



The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

- Kim E. Costello, Psy.D., LMHC, DAPA, BCPC
Carolyn McNulty\*, LMHC, GAL
Michelle L. Donley\*, LCSW
Rachel Agustines\*, MD
Alison Fuhr\*, ARNP
Kim Hughes\*, LMHC, LPC, NCC
Heather Bishop\*, LMHC
Lindsay Harrison\*, LMHC
JuliAnn Marzuola\*, LDN, LMHC
Nestor Levesque\*, LMHC
Marianne Williams\*, LMHC
Jennifer Lagergren\*, Psychometrist, Registered Mental Health Intern
Candice Lindsey, PAS
James Pham, Tutor
Whitney Wilkerson, Tutor
Melanie Kennedy, Tutor
The Costello Center
Other:

NEW CLIENT DATA FORM -ADULT

A. Basic Information

Name: Date:

Date of Birth: Gender: Race/Ethnicity:

Address: May we mail to this address? Yes No
Street City State Zip Code

Email address:

To be completed by TCC Office:
Client has completed email release?
Approval to email? Yes No

Telephone contact: May we leave a message?
Cell: Yes No
Home: Yes No
Work: Yes No

Employer: Occupation:

Religious Affiliation:

In Case of Emergency Contact:

Phone: Relationship:

Family

Marital status: Married Widow(er) Divorced Separated Single

Name of Spouse (if applicable):

Other Persons Living in Your Household (names, dates of birth, and relationship to you)

Name: Relationship DOB Other Information that May be Relevant

Table with 4 columns: Name, Relationship, DOB, Other Information that May be Relevant. Contains three rows of blank lines for data entry.

How did you hear about The Costello Center? Website Referred by: Other:

Are you the client being seen today? Yes No If not, what is your relationship to client?

If you are the Power of Attorney Please provide a copy of the PA to Provider.

Who is your appointment with today?

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- Other: \_\_\_\_\_

## B. Medical History

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Serious Medical Illnesses/Accidents (Identify and give dates): \_\_\_\_\_

Do you have a history of infectious diseases?  Yes  No If yes, please describe: \_\_\_\_\_

Do you have any allergies?  Yes  No If yes, please describe: \_\_\_\_\_

Are you currently taking medications?  Yes  No If yes, please list: \_\_\_\_\_

Have you been prescribed medications in the past?  Yes  No If yes, please list: \_\_\_\_\_

Surgeries or operations (Identify and give dates): \_\_\_\_\_

Any hospitalizations?  Yes  No If yes, please list date and reason: \_\_\_\_\_

Have you had previous counseling?  Yes  No If yes, with whom and when? \_\_\_\_\_

Are or have you been under the care of a psychiatrist?  Yes  No If yes, with whom and when? \_\_\_\_\_

## C. Primary reason for visit today:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Check any that apply and circle those that are the most significant:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abuse   | <input type="checkbox"/> Adjustments ( <i>Changing schools, parent's getting married or divorced, pet died, new job, job loss, etc.</i> ) | <input type="checkbox"/> Parent-child relationship problem                               |
| <input type="checkbox"/> Addictions  | <input type="checkbox"/> Bad dreams/nightmares  | <input type="checkbox"/> Non-family relationship problem ( <i>teacher, peers, etc.</i> ) |
| <input type="checkbox"/> Substance Use/Abuse ( <i>tobacco, alcohol, illegal/prescription drugs</i> ) | <input type="checkbox"/> Sleeping difficulties  | <input type="checkbox"/> Chronic illness   |
| <input type="checkbox"/> ADHD symptoms   | <input type="checkbox"/> Bed wetting  | <input type="checkbox"/> Eating problem  |
| <input type="checkbox"/> Anxiety symptoms  | <input type="checkbox"/> Career decisions   | <input type="checkbox"/> Sexual concerns   |
| <input type="checkbox"/> Anger or irritability   | <input type="checkbox"/> Learning disability  | <input type="checkbox"/> Cutting/Self-injurious behavior                                 |
| <input type="checkbox"/> Changes in mood   | <input type="checkbox"/> Learning/academic difficulties   | <input type="checkbox"/> Sadness or depressive symptoms                                  |
| <input type="checkbox"/> Obsessive thoughts  | <input type="checkbox"/> Personal growth  | <input type="checkbox"/> Suicidal thinking   |
| <input type="checkbox"/> Worry or guilt  | <input type="checkbox"/> Relationship problem   | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Lying   |   |  |

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

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## CLIENT GENERAL INFORMATION FORM

### Part A. Additional Emergency Contact Information (optional)

Full Name (Please Print) \_\_\_\_\_

Relationship \_\_\_\_\_

Home phone \_\_\_\_\_

Cell/work phone \_\_\_\_\_

### Part B. Academic Information (if applicable)

Highest Degree Earned: \_\_\_\_\_ Current School: \_\_\_\_\_

Present Grade/Degree Sought: \_\_\_\_\_ Were you referred by the school? Yes No

### Part C. Payment Information

Person responsible for invoice payments: \_\_\_\_\_ Phone Contact: \_\_\_\_\_

I authorize that my credit card may be kept on file: Yes No \_\_\_\_\_  
(Initials)

Credit/Debit Card Information:

Card Type:  Visa  MasterCard

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ V Code (3 digits on back of card): \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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## 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.**

We are required by specific Federal and State Laws to protect your privacy. The *Health Information Portability and Accountability Act (HIPAA)* establishes rules on how your health information may be used and shared, and how it must be protected. We are obligated to follow the Florida Law when it is more protective of your privacy than the Federal Law.

### Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by TCC staff or an Independent Consultant.

We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

### This notice of Privacy Practices describes:

- How and to what extent the privacy of your Protected Health Information is guaranteed.
- How your Protected Health Information may be used and shared.
- How you may access portions of your Protected Health Information and the procedure for doing so.

### Your Protected Health Information (PHI)

Your Protected Health Information includes any individual identifiable information created or received about you. Specifically it includes:

- Identification of symptoms, diagnosis, medicine, and your prognosis.
- Appointment times and dates with session summaries.
- Payment for services provided and payment received.

*Any notes taken during the session are classified in a separate category with their confidentiality protected so that you must give written permission to release them.*

### Use and Disclosure of your Protected Health Information (PHI)

Without your specific consent:

- We will not share with your managed care company (insurance) or Employee Assistance Program the PHI required to obtain approval for treatment and billing for services rendered.
- We will not share your PHI with another therapist or treatment facility.
- We will not share your PHI with another individual, including family members, except if the client is a minor.
- We are required to report child or elder abuse and/or neglect to the proper authorities. This report may include your PHI, if necessary.
- We are required to take action, including the release of your PHI, if we believe that you or someone else is in risk of harm to themselves or others.
- We may share your PHI with individuals or companies who participate in the management of our practice; each of these people has agreed to follow the terms of our Notice of Privacy Practices.
- We may release your PHI in case of a medical emergency to medical staff.

Client Signature: \_\_\_\_\_

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



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**We may release your PHI without your specific written consent for these additional reasons:**

Public Health	Patient Directories	Healthcare Oversight	When Required by Law
Health/Safety Activities	Law Enforcement	Workers' Compensation	
National Security	Judicial Proceedings	Coroner/Funeral Activities	
Military Activities	Correctional Facilities	Research	

**Your Privacy Rights**

You have the right:

- To decide with the exception of those listed above, if your PHI is given out to a third party and to specify what information is given. You do this by completing and signing the Consent Release Information. You may revoke this consent at any time.
- To review and get copies of your PHI. Your request must be in writing. There may be charges for copying and postage. Your request may be denied if it is determined that giving you your PHI may endanger your life or physical safety or that of another person.
- To request that corrections or additions be made to your PHI if you believe that there is an error or a significant omission. You or another health professional may add information to your record, but nothing will be removed from your PHI record. Under HIPAA rules, your request does not require a change of anything in your health records. However, if we deny your request, we will provide you with a written explanation. If we accept your request to change or add information, we will make reasonable efforts to tell others, including people you designate, of the change/addition in any future sharing of your PHI.
- To request additional limits on the use or disclosure of your PHI. However, as your provider, we are not required to agree to these additional limits if we have substantial reasons for not honoring your request.
- To request that we use a different way to speak with you in a confidential manner or to speak with you at a different location about your PHI.
- To obtain a list of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and other specific exceptions.
- To file a written complaint if you believe your privacy rights have been violated. Complaint can be submitted to the TCC Privacy Officer at 8081 38th Avenue North, St. Petersburg, FL 33710, or to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201

Your complaint must:

1. Be filed in writing, either on paper or electronically, by mail, fax, or email;
  2. Name the covered entity involved and describe the acts or omissions you believe violated the requirements of the Privacy Rule;
  3. Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause."
- Your decision to file a complaint will not be held against you in any way. However, it may be necessary for us to discuss whether it is appropriate for us to continue in a therapeutic relationship.
  - To receive a copy of this document upon request. *All requests must be made in writing to your therapeutic provider.*

**Our Legal Duty**

We are required to agree to the terms of this notice. However, we reserve the right to change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law or to meet any new requirements implemented by law for the benefit of your PHI.

Before any important changes are made to the privacy practice, you will receive a revised notice that will be available to you on your first scheduled visit following the revisions. Any changes in these privacy practices and the new terms of this notice will take effect from the date of the revised forwarding of all mental health information we keep on file.

I have read and I understand all items contained herein.

**Client Signature:** \_\_\_\_\_

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



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## INFORMED CONSENT & AGREEMENT FOR PSYCHOTHERAPY SERVICES

**WELCOME!** The following information is presented to you with the belief that by having a clear understanding and awareness of the business aspects of the clinical relationship it will provide the clarity needed to facilitate a healthy outcome in your personal therapeutic/academic process. By signing your initials to the bottom of each page you are indicating that you have read and understand all intake documents and the information contained in this document.

**INFORMATION ABOUT YOUR INDEPENDENT CONTRACTOR/ PROVIDER:** Your provider, will upon your request, share his/ her professional background information as it pertains to education, professional orientation, or area of expertise. Please also note that biographies of each **independent contractor** are posted on the website [www.thecostellocenter.com](http://www.thecostellocenter.com)

**RISKS AND BENEFITS OF THERAPY:** Psychotherapy/psychiatry are both a process in which a myriad of issues, events, experiences, medical history, memories, therapeutic history, as well as trauma will be discussed for the purpose of gathering information so that a treatment plan can be established. Psychotherapy/psychiatry provides an opportunity to understand yourself better as well as to assist you with identifying any problems or difficulties you may be experiencing in regards to your overall emotional state. This type of therapy is a joint effort between you and your provider.

Progress and success may vary depending upon the particular problems or issues that are being addressed, as well as many other factors. Participating in therapy **MAY** result in several benefits to you, including, but not limited to reducing stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, employment and family settings, increased capacity for intimacy, increased empowerment/awareness, as well as increased self-confidence. These benefits will also require substantial effort on your part, including active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. However, there is **NO** guarantee that therapy and/or psychiatry will yield any or all the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process **MAY** evoke strong feelings of sadness, anger, fear, anxiety, unpleasant side affects (EMDR or psychiatry as it relates to medication) etc. There **MAY** be times in which the provider will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is **YOUR** sole responsibility.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please discuss with your provider any concerns you may have regarding your progress in therapy.

Due to the varying nature and severity of problems and the individuality of each client, the provider is **unable** to predict the duration of therapy or to guarantee a specific outcome or result.

**EXPLANATION OF DUAL RELATIONSHIP:** While a healthy therapeutic relationship can be very personal in nature, it is important to be clear that the relationship with your provider is a professional one. Your provider holds their roles as a licensed professional in the highest esteem and believes the safety of the therapeutic relationship to be a vital part of the process of healing and growing. Professional boundaries will be maintained at all times. Since the community is quite small, there may be times in which the client and the provider may cross paths. The provider will **NOT** approach, you the client, in a public setting.

**TERMINATION OF THERAPY:** The ending of the therapeutic relationship is an important process and should be discussed during your regular session. If your provider has not heard from you in 90 days, without it being planned/discussed with provider, your records will indicate that you have been discharged. However, if at any time you choose to return, you are welcome to call and schedule an appointment.

**Initial \_\_\_\_\_ by initialing you have read and agree to the above terms and conditions**

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**PROFESSIONAL CONSULTATION:** Professional consultation is an important component of a healthy therapeutic practice. As such, providers may choose to participate in clinical, ethical and legal consultation with appropriate professional. During such consultations, any personal identifying information regarding you or your situation will **NOT** be revealed.

**COLLABORATION WITH OTHER PROFESSIONALS:** To provide quality services, providers often need to collaborate with other professionals, such as your physician, psychiatrist, gynecologist, past therapists, attorney's, and or other mental health professionals. You will be asked to complete a release/disclosure of information authorizing these exchanges; a release/disclosure form must be signed before these services are provided.

**RECORDS AND RECORD KEEPING:** Providers take notes during sessions, and will also produce other notes and records regarding your treatment. These notes constitute their clinical and business records, which by law, providers are required to maintain. Such records are the sole property of the **INDEPENDENT CONTRACTOR/PROVIDER**. Should you request a copy of your records, such a request **MUST** be in made in writing to your provider. Your **INDEPENDENT CONTRACTOR/PROVIDER** reserves the right, under Florida law, to provide you with a **treatment summary in lieu of actual records**. Your **INDEPENDENT CONTRACTOR/PROVIDER** also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider as you authorize. Your provider maintains records for a minimum of seven years following termination of therapy (as required by Florida law). After seven years, your records may be destroyed in a manner that preserves your confidentiality. Some **INDEPENDENT CONTRACTOR/PROVIDERS** use **paperless electronic progress forms/notes**. These are confidentially protected and these records will also be destroyed in a manner that preserves your confidentiality.

**CONFIDENTIALITY:** The information disclosed by you is confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else, cases involving suspected child abuse, elder or dependent adult abuse; cases in which providers are court- ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices", (Copies available upon your request).

**PSYCHOTHERAPIST/PSYCHIATRIST-PROVIDER -CLIENT PRIVILEGE:** The information disclosed by you, as well as any records created, is subject to the psychotherapist/psychiatrist/provider- client privilege. The psychotherapist/psychiatrist/provider-client privilege results from the therapeutic relationship between the provider and client in the eyes of the law. It is similar to the attorney-client privilege or doctor-patient privilege. Typically, the client is the holder of the psychotherapist/psychiatrist/provider. If your provider receives a subpoena for records, deposition testimony, or testimony in a court of law, providers will assert the psychotherapist/psychiatrist/provider-client privilege on your behalf until instructed, in writing by you, to do otherwise or approved by your representative. You should be aware that you might be waiving the psychotherapist/psychiatrist/provider -client privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding. You should discuss any concerns you might have regarding the psychotherapist/psychiatrist/provider client privilege with your attorney.

**CLIENT LITIGATION- The INDEPENDENT CONTRACTOR/ PROVIDERS/ OFFICE STAFF and The Costello Center's Employees will NOT voluntarily participate in any litigation or custody dispute** in which you and another individual, or entity are parties. It is the policy to not communicate with clients attorneys without the written request and consent of the client. Your provider will generally not write or sign letters, reports, declarations, or affidavits to be use in any client's legal matter. Providers will generally **NOT provide records or testimony unless legally compelled to do so.**

**FEES:** Even though your insurance company carrier may pay all or part of any psychotherapy or psychometric assessments you incur, it is **YOUR** responsibility for payment **at the time of each visit**. A **\$50.00 service charge** will be levied on all checks returned by a bank for any reason. **You** may discuss with your provider any questions about your fee for your appointment (s). **PLEASE NOTE** this fee structure does not apply for psychiatric fees. Psychiatric fee's **CAN NOT** be submitted to insurance for possible reimbursement, these providers are independent contractors and do **NOT** have a contractual fee with insurance providers for use at **this office**.

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**APPOINTMENT SCHEDULING AND CANCELLATION POLICIES:** When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, the **PROVIDER/INDEPENDENT CONTRACTOR** does not have sufficient time to fill that slot. Therefore, sessions must be canceled a minimum of 24 hours in advance (**this does not include voicemails left during non-business hours when the office is closed, notification of a cancellation must be given during business hours**) or the full fee for that session will be charged. Please note that if you are intending to submit to an insurance carrier (with the exception of psychiatry), most insurance carriers do not reimburse for missed appointments.

**INSURANCE:** Your Provider **DOES NOT** accept insurance. It is your responsibility to call and check the lists and scope of your insurance coverage. It is also your responsibility to obtain any pre approval or pre-certification from your insurance carrier. Your paid invoice receipt may be sufficient for proper claims handling by your carrier and a receipt will be provided to you at each visit.

**DELINQUENT ACCOUNTS:** You are responsible for all charges incurred and you understand that services **MUST** be paid in full at the time of each service unless other arrangements have been made in writing in advance through your individual **PROVIDER/INDEPENDENT CONTRACTOR**. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of any balances owing and attorney fees.

**INDEPENDENT CONTRACTOR/PROVIDER AVAILABILITY:** You **MAY LEAVE A NON-URGENT MESSAGE FOR YOUR** Provider at any time by calling The Costello Center (727) 345-2667. If you wish for your provider to return your call, please be sure to leave your name and phone number (s), along with a brief message concerning the nature of your call. **NON-URGENT** phone calls are generally returned within 48 hours during normal workdays. Please note our office closes early on Friday, at 3:00 pm.

#### **EMERGENCIES:**

Please understand that your provider is **UNABLE** to personally provide continuous 24 hour crisis service. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, **PLEASE CALL 911 to request emergency assistance, or go to the nearest emergency room. Email and phone messages are never to be used for urgent situations.**

**VACATIONS AND OTHER UNEXPECTED ABSENCES:** Taking time off is a part of self-care. Your **INDEPENDENT CONTRACTOR/PROVIDER** will periodically take time off for vacation and/or holiday and your therapeutic treatment may be temporarily on hold. Notification will be given in advance, whenever it is possible by your provider. Otherwise, if for some reason your Independent Contractor/Provider cannot make your scheduled time due to illness, a family emergency etc., The Costello Center will do their best to contact you as early as possible to notify you of the situation.

**PSYCHIATRIC SERVICES:** If you are meeting with the psychiatrist or nurse practitioner for psychiatric services, your initial visit will be an initial evaluation only, which will not guarantee the continuation of care by your provider, or same medications prescribed by previous providers or other providers. During your initial session, your provider will discuss your diagnosis, prognosis, the proposed/recommended treatment, the risks and the benefits associated with the proposed/recommended treatment, alternative treatments, the risks and benefits of alternative treatments and the risks of forgoing treatment should you refuse treatment.

**ANCILLARY SERVICES:** The Psychiatrists, Counselors, Certified Addiction Professionals, Nurse Practitioner, Psychometrists, Psychologists, Life Coaches, Tutors, Play Attention Coaches, are **ALL INDEPENDENT CONTRACTORS** and **NOT EMPLOYEES** of The Costello Center.

Initial \_\_\_\_\_ by initialing you have read and agree to the above terms and conditions

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The Costello Center  
8081 38<sup>th</sup> Ave N., St. Petersburg, FL 33710  
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- Kim E. Costello, Psy.D., LMHC, DAPA, BCPC  Carolyn McNulty\*, LMHC, GAL  Michelle L. Donley\*, LCSW  Rachel Agustines\*, MD  Alison Fuhr\*, ARNP  
 Kim Hughes\*, LMHC, LPC, NCC  Heather Bishop\*, LMHC  Lindsay Harrison\*, LMHC  JuliAnn Marzuola\*, LDN, LMHC  Nestor Levesque\*, LMHC  
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**E-MAIL AND PHONE COMMUNICATION:** Some clients prefer to communicate about appointment times or other administrative issues via e-mail. Although information stored on our computers is on an in-house serve, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition, once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. E-mail should be considered more similar to a “post-card” than to a sealed letter, and for that reason the risks of using email are listed below:

**A. General email risks include but are not limited to the following:** (A) Email can be immediately broadcasted worldwide and received by many intended and unintended recipients; (B) Recipients can forward email messages to other recipients without the original sender’s permission or knowledge; (C) Users can easily send an e-mail to the incorrect address; (D) Email is easier to falsify than handwritten or signed documents; (E) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy; and (F) Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning.

**B. Specific email risks include but are not limited to the following:** (A) Email containing information pertaining to a client’s diagnosis and/or treatment must be included in the client’s medical records. Thus, all individuals who have access to the medical record will have access to the email messages; (B) If you are sending your emails from your employer’s computer, your employer does have access to your emails; (C) While it is against the law to discriminate and Florida subscribes to a “no cause” termination policy, an employer who has access to your email can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure; (D) Insurance companies who learn of your PHI information could deny you coverage; (E) Although providers will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame. The exception would be when that email is part of a scheduled time frame for a prepaid email counseling session.

**C. Conditions for use of Email:** All email messages sent or received that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risk outlined above the security and confidentiality of email cannot be guaranteed. **Your consent to email correspondence includes your understanding of the following conditions:** (A) All emails to and from you concerning your personal health information (PHI) will be a part of your file and can be viewed by health care and insurance providers and TCC office support staff; (B) Your email messages may be forwarded within the center as necessary for diagnosis, treatment, and reimbursement. However, they will not be forwarded outside the office without your consent or as required by law; (C) Though all efforts will be made to respond promptly this may not be the case. Because the response cannot be guaranteed *please do not use email in a medical emergency*; (D) You are responsible for following up with the provider or support staff if you have not received a response; (E) Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, and developmental disability or substance abuse issues; (F) Since employers do not observe an employee’s right to privacy in their email system, you should not use your employer’s email system to transmit or receive confidential emails; (G) The Costello Center will take reasonable steps to ensure that all information shared through emails is kept private and confidential. However, The Costello Center is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct or system failure.

**Please initial the options that meet your needs. You can change this at any time by communicating to The Costello Center front office staff and your Provider in writing.**

\_\_\_\_\_ I do not wish to receive any treatment-related information via e-mail.

\_\_\_\_\_ I understand the risks of unencrypted e-mail, and **do hereby give permission** for The Costello Center and my Provider(s) to contact me or to reply to me via unencrypted e-mail.

Please provide preferred e-mail address \_\_\_\_\_

**Initial \_\_\_\_\_ by initialing you have read and agree to the above terms and conditions**

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### ACKNOWLEDGEMENT

By signing below, Client(s) acknowledge that Client(s) have reviewed and fully understand the *Notice of Privacy Practices*, as well as the terms and conditions of this *Informed Consent and Agreement*. Client(s) have the right to discuss such terms and conditions with their provider, and have had the right to have any questions with regards to its terms and conditions answered to the Client(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Provider. Moreover, Client(s) agree to hold Provider free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save Provider negligence, that may result from such treatment.

\_\_\_\_\_  
Client Name (please print)

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

\_\_\_\_\_  
Date

### FINANCIAL AGREEMENT

I understand that I am financially responsible for payment for all services rendered at the time of service and that I am obligated to pay all charges even if denied by my insurance carrier after self-submission. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my provider to collect money on my behalf.

\_\_\_\_\_  
Name of Responsible Party (please print)

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

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