



# CENTENNIAL PARK COUNSELING, PLC

**Thank you** for calling Centennial Park Counseling, PLC for an appointment. We look forward to serving you. We are confident your time with us will prove encouraging and helpful.

Please fill out the enclosed forms and bring them along with you to your first appointment. This will save valuable time and give us more time to discuss your needs.

Our office is conveniently located in the Image Building on 28<sup>th</sup> Street just a short distance off of the I-96 expressway. Take I-96 toward Lansing to the East 28<sup>th</sup> Street exit; turn right and go a few short blocks to Kraft Avenue. The office is located on the southeast corner of 28<sup>th</sup> Street and Kraft Avenue.

**Name:** Centennial Park Counseling, PLC  
**Address:** 2828 Kraft Avenue SE, Suite 186  
Grand Rapids, MI 49512

**Phone Number:** (616) 949-9550    **Fax Number:** (616) 949-9551

When coming for an appointment please use the front entrance to the building. Check in with the receptionist and she will inform you of our office location. Due to confidentiality you may choose not to give your name but just state that you are here for an appointment with Centennial Park Counseling. When you arrive in our office, please check in with our Administrative Staff and then wait in our client waiting area. Payment is due before your scheduled appointment. Your therapist will personally come to greet you and show you into his or her office.

**Because our building is secured, if appointments are after 5:30pm,** come to the main entrance and wait in the outer lobby as the main building will be locked. Your therapist will be there at the designated time or shortly thereafter to open the door. You may choose to call your therapist on the lobby phone to advise him or her of your arrival.

Do note this campus is a smoke free environment; please extinguish cigarettes in your vehicle.

Sincerely,

*Dr. Janice M. Bentley*

Dr. Janice M. Bentley  
Owner/President

# Centennial Park Counseling, PLC

PSY.D, LMSW, LPC, LLP, LMFT

2828 Kraft Avenue SE, Suite 186

Grand Rapids, MI 49512

(616) 949-9550

## CONSENT FOR SERVICES AND FEE AGREEMENT

To acquaint you further with the procedures and policies of our practice we are providing you with the following information. Please sign below, indicating your acceptance of the following terms:

**Practice:** We are a group of Doctoral and Master Degree therapists. We work with individuals, families, couples, children and organizations. It is our goal to assist you in understanding the particular problems that bring you here and help you find a way to resolve them.

**Office Hours:** Our administrative staff provides receptionist services Monday through Thursday from 8am – 6pm and Friday from 8am – 3pm. You may leave a message via voicemail with our staff by using the directory on the voice mail menu. We will make every effort to return your call as soon as possible. If we are unable to reach you, please call again. If for any reason your personal circumstances change in a way that affects your ability to pay or you have a change in home address or phone number, please contact the administrative staff immediately.

**Appointments/Missed Appointments:** Services are by appointment only. Scheduling appointments is done by calling our office at (616) 949-9550. If you need to cancel an appointment, please call the office as soon as possible. **Appointments cancelled with less than 24 hour notice may be billed to you.** Please note that insurance companies **do not** cover missed appointments.

**Confidentiality:** Your trust in us is extremely important. Your client records are our personal property and shall be treated as confidential. Please note that all client charts are kept for seven years following your closing date from counseling here at Centennial Park Counseling, PLC. After this time, records are destroyed. All information shared in session is confidential **except in circumstances governed by the laws including the mandatory reporting of alleged harm to self or others.** If we believe a consultation with another professional is important for your care, your confidentiality is protected under the "Privacy Practices" mandated by HIPAA (Health Insurance Portability and Accountability Act of 1996).

**Emergencies:** In case of a true emergency/crisis situation, please call 911 and/or go to the emergency room of a local hospital or call our office after-hours emergency crisis number at (616) 776-9684.

**Financial Responsibility:** The charges for Ph.D. and Psy.D therapists are as follows; a full session (53+ minutes) is \$155.00; a 45 minute session (38-52 minutes) is \$120.00; and a half session (16-37 minutes) is \$80.00. An initial evaluation for Ph.D. and Psy.D therapists is \$195.00 with additional charges for any testing. The charges for LMSW, LPC, and LLP therapists are as follows; a full session (53+ minutes) is \$125.00; a 45 minute session (38-52 minutes) is \$85.00; and a half session (16-37 minutes) is \$65.00. An initial evaluation for LMSW, LPC, and LLP therapists is \$165.00 with additional charges for any testing.

**Charges for extended phone calls and other services will be based upon the above charges for the time it takes to complete them.** If we are contracted with your insurance company, then contracted insurance rates apply. You are fully responsible for payment of all services rendered to you. We will bill your insurance company if we can verify your benefits. Full payment is expected at the time of service, unless we are a contracted provider for your insurance company. In the event that your insurance company denies coverage, you will be responsible for the full charge. We accept cash, check, and credit card payments with Visa, Discover and MasterCard. **Please make all checks out to: Centennial Park Counseling.** Upon review a service charge of \$5.00 per month may be added to all unpaid balances over 30 days. (Some insurance companies require an individual therapist to be supervised by our Clinical Director, in which case you will be billed under the name Dr. Randall Herrema.)

We will be happy to answer any questions you may have concerning our policies. We are looking forward to serving you.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person responsible for payment (if other than client) and phone number



## Cancellation Policy

### What if I Need To Cancel or Postpone My Appointment?

**Please contact our office at (616) 949-9550 to cancel an appointment.**

If for some reason you need to cancel or postpone the appointment, please be considerate of your therapist and other clients and give at least 48 hours notice. *Given the demand for appointment times, if less than 24 hours notice is given to cancel or reschedule your appointment or if you fail to show up for your scheduled appointment, you will be charged \$50.00 for the missed session.*

**Insurance does not pay for missed appointments. These charges are your responsibility.**

Payment will be due in full **before** the beginning of your next session. Future appointments will not be made until the Cancellation Charge has been paid in full.

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Signature of Client

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Date

Centennial Park Counseling, PLC  
2828 Kraft Avenue SE, Suite 186  
Grand Rapids, MI 49512

**PF 1000 NOTICE OF PRIVACY PRACTICES**

As required by the Privacy Regulations Created as a Result of the Health Portability and Accountability Act of 1996. (HIPPA)

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (AS A CLIENT IN THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**I. Our Commitment to Your Privacy**

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

**II. Uses and Disclosures**

**Treatment.** Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health care provider, such as your family physician or another professional counselor.

**Payment.** Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the clinical condition being treated.

**Health care operations.** Your PHI may be used as necessary to support the day-to-day activities and management of Centennial Park Counseling, PLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your PHI may be disclosed to federal, state or local law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Appointments.** Your PHI will be used by our staff to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. The contact may be made by phone, U.S. mail, email or texting.

**Informative Information.** Your PHI may be used to send you information on the treatment and management of your psychological/medical condition that you may find to be of interest. We may also send you information describing their psychological/health-related goods and service that we believe may interest you.

**\*\*If there is ever a breach of your healthcare information and it comes to our attention, we will inform you as soon as possible.**

### **III. Personal Rights**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to a restriction you request.
- The right to receive confidential communications concerning your psychological/medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.
- The right to inspect and/or copy your PHI that may be used to make decisions about you, including client psychological/medical records and billing records, but not including psychotherapy notes. The client's provider can provide a summary of the client's PHI if in the professional judgment of the client's provider, providing the client with unlimited access to his/her PHI would cause emotional/mental distress or endanger the life or physical safety of the client or another person. A client does not have the right to access Psychotherapy Notes relating to him/her except (i) to the extent the client's treating professional approves such access in writing; or (ii) the client obtains a court order authorizing such access. A provider has 30 days to reply.

### **IV. Requests to Inspect PHI**

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Administrative Coordinator at Centennial Park Counseling, PLC (616-949-9550). We may deny your access to PHI under certain circumstances, but in many cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

### **V. Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. We will post a copy of our current Notice in a visible location in our office at all times, and you may request a copy of our most current at any time.

### **VI. Complaints**

If you are concerned that your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your concerns to:

Jan Bentley, PsyD, LMSW  
Centennial Park Counseling, PLC  
2828 Kraft Avenue SE, Suite 186  
Grand Rapids, MI 49512

Or contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

### **VII. Contact Person**

The person you can contact for further information concerning our privacy practices is:

Jan Bentley, PsyD, LMSW  
Centennial Park Counseling, PLC  
2828 Kraft Avenue SE, Suite 186  
Grand Rapids, MI 49512  
(616) 949-9550

Centennial Park Counseling, PLC  
2828 Kraft Avenue SE, Suite 186  
Grand Rapids, MI 49512

**PF 2000 Consent to Use and Disclosure of  
Protected Health Information**

**Uses and Disclosure of Your Protected Health Information**

Your protected health information will be used by Centennial Park Counseling, PLC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**

You should review the “**Notice of Privacy Practices**” for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

**Requesting a Restriction on the Use or Disclosure of your Information**

You may request a restriction on the use or disclosure of your protected health information. Centennial Park Counseling, PLC may or may not agree to restrict the use or disclosure of your protected health information. If Centennial Park Counseling, PLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**

Centennial Park Counseling, PLC reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this consent form and received a copy of the Centennial Park Counseling, PLC “Notice of Privacy Practices” and give my permission to Centennial Park Counseling, PLC to use and disclose my health information in accordance with it.

\_\_\_\_\_

Date

\_\_\_\_\_

Name of Client (Print or Type)

\_\_\_\_\_

Signature of Client Representative

\_\_\_\_\_

Signature of Client

\_\_\_\_\_

Relationship of Client Representative

**Adult Intake Form**

To help your clinician understand your concerns, please answer the following questions on this form.

**Client's Legal Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**What is your reason for seeking therapy today?** \_\_\_\_\_

\_\_\_\_\_

**Gender Identity** (optional):  male  female  transgender  cisgender  non-binary

**Sexual Identity** (optional):  heterosexual  gay  lesbian  bisexual  pansexual  undecided

**Race/Ethnicity** (optional):

Please check the box that best represents your race/ethnic background. Please check all that applies.

- African American  Arab American  Asian or Pacific Islander  Caucasian  Hispanic  
 Multi-racial  Native American  Other: \_\_\_\_\_

**DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult**

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff, or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Are there other concerns not listed above that you want to discuss? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PREVIOUS COUNSELING:**

Outpatient (place and year) \_\_\_\_\_  
 Inpatient (place and year) \_\_\_\_\_  
 Intensive Outpatient Program/Partial (place and year) \_\_\_\_\_

**FAMILY & SUPPORTIVE RELATIONSHIPS**

Marital Status:  Single  Married  Divorced  Widowed  Committed partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, Neighbor, roommate, parents)	Quality of Relationship <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Living with you? <input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N

**EDUCATION**

Highest level completed:  
 high school  attended college or technical school  college degree  graduate degree  other \_\_\_\_\_

**EMPLOYMENT/CAREER**

employed  unemployed  disabled  retired  stay-at-home parent

**FINANCES**

Overall stress level:  high  medium  low

**SPIRITUALITY/RELIGIOUS BACKGROUND AND PRACTICE:**

Religious upbringing:  nonexistent  attending church  belief in God  other \_\_\_\_\_  
 Present practice:  inactive  active  searching  other \_\_\_\_\_

**TRAUMA HISTORY**

Have you had a history of trauma, abuse, or neglect?  Yes  No  
 If yes, what type of abuse or trauma occurred?  
 Physical  Sexual  Emotional  Neglect  Verbal

**MEDICATION**

Please list all current medications and supplements you are taking: (attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)?  Yes  No  
 Name of medication: \_\_\_\_\_ Explain reaction: \_\_\_\_\_  
 Name of medication: \_\_\_\_\_ Explain reaction: \_\_\_\_\_



**MEDICAL INFORMATION (Optional)**

Please check all medical issues for which you have had treatment:

- Allergies  
(e.g., allergic reactions, seasonal allergies, etc)
  - Bone disease  
(e.g., osteoporosis, arthritis, broken bones, etc)
  - Endocrine disease  
(e.g., diabetes, hypothyroid, low testosterone, etc)
  - Head and brain illness or injury  
(e.g., fainting, concussion, seizures, dementia, etc)
  - Immune disease  
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)
  - Mouth and teeth disease  
(e.g., gum disease, cold sores, canker sores, etc)
  - Poisoning & chemical exposure  
(e.g., overdose, lead exposure, work fumes, etc)
  - Other \_\_\_\_\_
- Blood disease  
(e.g., anemia, bleeding disorders, etc)
  - Digestive system disease  
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)
  - Genetic disease  
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)
  - Heart/cardiovascular disease  
(e.g., heart arrhythmia, heart attack, high blood pressure)
  - Lungs and breathing disease  
(e.g., asthma, COPD, emphysema, etc)
  - Muscle and movement disease  
(e.g., tremors, tics, Restless Legs, Parkinson's, etc)
  - Serious injuries and wounds  
(e.g., burns, cuts, stabs, crushed limbs, etc)

Check all areas where you have had past **surgeries**:

- Cancer  
(e.g., procedures for cancer treatment)
  - Ear, Nose, Throat  
(e.g., tonsillectomy, thyroidectomy, etc)
  - Obstetrics & Gynecology  
(e.g., hysterectomy, c-section, abortion, etc)
  - Plastic surgery  
(e.g., reduction, implant, reconstruction, etc)
  - Urology  
(e.g., kidney stones, hypospadias, erectile dysfunction, etc)
  - Weight loss  
(e.g., gastric bypass, band, sleeve, etc)
- Cardiac / Vascular  
(e.g., procedures for heart, blood clot, stroke)
  - Gastroenterology (digestive system)  
(e.g., stomach, gall bladder, liver, etc)
  - Orthopedic  
(e.g., joint replacement, bones, spinal fusion, etc)
  - Neurosurgery  
(e.g., brain surgery, spinal fusion, etc)
  - Vision  
(e.g., LASIK, eye muscle correction, etc)
  - Other: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Do you have any current or ongoing medical concerns? \_\_\_\_\_  
\_\_\_\_\_

Do you have problems with pain?                     Yes                     No

Severity of your pain?    (low)    1    2    3    4    5    6    7    8    9    10    (high)

Location of your pain? \_\_\_\_\_

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home?     Yes                     No

If yes, please explain \_\_\_\_\_

**SUBSTANCE USE:**

Do you use alcohol?     Yes     No    (If yes, number of drinks and frequency: \_\_\_\_\_)

Do you use recreational/illicit drugs?     Yes     No    (If yes, drug(s) of choice and frequency: \_\_\_\_\_)

Have others viewed your use as a problem?     Yes     No

Have you ever tried to cut down on your alcohol or drug use or quit using?     Yes     No

If yes, please explain: \_\_\_\_\_

Has alcohol/drug use interfered with family, work, or interpersonal life?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you had any prior substance abuse treatment?  Yes  No

When?

Where?

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

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

**LEGAL HISTORY:**

Involved with the legal system, Friend of the Court or Child Protective Services?  Yes  No

If yes, explain \_\_\_\_\_

Do you currently have a probation or parole officer?  Yes  No

If yes, name \_\_\_\_\_

Have you been involved with the legal system in the past?  Yes  No

If yes, explain: \_\_\_\_\_

**CLIENT'S SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**THANK YOU!**



**Notification & Coordination with Primary Care Physician/Psychiatrist**

2828 Kraft Ave SE, Suite 186, Grand Rapids, MI 49512

Phone (616) 949-9550 / Fax (616) 949-9551

**Authorization of Release and/or Exchange of Information**

**Client Name:** \_\_\_\_\_

**Client DOB:** \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_

**Physician Name/Clinic:** \_\_\_\_\_

Phone #: \_\_\_\_\_ and Fax #: \_\_\_\_\_

**Current Psychiatric Services** ( ) Yes ( ) No

Treating Psychiatrist/Clinic: \_\_\_\_\_

Phone #: \_\_\_\_\_ and Fax #: \_\_\_\_\_

**List All Current Medications: \*If more room needed, please attach separate sheet**

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

***It is helpful for your therapist to coordinate with your PCP/ Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP/ Psychiatrist Form.***

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed.

If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

**PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:**

I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, Centennial Park Counseling, PLC its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

**Extent of information to be disclosed:** ( ) Verbal Exchange or Written Summary or ( ) Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of client, parent, guardian  
and/or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**-----OR-----**

My therapist has explained to me the importance of coordinating medical and mental health services. At this time, I **choose not to sign** a release for the exchange and release of information with my primary care physician.

\_\_\_\_\_  
Signature of client, parent, guardian  
and/or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**For Office Use Only:**

Therapist Name: \_\_\_\_\_ Current Diagnosis: \_\_\_\_\_

Other Clinical Information: \_\_\_\_\_

CPC Administrative Staff – Faxed by: \_\_\_\_\_ On (date): \_\_\_\_\_



## Authorization for Scheduling, Billing, and Payment Purposes

This form, when completed and signed by you, authorizes the person(s) whom you have indicated below to call on your behalf for scheduling, billing and payment issues only.

I authorize \_\_\_\_\_

Please indicate your relationship with this person below:

Spouse     Significant other     Parent/Guardian     Other: \_\_\_\_\_

---

I authorize \_\_\_\_\_

Please indicate your relationship with this person below:

Spouse     Significant other     Parent/Guardian     Other: \_\_\_\_\_

---

I authorize \_\_\_\_\_

Please indicate your relationship with this person below:

Spouse     Significant other     Parent/Guardian     Other: \_\_\_\_\_

- This authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to the Centennial Park Counseling, PLC.

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