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: _____

CLIENT DATA FORM – CHILD/ADOLESCENT

A. Basic Information

Child/Adolescent's Name: _____ Date: _____

Date of Birth: _____ Gender _____ Race/Ethnicity _____

Address: _____ Phone: _____
Street City State Zip Code

Mother: _____ Age: _____ Marital Status: _____

Phone: _____ May we leave a message? ❑Yes ❑ No

Email: _____

Address (if different than client): _____
Street City State Zip Code

May we mail to this address? ❑ Yes ❑No

Place of Employment: _____ Occupation: _____

Work Phone: _____ Highest Degree Earned: _____

Father: _____ Age: _____ Marital Status: _____

Phone: _____ May we leave a message? ❑ Yes ❑ No

Email: _____

Address (if different than client): _____
Street City State Zip Code

May we mail to your home? ❑ Yes ❑ No

Place of Employment: _____ Occupation: _____

Work Phone: _____ Highest Degree Earned: _____

Who has legal custody? ❑ Mom ❑ Dad ❑ Joint ❑ Other, please specify: _____

Is there a court order concerning custody? ❑ Yes ❑ No

Other Persons Living in Client's Household (names, dates of birth, and relationship to client)

Name:	Relationship	DOB	Other Information that May be Relevant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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What is your relationship to the client? _____

Is there a court order appointing you as guardian? ❑ Yes ❑ No

If NOT the Mother/Father, please complete the following:

Name: _____ Phone: _____ May we leave a message? ❑ Yes ❑ No

Address (if different than child's): _____
Street City State Zip Code

May we mail to your home? ❑ Yes ❑ No

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

❑ Other: _____

Who is the appointment with today? _____

B. Medical History

Primary Care Physician: _____ Phone Number: _____

Pregnancy and Birth History: ❑ Full term ❑ Premature ❑ Adopted, please specify: _____

_____

Please list any unusual circumstances during the clients first five years (separation/divorce, deaths in family, etc.):

_____

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

_____

Surgeries or operations (Identify and give dates): _____

_____

Hospitalizations? ❑ Yes ❑ No If yes, please list date and reason: _____

_____

Does your child/adolescent have a history of infectious diseases? ❑ Yes ❑ No If yes, please describe:_____

_____

Does your child/adolescent have any allergies? ❑ Yes ❑ No If yes, please describe: _____

_____

Is your child/adolescent currently taking medications? ❑ Yes ❑ No If yes, please list: _____

_____

Has your child/adolescent taken prescribed medications in the past? ❑ Yes ❑ No If yes, please list: _____

_____

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Is or has your child/adolescent been under the care of a psychiatrist? ❑ Yes ❑ No If yes, with whom and when?

_____

Has your child/adolescent had previous counseling? ❑ 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:

__Abuse
__Addictions
__Substance Use/Abuse *(tobacco, alcohol, illegal/prescription drugs)*
__ADHD symptoms
__Anxiety symptoms
__Anger or irritability
__Changes in mood
__Obsessive thoughts
__Worry or guilt
__Lying
__Adjustments *(Changing schools, parent's getting married or divorced, pet died, new job, job loss, etc.)*
__Bad dreams/nightmares
__Sleeping difficulties
__Bed wetting
__Career decisions
__Learning disability
__Learning/academic difficulties
__Personal growth
__Relationship problem
__Parent-child relationship problem
__Non-family relationship problem *(teacher, peers, etc.)*
__Chronic illness
__Eating problem
__Sexual concerns
__Cutting/Self-injurious behavior
__Sadness or depressive symptoms
__Suicidal thinking
__Other:_____

Parent/Guardian Signature: _____Date:_____

Client (Child/Adolescent) General Information Form

Part A. Emergency Contact Information

_____ _____
Full Name (Please Print) Relationship

_____ _____
Home phone Cell/work phone

Part B. Academic Information (if applicable)

Current School: _____

Grade: _____ GPA: _____ Were you referred by the school? Yes No

Are there any problems at school? ❑ Yes ❑ No If yes, please describe: _____

_____

_____

_____

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Part C. Payment Information

Person responsible for session 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 and your minor child (client) 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 the client's privacy. The *Health Information Portability and Accountability Act (HIPAA*) establishes rules on how the client's 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 the client's privacy than the Federal Law.

Our pledge to clients:

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

We are required by law to:

- Keep medical information about the client private.
- Give the client this notice of our legal duties and privacy practices with respect to medical information about the client.
- 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 the client's Protected Health Information is guaranteed.
- How the client's Protected Health Information may be used and shared.
- How you may access portions of the client's Protected Health Information and the procedure for doing so.

The Client's Protected Health Information (PHI)

The client's Protected Health Information includes any individual identifiable information created or received about them. Specifically it includes:

- Identification of symptoms, diagnosis, medicine, and their 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 or the minor's legal guardian must give written permission to release them.

Use and Disclosure of the client's Protected Health Information

(PHI) Without specific consent from you or the minor's legal guardian:

- We will not share with the client's 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 the client's PHI with another therapist or treatment facility.
- We will not share the client's 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 the client's PHI, if necessary.
- We are required to take action, including the release of the client's PHI, if we believe that the client or someone else is in risk of harm to themselves or others.
- We may share the client's 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 the client's PHI in case of a medical emergency to medical staff.

Parent/Guardian Signature: _____ Date: _____

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We may release the client's 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	

Client's Privacy Rights

You (Parent/Guardian) have the right:

- To decide with the exception of those listed above, if the client's PHI is given out to a third party and to specify what information is given. This is done by completing and signing the Consent Release Information. You may revoke this consent at any time.
- To review and get copies or your PHI. The request must be in writing. There may be charges for copying and postage. The request may be denied if it is determined that releasing the client's PHI may endanger their life or physical safety or that of another person.
- To request that corrections or additions be made to the client's 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.

Parent/Guardian Signature: _____ Date: _____

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Parent/Guardian Informed Consent & Agreement for Psychotherapy Services of a Minor

WELCOME! The following information is presented 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 the client's personal therapeutic/academic process. By signing your initials at the bottom of each page you are indicating that you have read and understand all intake documents and the information contained in this document on behalf of the minor being treated.

INFORMATION ABOUT YOUR INDEPENDENT CONTRACTOR/ PROVIDER: Your child's 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.

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 for your child to understand him/herself better as well as to assist the child with identifying any problems or difficulties they may be experiencing in regards to their overall emotional state. This type of therapy is a joint effort between you, your child and their 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 your child, 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 child's perceptions and assumptions, and offer different perspectives. The issues presented by your child 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 child's personal relationships is **YOU and/or YOUR Child's** 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 child's provider any concerns you may have regarding your child's 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 child's provider is a professional one. Your child's 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 or your child 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 child's regular session. If your child's provider has not heard from you in 90 days, without it being planned/discussed with provider, your child's records will indicate that they have been discharged. However, if at any time you choose for your child to return, you are welcome to call and schedule an appointment.

Parent/Guardian Initial _____ by initialing you have read and agree to the above terms and conditions on behalf of the minor

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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 your child or their situation will **NOT** be revealed.

COLLABORATION WITH OTHER PROFESSIONALS: To provide quality services, providers often need to collaborate with other professionals, such as your child's physician, psychiatrist, gynecologist, past therapists, attorney's, and or other mental health professionals. You will be asked to complete a release/disclosure of information on your child's behalf 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 child's 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 child's records, such a request **MUST** be made in writing to their provider. Your child's **INDEPENDENT CONTRACTOR/PROVIDER** reserves the right, under Florida law, to provide you with a **treatment summary in lieu of actual records.** Your child's **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 child's provider maintains records for a minimum of seven years following termination of therapy (as required by Florida law). After seven years, your child's records may be destroyed in a manner that preserves their 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 child's confidentiality.

CONFIDENTIALITY: The information disclosed by your child 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 your child poses a threat of serious harm to themselves 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 your child, 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 child's 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 child's behalf until instructed, in writing by you, to do otherwise or approved by your child's representative. You should be aware that you might be waiving the psychotherapist/psychiatrist/provider -client privilege regarding your child's entire treatment if you make their mental or emotional state an issue in a legal proceeding. You should discuss any concerns you might have regarding your child's 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 clients parents/guardians. Your child's provider will generally not write or sign letters, reports, declarations, or affidavits to be used 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 your child 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 child's provider any questions about your child's fee for their 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.

Parent/Guardian Initial _____ by initialing you have read and agree to the above terms and conditions on behalf of the minor

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8081 38th Ave N., St. Petersburg, FL 33710
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APPOINTMENT SCHEDULING AND CANCELLATION POLICIES: When an appointment is scheduled, that time is reserved for your child. 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 child's 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 child's 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 child's individual **PROVIDER/INDEPENDENT CONTRACTOR.** Should your child's 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 interest and any collection expenses of any balances owing, court, and attorney fees.

INDEPENDENT CONTRACTOR/PROVIDER AVAILABILITY: You **MAY LEAVE A NON-URGENT MESSAGE FOR YOUR CHILD'S** Provider at any time by calling The Costello Center **(727) 345-2667**. If you wish for your child's 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 child's 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 child's 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 child's **INDEPENDENT CONTRACTOR/PROVIDER** will periodically take time off for vacation and/or holiday and your child's therapeutic treatment may be temporarily on hold. Notification will be given in advance, whenever it is possible by your child's provider. Otherwise, if for some reason your child's Independent Contractor/Provider cannot make your child's 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 your child is meeting with the psychiatrist or nurse practitioner for psychiatric services, your child's initial visit will be an initial evaluation only, which will not guarantee the continuation of care by your child's provider, or same medications prescribed by previous providers or other providers. During your child's initial session, your child's provider will discuss with you and/or your their 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 and/or your child 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.

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E-MAIL AND PHONE COMMUNICATION: Some parents/guardians 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 child's 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 child's diagnosis or treatment or that are part of your child's medical record will be treated as part of their 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 child's personal health information (PHI) will be a part of their 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, but will not encrypt, 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.

Parent/Guardian 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_____

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Acknowledgement

By signing below, the Parent or Guardian 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*. Parent or Guardian has 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 Parent or Guardian satisfaction. Parent or Guardian agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Provider. Moreover, Parent or Guardian 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's Parent or Guardian	Date

Financial Agreement

I understand that I am financially responsible for payment for all services rendered to my minor child _____, 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

Please indicate relationship to client: ❑ Mother ❑ Father ❑ Court Appointed Guardian

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