphasis will be on understanding the nature of your personal problems and on creating a plan of treatment. Psychotherapy will consist largely of an ongoing dialogue between you and your therapist(s) about 1) problematic behavior, feelings or attitudes, which may be deeply entrenched, 2) what new behaviors, feelings or attitudes you might adopt; and 3) how you might adopt them. Our training, resources, and experience will be used to help you identify, select, and accomplish these desired changes.

You may be given homework assignments, which help carry on our work between sessions. These assignments may include reading, keeping records of behaviors, feelings or attitudes, or experiencing new activities. Any difficulties in accomplishing these assignments should be reported promptly, so that we may develop assignments that you will be able to accomplish.

We encourage you to ask questions at any time. The more deeply you understand what we are doing, the more effectively you will be able to cooperate with it and accomplish the changes you desire. We will evaluate the effectiveness of our work on an on-going basis. By mutual agreement with your specific psychotherapist you may record your sessions.

Psychotherapy is not magic. The extent to which you are open and honest about yourself will determine how accurately we can assess your situation and recommend appropriate methods and goals. Your persistence in carrying out homework assignments will significant impact on how much you accomplish.

There can be discomfort involved in participating in psychotherapy. You may remember unpleasant events, or have aroused intense feelings of anger, fear, anxiety, depression, frustration, loneliness, helplessness, or other unpleasant feelings. Homework assignments can at times be uncomfortable. Your family and friends may need time to adjust to changes you make.

In addition to accomplishing your stated goals, there may be additional benefits to participating in psychotherapy, including greater maturity as a person, better understanding of personal goals and values, improved ability to relate to others, and greater self-confidence, self-respect, and self-acceptance.

If you arrive a few minutes ahead of your appointment time, you will have the opportunity to set aside the irrelevant concerns of the day, and prepare for your session.

Turn over

Confidentiality

In accordance with professional ethics and California law, the information revealed in psychotherapy is confidential, and will not be revealed to anyone without your written permission, except as required by law. California law requires that we make appropriate reports if you are suicidal, homicidal, or gravely disabled, if any child or elder adult has been abused or neglected, or if you have viewed child pornography online.

Medications and Medical Procedures

Psychologists are not physicians, and do not prescribe medication or perform medical procedures. If evaluation by a physician is indicated, we can recommend one, or you may consult your personal physician.

Emergencies

Your psychotherapist is generally available during normal working hours. If you have an emergency outside of these hours, call 911. Routine business, including the making of appointments, can often be handled during normal working hours by the administrative staff, by calling 858-546-1100.

Fees

Except in cases of emergency, you will be expected to pay for appointments not canceled at least 48 hours in advance. Your appointment time is set aside specifically for you, and cannot usually be given to someone else with less than 48 hours notice.

We charge by the hour for our services. In addition to the time spent directly with you in the office, we charge for any other time spent on your behalf, including telephone calls with you or others, reading or writing documents, doing research, meetings with others, or other activities. Please see the administrative staff for current hourly rates for each provider.

Surcharges for special services may apply. Whenever feasible you will be informed if surcharges apply. The most common surcharges are for legal testimony or after hour's services.

Please sign below to indicate that you understand and agree to the information provided here, and that you consent to treatment. We recommend that you keep a copy of this form, and refer to it from time to time during our work together.

_____ _____

Name Date

_____

Signature

Practical Recovery Psychology Group, Inc.
CA License PSY7732
www.practicalrecovery.com
800-977-6110

8950 Villa La Jolla Drive, Suite B214
La Jolla, CA 92037
Tel: (858) 546-1100
Fax: (858) 455-0141

Agreement to Be Financially Responsible

For Client _____

I, _____ SSN _____

am the financially responsible party for the above client. I understand and agree to the terms for payment to Practical Recovery Psychology Group, Inc. (PRPG) as indicated below for scheduled outpatient services. Outpatient services may include but are not limited to: psychological assessment, psychotherapy, treatment, care coordination or other time spent on behalf of a client, even though a client may not be present, ancillary or alternative services such as massage, hypnosis, acupuncture or personal coaches/companions. I understand that if I will be billing for out-of-network insurance benefits, unlicensed therapists are not a covered benefit through insurance and it is my responsibility to check to see if ancillary or alternative services will be covered under my plan.

For Outpatient or Individual Psychotherapy, payment is expected at the time of service. Payment may be made by cash or check, or charged to the credit card listed below. There is a $35 fee for any returned checks. For Intensive Outpatient (IOP), I understand that at the end of each week, the full amount will be due and payable for the following week's sessions. Any balance owing will also be charged at that time.

Cancellations of appointments must be made 48 hours in advance in order to not be charged to my account. Email and texts are not acceptable notification of cancellations.

IOP Clients: PRPG will do a courtesy verification check of the client's insurance benefits; however, PRPG does not guarantee benefits and/or payment in any amount by the client's insurance provider. In order to utilize insurance coverage, PRPG must be notified by the client at the time of admission, in order to verify benefits and obtain pre-authorization. Please note that pre-certification and authorization of coverage does not guarantee reimbursement. The client is responsible to confirm their insurance eligibility and benefits prior to admission. PRPG will make every reasonable effort to bill and collect payment through the client's health care insurance; however, release of reimbursement by the insurance company is dependent on eligibility, availability of benefits, and applicable deductibles, co-payments or other limitations. In the event the client's insurance company pays for treatment, these benefits shall be assigned to PRPG for application to the client's bill. It is further agreed that PRPG may collect any such payment and shall then relieve the client of any contractual or legal obligations to the extent of such payment. Checks that are sent from the insurance company directly to the client must be signed to PRPG the day received. Daily finance charge of the maximum allowed by law will be added to client's bill if checks are not turned over to PRPG immediately.

I understand that I have the right to terminate this agreement at any time, but must do so in writing delivered in person, by fax, or through U.S. mail to the address above. The termination is effective 48 hours after PRPG receives my termination request. If I fax my termination letter, I will mail the signed original to the above address on the same day.

Signature of Responsible Party _____ Date _____

I authorize PRPG to keep my signature on file and to charge my credit card listed below according to the terms of the above agreement. At the end of treatment services, any credit balance on my account will be credited back to my credit card. Charges to my card will be a one-time charge, OR:

_____ (initials) Recurring charges for this ongoing treatment

Cardholder Name: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Security Code: _____ Expiration Date:_____

Signature of Cardholder:_____ Date: _____

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Additional Requested Information

Client Name: _____ Date of Birth: _____

Phone #: _____ Email: _____ Driver License#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer Name (Client, or, if client is a minor, Guardian's employer): _____

Job Title: _____ Employer Phone: _____

Employer Address: _____

May we add your email address to our mailing list (1 client support e-mail per week)? | Yes | No

How did you hear about Practical Recovery Psychology Group, Inc.? _____

Phone: _____

Can we thank them for the referral? | Yes | No

If you found us on the internet: ☐ search engine (any search terms you remember?)
_____
☐ soberrecovery.com ☐ smartrecovery.org ☐ moderation.org
☐ I don't remember

In Case of Emergency, Notify: _____ Relationship to you: _____

Phone: _____ Address: _____

Please help us protect your privacy by checking the appropriate boxes:

Do	Do not	leave messages on my **HOME** answering machine.
Do	Do not	leave messages with any other person answering home phone.
Do	Do not	leave messages on my **WORK** voice mail.
Do	Do not	leave messages with co-workers.
Do	Do not	leave messages on my **CELL PHONE** voice mail.
Do	Do not	leave messages with any other person answering cell phone.
Do	Do not	leave messages via **E-MAIL**.

Practical Recovery Psychology Group, Inc.
8950 Villa La Jolla Drive, Suite B214
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Tel: (858) 546-1100 Fax: (858) 455-0141

A. Tom Horvath, Ph.D., ABPP, President
California Psychology License PSY7732

Required HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

For Treatment. I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

To Obtain Payment for Treatment. I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

For Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When federal, state, or local laws require disclosure**. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.
2. **When judicial or administrative proceedings require disclosure**. For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.
3. **When law enforcement requires disclosure**. For example, I may have to use or disclose your PHI in response to a search warrant.
4. **When public health activities require disclosure**. For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
5. **When health oversight activities require disclosure**. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. **To avert a serious threat to health or safety**. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
7. **For specialized government functions**. For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

8. **To remind you about appointments and to inform you of health-related benefits or services**. For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object**.
Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

D. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**
You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.

B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

D. **The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. **HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**
If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES:** Ana Ferraro, Office Manager: (858) 546-1100, ext. 235.

VII. **Effective Date of This Notice**
This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Practical Recovery Psychology Group, Inc.'s Notice of Privacy Practices.

Name _____

Signature _____

Date _____

You may refuse to sign this acknowledgement

For Practical Recovery Psychology Group, Inc. Use Only

We made every attempt to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Above named individual refused to sign

_____ Emergency situation prevented obtaining signature

_____ Other (Please Specify)

_____

_____

_____

_____

_____

Authorization to Release Confidential Information to the Practical Recovery Psychology Group, Inc. Professional Staff

Practical Recovery Psychology Group, Inc. (PRPG) consists of a team of treatment specialists. I desire to benefit from the expertise of this entire treatment team, either by my direct contact with team members, or by consultation about me provided to team members by one another.

Therefore, I, _____, hereby authorize any member of the PRPG professional staff and any outside providers I have been referred to (or, I limit this authorization to the following members): _____

_____

To release to any member of the PRPG professional staff and any outside providers I have been referred to (or, I limit this authorization to the following members): _____

_____

Any information that has been gathered about me for the purpose of coordinating and enhancing the effectiveness of my treatment at PRPG.

I understand that at any time I may revoke this consent to release information. I also understand that any release that has been made prior to revocation, and which was based on the authorization I am now signing, shall not constitute a breach of my right to confidentiality.

Unless I revoke this authorization prior to such time, it shall remain valid until the termination of my services with PRPG.

I have a right to receive a copy of this authorization and do/do not (circle) want one.

_____

(Signature of client) (Date)

_____

(Parent, Guardian, or Legal Representative) (Date)

_____

(Signature of staff witnessing consent) (Date)

PRACTICAL RECOVERY PSYCHOLOGY GROUP, INC.

PRE-DOCTORAL PSYCHOLOGY INTERN,
POST-DOCTORAL PSYCHOLOGY FELLOW AND M.F.T. INTERN NOTIFICATION

All services at Practical Recovery Psychology Group, Inc., are overseen by Arthur Thomas Horvath, Ph.D., ABPP, President and Clinical Director. As required by California law, Psychology Interns, Fellows, and MFT Interns, are under additional supervision requirements, in preparation for licensure as Psychologists or Marriage Family Therapists and have an additional designated supervisor, as listed below.

Interns and Fellows:

- Reya Kost, PsyD, Post-Doctoral Fellow, California Psychology License # PSB94021322, supervised by A. Tom Horvath, Ph.D. ABPP, License # PSY7732.

- Thad Camlin, PsyD, Post-Doctoral Fellow, Calif Psychology License # PSB94022498, supervised by, and has his practice monitored by, A. Tom Horvath, Ph.D. ABPP, License # PSY7732.

My signature below indicates I have read and understood this form.

_____ _____

Signature of the Client/Guardian/Legal Representative Date Signed

Practical Recovery Psychology Group, Inc.
CA License PSY7732
www.practicalrecovery.com
1-800-977-6110

8950 Villa La Jolla Drive, Suite B214
La Jolla, CA 92037
Tel (858) 546-1100
Fax (858) 455-0141

CONSENT TO RELEASE INFORMATION

I _____ hereby consent to communication between Practical Recovery

Psychology Group (PRPG) and _____
(Name of person and relationship to client, phone number and fax.)

Please **initial** the corresponding choices: **Communication is:**

( ) **FROM** PRPG **TO** this person/entity
( ) **FROM** this person/entity **TO** PRPG

To Communicate with and disclose to one another the following information:

( ) All information
( ) My name and other identifying information
( ) My status as a patient at PRPG
( ) Initial Evaluation
( ) Attendance
( ) Summary of Treatment Plan, Progress and Compliance
( ) Date of Admission
( ) Urinalysis Results
( ) Other_____

( ) Financial Information
( ) Progress Report
( ) Discharge Summary
( ) Treatment Plan(S)
( ) Legal Information
( ) Court Records
( ) Date of Discharge
( ) Psychiatric Evaluation

The purpose of the disclosures authorized in this consent is to:
_____

It may be transmitted in the following forms: ( ) Written ( ) Oral ( ) Electronic ( ) Audio ( ) Video

This consent automatically expires in: ( ) Six Months ( ) One Year ( ) Specific Date _____

I understand that alcohol and/ or treatment records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Resident Records, 42C.F.R.pt 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts 160 &164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that recipients of this information may re-disclose it only in connection with their official duties. I understand that Practical Recovery Psychology Group, Inc. may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the patient is prohibited.

Client Signature: _____ Date:_____

Witness Signature: _____ Date:_____