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

______________________________________ _______________________

Signature of Client 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 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

Centennial Park Counseling, PLC

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

Child/Adolescent Intake Form

(Age 17 or under)

Dear Parent/Guardian: To help your clinician understand and help your child/adolescent, please answer the questions on this form and bring it with you to his/her first appointment.

Child/Adolescent's Legal Name: ___________________________ ☐ Male or ☐ Female **DOB:**__________________

Forms completed by: ______________________________ Relationship to child/adolescent: _______________________

Is this child/adolescent adopted? ☐ Yes or ☐ No

Describe his/her best characteristics:

____

RACE/ETHNICITY (optional)

Please check the box that best represents your child/adolescent's race/ethnic background:

☐ African-American/Black ☐ Arab American ☐ Asian or Pacific Islander ☐ Hispanic ☐ Multi-racial
☐ Native American ☐ White/Caucasian ☐ Other: ____________________________ or check all that apply

PRESENTING PROBLEM/REASON FOR TREATMENT

What is the primary reason for having your child/adolescent come in for counseling? _____________________________

____

____

DSM-5 Parent/Guardian - Rated Level 1 Cross-Cutting Symptom Measure – Child/Adolescent

	During the past TWO (2) WEEKS, how much (or how often) has your child/ adolescent…	**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. Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up to early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
	5. Had less fun doing things than he/she used to?	0	1	2	3	4	
IV.	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Seemed angry or lost his/her temper?	0	1	2	3	4	
V.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VI.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
VII.	12. Not been able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
VIII.	14. Said that he/she heard voices – when there was no one there – speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
IX.	15. Said that he/she had a vision when he/she was completely awake – that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?						
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	

XI.	18. Seemed to worry a lot about things he/she touched being dirty or having germs or be poisoned?	0	1	2	3	4	
XII.	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS**, has your child/adolescent…						
XIII.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	0	1	2	3	4	
	21. Smoked a cigarette, a cigar, or pipe, or using snuff, or chewing tobacco?	0	1	2	3	4	
	22. Used 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	
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	0	1	2	3	4	
	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	0	1	2	3	4	
	25. Has he/she EVER tried to kill himself/herself?	0	1	2	3	4	

Are there other concerns (not listed above) that you want to discuss?
____
____
____

How have these concerns impacted your child/adolescent's daily life?
____
____

YOUR CHILD/ADOLESCENT'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? □No □Yes
If yes, how long?
____

What are the current custody/visitation arrangements? ____
____

Please tell us about the household/family which your child/adolescent spends the majority of his/her time (or who currently lives with your child/adolescent). List primary household information first, and then list other living situations/supportive relationships:

Name	Age	Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle)	Quality of Relationship	Living with you?
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No
			□ Good □ Fair □ Poor	□ Yes □ No

YOUR CHILD/ADOLESCENT'S LIFE STORY

Where does your child/adolescent attend school?

____

What is the highest grade level of school he/she has completed?

____

What have been his/her usual report card grades?

____

What have been his/her most recent grades?

____

Has he/she experienced any of the following in school?

☐ Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Emotional Problems

Has there been any academic (IEP) or psychological testing done at school or elsewhere? ☐ No ☐ Yes

If yes, when?

____

Results:

____

Has your child/adolescent ever received previous counseling, therapy, or psychiatric treatment? ☐ No ☐ Yes

If yes, with whom? ____

Has your child/adolescent ever been the victim of abuse or neglect? ☐ No ☐ Yes

If yes, was the abuse: ☐Physical ☐Sexual ☐Emotional ☐Neglect ☐Verbal

Please list any contacts your child/adolescent has had with the courts (including Friend of the Court):

____

Please list any contacts your child/adolescent has had with the police or Child Protective Services:

____

Has your child/adolescent ever had a problem with alcohol or other drugs? ☐No ☐Yes

Explain any 'Yes" answers above

____

____

What is your family's current religious affiliation? ____

Describe family involvement: ____

MEDICAL HISTORY

Does your child/adolescent have any current medical concerns?

____

____

Has he/she had any past surgical procedures? ☐No ☐Yes

If yes, list: ____

Has he/she been exposed to any contagious diseases such as Tuberculosis? ☐No ☐Yes

If yes, to what and when did the exposure take place? ____

Are immunizations current? ☐No ☐Yes

Please list all current medications and/or supplements your child/adolescent is currently taking:

(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

List any emergency room visits (age, reason):____

FAMILY/MEDICAL HISTORY

Were there any complications with the pregnancy of this child/adolescent that might have impacted his/her prenatal health or development? (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)

□ □No □ □Yes

Were there significant problems with his/her health or development in the first few years of his/her life?

(e.g: needed to be revived at birth, failure to thrive, or missed significant developmental milestones)□ □ No □ □ Yes

If yes, please explain:

____

____

Biological Father's Name: ________________________ Age: _________ Education: _________________________

Occupation: _________________________________ Deceased? □ □No □ □Yes (If yes, when? _______________)

Description of relationship between father and child/adolescent: ____

Biological Mother's Name: ________________________ Age: ________ Education: _________________________

Occupation: _________________________________ Deceased? □ □No □ □Yes (If yes, when? _______________)

Description of relationship between mother and child/adolescent: ____

Has anyone in your child/adolescent's extended family (ex: parent, grandparent, uncle/aunt) had a psychiatric illness?

□No □ □Yes

If yes, please describe to the best of your ability (Who, symptoms/diagnosis, were they hospitalized?)

____

____

Has anyone in your child/adolescent's family attempted suicide? □ □No □ □Yes

If yes, who?

____

Has anyone in your child/adolescent's family had a problem with or been treated for substance abuse problems?

□No □ □Yes

If yes, who?

____

Feel free to list any additional information you feel may be helpful to the clinician who will be working with your child/adolescent:

____

____

____

____

____

Completed by: ____ Date: ___________________

(Please sign your name)

THANK YOU!

CENTENNIAL PARK COUNSELING, PLC

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

(THIS IS A RELEASE OF INFORMATION FORM - NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/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:____

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):* ____________________

CENTENNIAL PARK COUNSELING, PLC

Notification & Coordination with Education Professionals
2828 Kraft Ave SE, Suite 186, Grand Rapids, MI 49512
Phone (616) 949-9550 / Fax (616) 949-9551

Authorization of Release/Exchange of Records and Information

Client Name: **Client DOB:**

Parent/Guardian:

School Name: ____________________________________ **Address:** ____
Phone #: ____ **Fax #:** ____
School Representative(s): ____

It is helpful for your therapist to coordinate with your school. Please indicate below whether you chose to give consent for the release of any or all information in this coordination with your school system.

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 school representative(s) 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 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 educational and mental health services. At this time, I ***choose not to sign*** a release for the exchange and release of information with the school representative(s).

________________________________ ___________ ________________________________ ______________
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):* ________________________

2828 Kraft Avenue SE, Suite 186
Grand Rapids, MI 49512
(616) 949-9550

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 indication your relationship with this person below:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _______________

I authorize ____

Please indication your relationship with this person below:

☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _______________

I authorize ____

Please indication 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: ___________________