The Barden Group, LLC

Client Information and Informed Consent

*******(Please print single-sided only and retain this page for your records.)*******

About your therapist

X'Cel Cedeno, MA, LPC is a Licensed Professional Counselor in the state of Georgia (license # LPC010115) with a Master's degree in Mental Health Counseling from University of Phoenix. X'Cel has vast experience providing therapeutic services for adults, couples and families in diverse populations. X'Cel is a Certified Clinical Trauma Professional and has received training in Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Solution Focused Therapy (SFT) and Acceptance and Commitment Therapy (ACT) to effectively treat symptoms related to anxiety, depression, adjustment disorders, grief, addiction disorders and marriage/family conflict resolution.

About The Barden Group, LLC

The Barden Group, LLC a limited liability company in the state of Georgia providing a comprehensive therapeutic environment in which our therapists can provide counseling services for adolescents and adults. The Barden Group maintains professional offices for client therapy, as well as group services and peer consultation contracting with both fully licensed therapists and associate licensed therapists who all provide a full range of therapeutic services for adolescents, parents, families and individuals.

Potential Risks of Counseling

Your participation in counseling is of your own voluntary decision and may pose some risk to you. Therapy can produce a wide-range of positive and negative emotions which may make you uncomfortable or may impact your relationship with others. If you experience any difficulties during the course of your sessions, you should immediately discuss your concerns with your therapist.

In case of Emergencies

The Barden Group, LLC is NOT an emergency services provider. Therefore, we do NOT provide emergency services to potential or current clients.

If you are experiencing a life-threatening emergency, please call 911 immediately.

The following is a list of <u>non-emergency</u> mental health resources that may be contacted for afterhours services:

National Suicide Prevention Lifeline	800-273-8255
Cobb Mental Health Crisis Line...	770-422-0202
Ridgeview Institute...	770-434-4567
Peachford Hospital...	770-455-3200
Lakeview Behavioral Health...	678-713-2600

Client Information (***please add additional pages as needed***)

Client Name: _______________________________________ Date of Birth: ______

Parents/Guardians:(if child client) ____
(If the client is a minor with divorced parents; if client has been adopted; or is under guardianship of someone other than a biological parent (regardless of age), a valid custody agreement must be presented at the initial session. **No exceptions**).

Address: ____ City/Zip: ______________

Home Phone: ____________________________ Cell Phone: _______________________

Email Address: ____

Employer/Occupation/School Info/Grade: ____

Emergency Contact (Name, Relationship, Phone): ___________________________________
(Please complete an Authorization for Release of Information form for your Emergency Contact)

Referred by: ____

What is the primary reason you are seeking counseling at this time?

____

____

____

When did you first notice the problem, issue, or symptoms?

____

____

____

What have you already tried to improve the problem or symptoms? What has helped or has not helped?

____

____

____

Have you or your child or family ever been in counseling before? If yes, please provide approximate dates and provider. What helped or did not help?

____

____

____

Please list current medications (including supplements), dosage, prescribing physician and office telephone number, and length of time taking this medication. (Please complete an Authorization for Release of Information form for your prescribing doctor)

Please list all allergies (including animals, drugs, foods, etc.):

Have you ever expressed or experienced thoughts or feelings of suicide, self-harm, or harm to others? If yes, please provide approximate time frame(s) and details.

Please describe any significant medical history (including chronic conditions, hospitalizations, surgeries, premature birth, etc.)

What goals or changes would you like to see accomplished by you, your child and/or family through counseling?

Please list anything else you would like me to know before we begin our work together:

CONFIDENTIALITY

Due to the sensitive nature of counseling, privacy and confidentiality will be of the utmost concern. Therefore, it is required that any and all information presented within the session(s), whether by the facilitator, therapist, counselor, or group leader (hereafter referred to as "counselor"); or client is not to be discussed outside of the therapeutic setting with anyone except for the following exceptions required by law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, including suicidal and homicidal ideation 3) There is a reasonable suspicion of abuse/neglect against a minor, elderly person (60 years or older), or a dependent adult, 4) A court order is received directing the disclosure of information. Before mandated disclosure, privileged communication will be asserted on behalf of the client. Further, clients will be apprised of all mandated disclosures as soon as notification has been received. The Patriot Act of 2001 requires that in certain circumstances, I am required to provide federal law enforcement agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Confidentiality includes not acknowledging your receipt of services without your permission. Therefore, if you happen to see your therapist outside the office setting, please do not be insulted if your therapist does not initiate contact. This is for your protection; however, you may initiate an interaction based on your level of comfort and disclosure.

Additionally, some therapists may be able to provide paperwork for you to file with your insurance company; however, insurance companies require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies. Please check with your therapist for clarification.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

In **working with couples and families**, the couple as an entity and the family as an entity is the client and the therapist is not providing individual therapy for either half of the couple or for any one member of the family although session with individuals in the couple/family may be a part of the couples/family therapy. The therapist ***will not be a "secret keeper" nor will the therapist facilitate secret keeping.*** If anything significant is revealed in an individual session that the therapist feels another party needs to be told, the therapist will require it be brought up in the next session together, so it may be therapeutically addressed. If the individual refuses to reveal the therapist recommended subject, the therapist has the right to terminate the therapeutic relationship and refer the couple or family to another therapist for treatment.

In the case of my death or major medical incapacitation, my records will be accessed by Glen Barden, LPC.

Signature indicating I have read and received the Notice of Confidentiality and its limits:

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: ____________________________________

Client 2/Parent/Legal Guardian - Printed Name: ____

Client 2/Parent/Legal Guardian - Signature and date: ____________________________________

Electronic Communication

Secure and private communication of Protected Healthcare Information (PHI) cannot be fully assured utilizing cell/smart phone; email or other electronic technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances.
This therapist uses Simple Practice as her digital/ record keeping/ communication platform, which is HIPAA Compliant. Use of non-secure technologies to contact your therapist will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. **Please check below which modes of communication are permitted and which are not permitted.** This consent may be altered at any time should circumstances of preferences change. If client chooses not to allow non-secure modes of communication, contact will only be made via wire-to-wire phone; wire-to-wire fax; or regular mail utilizing the address provided on page two of this document.

Voice Communication **to** client's non-secured cell/smart phone for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed

If permitted, list permitted number(s): _________________________

Voice Communication **from** X'Cel's non-secured cell/smart phone for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed
Authorized 3rd-Party Contact ___Allowed ___Not allowed
(e.g. Other Providers, Doctors, etc.)

Text Communication **to** client's non-secured cell/smart phone for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed

Text Communication **from** X'Cel's non-secured cell/smart phone for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed
Authorized 3rd-Party Contact ___Allowed ___Not allowed
(e.g. Other Providers, Doctors, etc.)

Fax Communication **to** client's non-secured/e-fax for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed

If permitted, list permitted fax number(s): ______________________

Fax Communication **from** X'Cel's non-secured/e-fax for:

Scheduling Appointments ___Allowed ___Not allowed
Appointment Reminders ___Allowed ___Not allowed
Between Session Contact ___Allowed ___Not allowed
Authorized 3rd-Party Contact ___Allowed ___Not allowed
(e.g. Other Providers, Doctors, etc.)

Email Communication **to** client's non-secured email for:

Scheduling Appointments	___Allowed	___Not allowed
Appointment Reminders	___Allowed	___Not allowed
Between Session Contact	___Allowed	___Not allowed

If permitted, list permitted email address(es): _____________________________________

Email Communication **from** X'Cel's non-secured/email for:

Scheduling Appointments	___Allowed	___Not allowed
Appointment Reminders	___Allowed	___Not allowed
Between Session Contact	___Allowed	___Not allowed
Authorized 3rd-Party Contact (e.g. Other Providers, Doctors, etc.)	___Allowed	___Not allowed

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Teleconferencing based communication **to** client's non-secured portal/cell/smart phone for:

Scheduling Appointments	___Allowed	___Not allowed
Appointment Reminders	___Allowed	___Not allowed
Between Session Contact	___Allowed	___Not allowed

If permitted, list permitted site(s) or methods: _____________________________

Teleconferencing based communication **from** X'Cel's secured portal/cell/smart phone for:

Scheduling Appointments	___Allowed	___Not allowed
Appointment Reminders	___Allowed	___Not allowed
Between Session Contact	___Allowed	___Not allowed
Authorized 3rd-Party Contact (e.g. Other Providers, Doctors, etc.)	___Allowed	___Not allowed

If permitted, list permitted site(s) or methods: _____________________________

Written Communication including Protected Healthcare Information (PHI), billing, and termination notices via USPS mail sent to the address listed on page two of this document from X'Cel Cedeno listing The Barden Group as the return address on the envelope.

___Allowed ___Not allowed

Statement of Validation

I have read the statement of services regarding non-secure electronic communication, it has been adequately communicated to me, and I understand the contents and limits to confidentiality.

By Client(s):

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: ____

Legal proceedings

1. THE BARDEN GROUP, LLC requests all clients waive the right to subpoena THE BARDEN GROUP Counselors to court**.** This policy is set in order to preserve the efficacy and integrity of the therapeutic progress and relationship with you and/or your family. A Counselor's appearance in court often damages the therapeutic relationship between the client and Counselor, and it is the Counselors ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of their clients. By signing this agreement, you are waiving right to subpoena your Counselor and agreeing in fact to not have any clinical or personal records of the Counselor subpoenaed. THE BARDEN GROUP, LLC Counselors will be happy to provide a referral to another therapist who will be willing to appear in court as an alternative if you would prefer.

2. In cases whereby a THE BARDEN GROUP, LLC Counselor is subpoenaed to appear in court regardless of this waiver – whether to testify or not – an upfront, non-refundable, non-prorated charge of $1500.00 for one-half (1/2) day will be paid five days in advance. An additional charge of $375/hr. (rounded up to 15-minute intervals) will be charged for Court Related work, including: any court-mandated appearances, personal preparation, document preparing, consultations with attorneys and/or the guardian ad litem, et al and travel time. All travel costs including airfare, $0.58 per mile driving allowance, hotel expense (location acceptable to counselor), and $50 per diem meal allowance will be incurred by the client.

I understand these policies and hereby waive all rights to subpoena Glen N. Barden, MA, LPC and the clinical record for any current or future legal proceedings.

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: ____________________________________

Client 2/Parent/Legal Guardian - Printed Name: ____

Client 2/Parent/Legal Guardian - Signature and date: ____________________________________

Scheduling and Cancellations

Scheduling appointments is handled directly with your counselor. Methods of communication are outlines in the Electronic Communications Policy page within this Informed Consent document. A minimum of 24 hours is required to cancel an appointment. If a client does not arrive for a scheduled appointment or cancels within 24 hours, a fee of the greater of the full session rate or $75 will be billed. If there is a true, unavoidable emergency or serious or contagious illness, please call as soon as possible and I will work with you to reschedule and you may request waiver of the 24 hour policy.

Session parameters

Individual counseling sessions and relationship/family sessions are 50 minutes. Sessions will start and end on time. To respect other appointments, if you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance

This therapist accepts BCBS (Blue Cross Blue Shields) and United Health Care for health insurances and most HSA and MRA cards are directly accepted or sessions may be eligible for reimbursement; application towards deductibles; or application towards out-of-network coverage should be discussed with the therapist before the first session.

All fees are paid directly to The Barden Group, LLC. THE BARDEN GROUP, LLC accepts cash, checks, Master Card, Visa, American Express and most debit cards associated with Healthcare Savings Account (HSA) and Medical Reimbursement Account (MRA). Please note debit or credit card payments are subject to a 3% processing fee.

There is a $25 fee for any returned checks or declined credit card transaction due to insufficient funds. That $25 fee is due at the time of your next session, along with the payment for that session. In the event of two (2) declined transactions, prepayment will be required going forward.

Individual Initial Intake Session - $140.00 (80 minutes)

Individual Sessions - $115.00 (50 minutes)

Family / Couples Initial Session - $150.00 (80 minutes)

Family / Couples Sessions - $130.00 (50 minutes)

DBT , ACT Group Sessions - $40.00

Non-court related preparation of Treatment Summaries or Letter(s) requested by clients: $50 per item.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask about reduced fee options. I will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once approved.

Signature indicating I have read and understand the Notice of Scheduling and Cancellations Policy:

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: ____

Client 2/Parent/Legal Guardian - Printed Name: ____

Client 2/Parent/Legal Guardian - Signature and date: ____

Notice of Privacy Practices

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. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

1) When there is a serious threat to your health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
2) Some lawsuits and legal or court proceedings.
3) If a law enforcement official legally requires me to do so.
4) For workers compensation and similar benefit programs.

There are situations like these that do not happen very often. They are described in the long version of the NPP.

Client Records

You should be aware that, pursuant to Health Information Portability and Accountability Act (HIPAA), I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $35, plus postage charged for copying and mailing any records.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists 237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Signature indicating I have read and received the Notice of Privacy Policies:

Client 1/Parent/Legal Guardian - Signature and date: ______________________________________

Client 2/Parent/Legal Guardian - Signature and date: ______________________________________

Agreement to Enter into Counseling Services and Fee for Services Agreement

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

Every time I schedule an appointment with my therapist I understand that I am entering into a contract with The Barden Group, LLC for the professional time and services provided for within that appointment time. 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 confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist's professional fees as outlined in our Agreement to enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agreed that my fee for sessions will be $________and I agree to pay this fee at the time of each session. I understand that THE BARDEN GROUP, LLC does not reimburse for cancelled appointments that were paid for in advance but that any such fees will be credited to my account and applied to future services provided.

I understand that The Barden Group, LLC's cancellation policy requires 24 hours advanced notice to be released from the contract for my therapist's time and services of preparation for my session.
I agree that if I fail to cancel my appointment within the 24-hour minimum time period prior to my session I will be charged the greater of the full session rate or $75 for the appointment. I also understand if there is an emergency that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy.

I understand there is a $25 fee if my credit card or check is declined due to insufficient funds. That $25 fee is due at the time of my next session, along with the payment for that session. In the event of two (2) declined transactions, I understand cash payment will be required going forward.

I authorize ______________________________ to schedule appointments on mine and their behalf.

(For example, spouse or minor who drives self to appointment but is not responsible for payment).

I hereby authorize THE BARDEN GROUP, LLC to charge my Visa/ Master Card/ American Express/ HSA/ MRA (circle one)

Credit card number: (Please print legibly) ____

Exp. Date_____________ CVC Code: ___________ Zip Code: ________________

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: _______________________________________

Client 2/Parent/Legal Guardian - Printed Name: ____

Client 2/Parent/Legal Guardian - Signature and date: _______________________________________

Therapist Signature and date: ____

<u>Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19</u>

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Barden Behavioral Health has put in place preventative measures to reduce the spread of COVID-19; however, Barden Behavioral Health **cannot guarantee** that you or your family will not become infected with COVID-19. Further, attending in-person appointments with Barden Behavioral Health **could <u>increase</u>** your risk and your family's risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my family may be exposed to or infected by COVID-19 by attending in-person appointments with Barden Behavioral Health and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Barden Behavioral Health may result from the actions, omissions, or negligence of myself and others, including, but not limited to Barden Behavioral Health, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my family (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with Barden Behavioral Health. On my behalf and/or on behalf of my family, I hereby release, covenant not to sue, discharge, and hold harmless the Barden Behavioral Health, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Barden Behavioral Health, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Barden Behavioral Health.

Client 1/Parent/Legal Guardian - Printed Name: ____

Client 1/Parent/Legal Guardian - Signature and date: ____________________________________

Client 2/Parent/Legal Guardian - Printed Name: ____

Client 2/Parent/Legal Guardian - Signature and date: ____________________________________

Emergency Contact - Authorization for Release of Information

Client Name: ____Date of Birth: ___________________

I have been informed that under Georgia State Law and Federal Law, that all verbal, written and/or electronic communication between a client and Counselor is considered privileged information which may not be disclosed by the Counselor unless given consent by the client. Records maintained by the Counselor may contain alcohol and drug treatment information, client photographs, medical conditions and or psychiatric/psychological or other mental health privileged or confidential information. I have also been informed that client records maintained by a Counselor or other mental health or medical professional may not be disclosed to third parties except with the Client's consent or through legal process.

Therefore, I hereby request/authorize X'Cel Cedeno, LPC of The Barden Group to obtain and/or release information to and from:

(Name of Source or Recipient of Information: ____

____ ___________________ _____ _____________
(Address) (City) (State) (Zip Code)

Telephone: ___________________________________ Fax: _____________________________________

The information will be used/disclosed for the following purpose(s):

_____ Background Information / Assessment
_____ Continuation of Care
__X__ Other ___Emergency Contact____

I understand and agree that this Authorization will be valid and in effect until ________ /_______ /_________. I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.

I understand that I can revoke or cancel this Authorization at any time by submitting a letter to my therapist. If I do this, it will prevent any releases after the date it is received but cannot change the fact that information may have been sent or shared before that date.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient of your information of which is not the responsibility of Glen Barden, LPC or The Barden Group and may no longer be protected by the HIPAA Privacy rule.

I agree to indemnify and hold harmless Glen Barden, LPC and The Barden Group's owner members, contractors and staff from all liability that may arise from the release of the information herein requested.

____ _______________________________
Client or Legal Guardian - Printed Name **Date**

____ _______________________________
Client or Legal Guardian - Signature **Date**

Prescribing/Referring Physician - Authorization for Release of Information

Client Name: ____Date of Birth: _________________

I have been informed that under Georgia State Law and Federal Law, that all verbal, written and/or electronic communication between a client and Counselor is considered privileged information which may not be disclosed by the Counselor unless given consent by the client. Records maintained by the Counselor may contain alcohol and drug treatment information, client photographs, medical conditions and or psychiatric/psychological or other mental health privileged or confidential information. I have also been informed that client records maintained by a Counselor or other mental health or medical professional may not be disclosed to third parties except with the Client's consent or through legal process.

Therefore, I hereby request/authorize X'Cel Cedeno, LPC of The Barden Group to obtain and/or release information to and from:

(Name of Source or Recipient of Information: ____

____ _________________ _____ ____________
(Address) (City) (State) (Zip Code)

Telephone: ________________________________ Fax: __________________________________

The information will be used/disclosed for the following purpose(s):

__X__ Background Information / Assessment
__X__ Continuation of Care
_____ Other ____

I understand and agree that this Authorization will be valid and in effect until ________ /_______ /_________. I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.

I understand that I can revoke or cancel this Authorization at any time by submitting a letter to my therapist. If I do this, it will prevent any releases after the date it is received but cannot change the fact that information may have been sent or shared before that date.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient of your information of which is not the responsibility of Glen Barden, LPC or The Barden Group and may no longer be protected by the HIPAA Privacy rule.

I agree to indemnify and hold harmless Glen Barden, LPC and The Barden Group's owner members, contractors and staff from all liability that may arise from the release of the information herein requested.

____ ____________________________
Client or Legal Guardian - Printed Name **Date**

____ ____________________________
Client or Legal Guardian - Signature **Date**