Grace Jones Family Therapy, LLC
28 Parkway Commons Way, Greer, SC 29650
(864) 990-5617 | grace@gracejonesfamilytherapy.com
www.gracejonesfamilytherapy.com

Office Policies and Agreements

Welcome to Grace Jones Family Therapy. I am pleased that you have chosen me to serve you at this time in your life. This form will provide information about our professional services and special conditions related to our services; summary information about the Health Insurance Portability and Accountability (HIPAA), confidentiality, and about your rights as a client; and business practices.

This document represents an agreement between us. You may revoke this agreement at any time. That revocation will be binding, except in the following cases: 1) Grace Jones Family Therapy, LLC has already taken action in reliance upon this agreement, 2) Grace Jones Family Therapy, LLC has legal obligations on it by a court of jurisdiction, or 3) if you have not satisfied financial obligations that you have incurred. Your signature below indicates that you have an understanding of the information, and you freely consent to the services described herein. It is important that you read this form carefully and in its entirety.

Grace Jones Family Therapy, LLC follows the code of ethics of the following boards and organizations:

- South Carolina Department of Labor, Licensing and Regulation; Board of Examiners for Counselors, Therapists, & Psycho-Educational Specialists
- American Association for Marriage and Family Therapy (AAMFT)

APPOINTMENTS AND FEES

Appointments are given out on a first come, first serve basis. It is your responsibility to remember your appointment times. If you arrive late, the session will still have to end on time. Please note that if Grace Jones Family Therapy, LLC causes a late start, we will still provide a full session.

The 60-minute initial assessment fee is $150. All other 50-minute subsequent appointments are $140. Some sessions may last more than 50 minutes. The usual rate will be charged proportionate to the time used. Office hours are Monday-Thursday from 9AM-6PM.

Therapy sessions may be conducted in the office or via telehealth.

Grace Jones Family Therapy, LLC is willing to use email for scheduling purposes only. Please be aware that email is not completely secure or confidential. Additionally, if you choose to communicate with us by email, be aware that all emails are retained in logs of Internet Service Portals (IPSs) and that any correspondence via email, by law, becomes a part of your medical record.

Payment is expected in full at the time of service. Fees are payable via cash, check, or credit card (Visa, Mastercard, Discover). Make your checks payable to "Grace Jones Family Therapy, LLC". Please note that if

your check is returned for non-sufficient funds, you will be assessed a $30.00 fee and you will be required to pay for your visit plus the check fee by cash or by credit card.

In case of divorce or marital separation, the party responsible for the account is the parent authorizing treatment. If a court order requires the other parent to pay part or all of the medical expenses, it is the authorizing parent's responsibility to collect from the other parent.

If any problem arises during the course of your treatment regarding your ability to pay, please be sure to discuss this so that we can consider alternative arrangements that may allow you to continue with treatment.

INSURANCE

Grace Jones Family Therapy, LLC is in network with BlueCross BlueShield (BCBS). To use your BCBS insurance benefits, a client insurance information form must be completed prior to your first appointment. The information on the form will be used to verify benefits and for filing purposes. Unfortunately at this time, Grace Jones Family Therapy, LLC does not currently participate with any other insurance companies and we do not bill for out-of-network reimbursement. For out-of-network, it is the responsibility of the client to check if your insurance benefits include outpatient therapy services (individual or family). You will be provided with the necessary documentation if you wish to submit your claims for out-of-network benefits.

NO SHOW/ CANCELLATION

In order to provide the highest quality care, Grace Jones Family Therapy, LLC will require payment for missed therapy sessions. Missed appointments or cancellations without a 48 hour advance notice will be charged the full session fee which is never reimbursable by insurance. Please note, all Monday appointments must be cancelled by 12 noon on the prior Friday. If you cancel less than 48 hours in advance due to illness and provide a doctor's note, we will waive the Late Cancellation fee. The doctor's note should be provided at the time of your next scheduled session. If you miss more than two consecutive appointments without notice, you may be subject to termination as a client. Grace Jones Family Therapy, LLC reserves the right to cancel or reschedule an appointment at any time, for any reason.

AFTER HOURS CONTACT AND EMERGENCIES

The operating hours of Grace Jones Family Therapy, LLC are Monday through Thursday from 9:00 am to 6:00 pm. We are not equipped to offer treatment in an emergency or walk-in service. For this reason, it is important to be aware of general support services that are available through your community. In the event of an emergency, please dial 911 or go to the nearest hospital for an evaluation. Below are additional emergency services:

National Suicide Prevention Hotline: 1.800.273.8255
Marshall I. Pickens Hospital: 864.455.8988
Greenville Mental Health Center: 864.241.1040
The Carolina Center for Behavioral Health: 864.235.2335

REFERRALS TO OTHER PROFESSIONALS

There are times when a referral to a counselor/therapist, psychiatrist, other medical specialist or exercise specialist is necessary for me to be able to provide the appropriate treatment for the client. If the client chooses not to accept the referral against my advice, it is sometimes necessary for me to terminate my work with this client if I deem that the client's health is at stake or that continuation of treatment with me without the other professional(s) will be of no service to the client. Grace Jones Family Therapy, LLC contracting providers involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate method to assist you.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A federal law, HIPAA, provides privacy protection for medical records and rights for clients about the use and disclosure of your Protected Health Information (PHI). HIPAA requires that Grace Jones Family Therapy, LLC provide you with a Notice of Privacy Practices for use and disclosed the PHI for treatment, payment and health care options. The Notice of Privacy Practices explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that Grace Jones Family Therapy, LLC has provided you with this information.

CONFIDENTIALITY

Laws protect the privacy of communications between patients and their medical providers. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations Grace Jones Family Therapy, LLC will only release information about your treatment to others if you sign a written authorization that meets certain legal requirements.

In the following situations, no authorization is required:

a) Aspects of outpatient therapy may be shared within Grace Jones Family Therapy, LLC for educational, therapeutic, and treatment team reasons. All staff members are legally and ethically bound to keep this information confidential.

b) Information is also shared for administrative purposes such as appointment scheduling, billing, and quality assurance. All staff members are legally and ethically bound to keep this information confidential. Staff members have been given training about protecting your privacy.

c) On occasions, Grace Jones Family Therapy, LLC may find it helpful to consult with an outside health or mental health professional. During such consultations, identifying information is disguised to protect your confidentiality. The other professional is legally bound to keep the information confidential. All consultations are noted in the therapist's record.

d) Disclosures required to collect on overdue fees.

There are situations where Grace Jones Family Therapy, LLC may be required or permitted to disclose information without your authorization. These situations are unusual. They may include:

a) If Grace Jones Family Therapy, LLC has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a(n) child, elderly patient or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Welfare. Once the report is filed, we may be required to provide additional information.

b) If a patient communicated an explicit threat of serious harm to a clearly identifiable victim(s), and has the apparent intent to carry out such threat, Grace Jones Family Therapy, LLC may be required to take appropriate actions. These may include notifying potential victims, contacting the police and/or seeking hospitalization for the client.

c) If we believe that there is a high threat that a patient will physically harm him or herself, we will also take protective actions.

d) Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order Grace Jones Family Therapy, LLC to disclose personal health or treatment information. We may also be required to provide information about court ordered evaluations or treatments. If you are involved in or are contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order Grace Jones Family Therapy, LLC to disclose information.

e) Grace Jones Family Therapy, LLC is required to provide information requested by a legal guardian of a minor child.

f) If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), Grace Jones Family Therapy, LLC may be required to provide it.

g) If a patient files a worker's compensation case, Grace Jones Family Therapy, LLC may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the file was formed.

h) If a client files a complaint or a lawsuit against Grace Jones Family Therapy, LLC we may disclose relevant information regarding the client in order to defend itself.

If any of these situations arise, Grace Jones Family Therapy, LLC would make every effort to fully discuss with you before taking action and would limit disclosure to what is necessary. While this written summary of exceptions of confidentiality should prove helpful in informing you of potential problems, it is important that you discuss with us any questions you have. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

SOCIAL MEDIA

Please note that Grace Jones Family Therapy, LLC and its staff will not accept any requests to be "connected" to clients on social networking sites. This can compromise your confidentiality and our respective privacy and may also blur the boundaries of the therapeutic relationship.

CLIENT LITIGATION

Grace Jones Family Therapy, LLC and its staff will not voluntarily participate in any litigation or custody dispute. This includes communication with the client's attorney, as well as documentation such as letters, reports and affidavits. Should we be ordered by a court of law to appear as a witness in action involving the client, you agree to reimburse us for any time spent out of the office, for preparation and for travel at the rate of $140.00 per hour plus expenses. You also agree to release us from therapeutic duty and terminate our therapeutic relationship.

MINORS AND PARENTS

Please be informed that any person with legal rights pertaining to a child (e.g. legal guardian) may have the right to terminate a child's treatment. As stated earlier, Grace Jones Family Therapy, LLC will honor all requests for information by a legal guardian of a minor child.

Children under 18 years of age, who are not emancipated from their parents, should be aware that the law allows parents to examine their medical records. Typically with a parent's agreement, Grace Jones Family Therapy, LLC only provides general information about the progress of a child's treatment. With teenagers, more detailed disclosures are typically discussed beforehand with the teenager in order to minimize his/her objections and concerns, unless the therapist feels it is a crisis situation, including personal risk or physical danger to the minor.

In the context of family therapy, should family members be seen individually, material discussed may be shared with family members when your therapist believes it to be in everyone's best interest. In this circumstance, your therapist would encourage the individual to initiate sharing the information, but he/she reserves the right to bring up the information if he/she thinks it is useful for the whole family.

BENEFITS AND CONSEQUENCES OF OUTPATIENT THERAPY

Persons contemplating outpatient therapy should realize that clients frequently make significant changes in their lives. People often modify their emotions, attitudes, beliefs and behaviors. Clients may make changes in their marriage, jobs or other significant aspects of their lives. Because of outpatient therapy, clients may begin to feel differently about themselves and alter significant aspects of their lives. It is important to understand that some of the changes you may be seeking can take time. If you are seeing me for an Eating Disorder, it is not uncommon to have to be seen for three to five years for effective reduction, and/or elimination of symptoms and relapse prevention. If you have questions about the benefits and consequences of outpatient therapy, please feel free to ask at any time.

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Professional Disclosure Statement and Consent for Treatment

I understand that my participation in outpatient therapy is voluntary. I may terminate the therapeutic relationship at any time and will discuss any reasons for doing so with Grace Jones, MMFT, LMFT, CEDS.

I understand that all information shared is held in strict confidence and is only released by my written permission to specific persons or institutions for specific reasons. I further understand that there are some exceptions to confidentiality, which are mandated by state statute.

I have received and read a copy of Grace Jones Family Therapy, LLC's "Office Policies and Agreements" and understand its content. Under its terms, I further acknowledge that I consent to and seek treatment with Grace Jones, MMFT, LMFT, CEDS until such time as treatment goals are met or reasons for termination of services have been specified. I understand that outpatient therapy is a mutual relationship, which may be terminated by either party for specified reasons.

The signature(s) below confirm that I understand and accept all the information contained in Grace Jones Family Therapy, LLC's "Office Policies and Agreements" as well as the "Professional Disclosure Statement and Consent for Treatment."

_____ _____
Patient Signature *Date*

_____
Patient Printed Name

_____ _____
Parent/Guardian Signature *Date*

_____
Parent/Guardian Printed Name

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Patient Bill of Rights

You have the right to expect the following aspects of care:

1. To be treated with respect and dignity.
2. To an orientation to the treatment center and the explanation of the charges of care.
3. To participate in the assessment of your needs, including the elements of your life-style, freedom of thought, religious preference, values, concepts of health and illness, cultural heritage and practices regardless of race, color, religion, national origin, age, sex, disadvantaged status, political affiliation or handicap.
4. To an individualized written treatment plan; treatment based on that plan; periodic review and reassessment of needs; and revisions of the plan including a description of the services that may be needed for follow-up.
5. To receive medical, psychiatric care and treatment in the least restrictive setting possible suited to meet your individual needs.
6. To refuse treatment.
7. To refuse to participate in research with the informed, voluntary, written consent of the client; to protection associated with such participation; and opportunity to revoke such consent.
8. To view policies, procedures and information about the relationship between care, treatment and services and staff financial incentives upon request.
9. To freedom from involuntary restraining or seclusion.
10. To a humane treatment environment that affords protection from harm, appropriate privacy and freedom from verbal or physical abuse.
11. To confidentiality of treatment records except as required by law.
12. To request to see medical records at a reasonable time and to be given written reasons if the request is denied.
13. To access, upon request, to the clients own client records in accordance with the state law.
14. To have the opportunity to register and to vote.
15. To be informed of all rights.
16. To legal counsel and all other requirements of due process.
17. To refuse to make public statements acknowledging gratitude to the program or perform at public gatherings.
18. To a smoke-free environment as stated in the agency's policies and procedures.

Patient Responsibilities

1. To provide to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medication and other matters relating your health.
2. To report unexpected changes in your condition.
3. To assist the treatment team in establishing goals for improved health and develop and implement a plan to achieve that goal and to follow your recommended treatment plan.
4. To accept responsibility for your actions should you refuse treatment.
5. To be responsible for the financial obligations related to your healthcare.
6. To follow Grace Jones Family Therapy, LLC's rules and regulations related to patients.
7. To be considerate and respectful of the property, other persons and the facility.
8. To control your own behavior.
9. To assure that the facility obligations of healthcare are fulfilled as promptly as possible.
10. To ask questions when you do not understand what you have been told about your care of what you are expected to do.

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Child/Adolescent Intake Form

(Please Print)

Client Name: _____ Date:_____

PARENT/GUARDIAN INFORMATION			
Parent/Guardian Name:		Relationship to Client:	
Street Address:		Suite/Apartment Number:	
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No
Home Phone: ( )			May We Leave a Message Here: ❑ Yes ❑ No
Mobile Phone: ( )			May We Leave a Message Here: ❑ Yes ❑ No
Work Phone: ( )			May We Leave a Message Here: ❑ Yes ❑ No
Email Address: ( )			May We Send Email Here: ❑ Yes ❑ No

CLIENT EMERGENCY CONTACT IF OTHER	
Name:	Relationship:
Home Phone: ( )	Mobile Phone: ( )

PARENT/GUARDIAN EMPLOYMENT INFORMATION				
Employer:			Length of Employment:	
Occupation:			Average Hours Worked Per Week:	
Average Annual Salary:	❑ $0 to $10,000	❑ $10,001 to $20,000	❑ $20,001 to $40,000	❑ $40,001 to $50,000
	❑ $50,001 to $60,000	❑ $60,001 to $80,000	❑ $80,001 to $100,000	❑ More than $100,000

PARENT/GUARDIAN EDUCATION INFORMATION		
(Circle) Last Year of School Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: _____
Are You Currently in School? ❑ Yes ❑ No	If Yes, What School:	

PARENT/GUARDIAN RELATIONAL INFORMATION			
Current Status:			
❑ Single	❑ Dating	❑ Married	❑ Divorced
❑ Engaged	❑ Living together	❑ Separated	❑ Widowed

I hereby give Grace Jones Family Therapy permission to provide therapy services for the client mentioned above:
Signature of parent or legal guardian:

Signature:_____ Date: _____

CLIENT INFORMATION

Client's DOB: _____ Age: _____ School _____ Grade: _____

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? ❑ Yes ❑ No

If yes, Who: _____ When: _____

What was the previous symptom or diagnosis: _____

Has anyone in your family been treated for a mental disorder? ❑ Yes ❑ No

If yes, Who & What were they treated for? _____

_____

Physician's Name: _____ Date of last physical exam: _____

Significant past medical conditions and years occurred:_____

_____

Current medical conditions (include any known allergies or dietary concerns) _____

_____

_____

Medications/dosage patient is currently taking and for what reason: _____

_____

Briefly describe major reasons for coming to counseling and what you hope to accomplish: _____

_____

_____

How would you describe the severity of the issues/problems: ❑ Crisis ❑ Severe ❑ Moderate ❑ Mild

Therapist Notes: _____

_____

_____

_____

_____

_____

Child/Adolescent Comprehensive Psychosocial Assessment Family Information:

Family	Name	Age	Educ.	Occupation	At Home
Dad					
Mom					
Stepdad					
Stepmom					
Bro/Sis					
Bro/Sis					
Bro/Sis					

Has your child ever lived with anyone else? ❑ Yes ❑ No

If so, who? _____

Is your child adopted? ❑ Yes ❑ No

If so, how old was your child? _____

A. Your Child's Development:
Please list the approximate age at which your child:

	Age	Problems
Walked	_____	❑ Yes ❑ No
Talked	_____	❑ Yes ❑ No
Toilet Trained	_____	❑ Yes ❑ No
Puberty/1st Menstruation	_____	❑ N/A ❑Yes ❑ No
Sexually Active	_____	❑ N/A ❑Yes ❑ No

B. Family History:
Has anyone in your immediate family ever had any of the following problems?

1. Epilepsy or Diabetes? ❑ Yes ❑ No
2. Significant Medical Problems? ❑ Yes ❑ No
3. Mental Illness Requiring Hospitalization? ❑ Yes ❑ No
4. Counseling for Emotional Problems? ❑ Yes ❑ No
5. Current or past use of alcohol/drugs? ❑ Yes ❑ No
6. Suicidal Behavior? ❑ Yes ❑ No

If yes to any of the above please list who:_____

_____

Therapist Notes:

C. Your Child's Behavior:

1. Does he/she get along well w/others? ❑ Yes ❑ No ❑Sometimes
2. Does your child follow instructions? ❑ Yes ❑ No ❑Sometimes
3. Is your child appropriate with pets? ❑ Yes ❑ No ❑Sometimes
4. Does your child have self-control? ❑ Yes ❑ No ❑Sometimes
5. Has your child ever set a fire? ❑ Yes ❑ No ❑Sometimes
6. Does your child cry easily? ❑ Yes ❑ No ❑Sometimes
7. Has your child ever used alcohol or other drugs? ❑ Yes ❑ No ❑Sometimes
8. Has your child ever experienced problems with the law? ❑ Yes ❑ No
9. Has your child ever talked about, threatened or tried to harm himself or herself? ❑ Yes ❑ No
10. Has your child ever threatened to or harmed others? ❑ Yes ❑ No
11. Has your child ever used tobacco products? ❑ Yes ❑ No

D. Your Child's Education:

1. What school is your child attending? _____
2. In what grade is your child? _____

1. Has your child attended a special education program? ❑ Yes ❑ No
2. Has your child repeated, skipped or had any Interruptions in his/her education? ❑ Yes ❑ No
3. How many days has he/she missed this year? _____

E. Activities, Interests and Strengths:

1. What does your child do in his/her spare time?

_____

2. What does your child do well?

_____

F. Spiritual: Please describe your child's religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of as we meet withhim/her?

_____

_____

Therapist Notes

G. Health

Has your child experienced any of the following: If Yes, When?

Problems during pregnancy?	❑ Yes	❑ No
Complications at birth?	❑ Yes	❑ No
Soiling or lack of bowel control?	❑ Yes	❑ No
Urinary problems?	❑ Yes	❑ No
Seizures or Convulsions?	❑ Yes	❑ No
Eye/Ear Problems?	❑ Yes	❑ No
Complications from high fever?	❑ Yes	❑ No
Persistent Headaches?	❑ Yes	❑ No
Persistent Stomach Aches/Nausea Or Vomiting?	❑ Yes	❑ No
Sleeping Problems?	❑ Yes	❑ No
Physical, Sexual or Emotional Abuse?	❑ Yes	❑ No
Poor Appetite?	❑ Yes	❑ No
Significant Weight Loss or Gain?	❑ Yes	❑ No
Frequent Colds/Respiratory	❑ Yes	❑ No
Self-Injury, Rocking, Head Banging?	❑ Yes	❑ No
Coma or Unconsciousness	❑ Yes	❑ No
Serious Injury Resulting From Accidents	❑ Yes	❑ No

Therapist Notes

TERMS OF SERVICE

I hereby give Grace Jones Family Therapy permission to provide therapy services for the client mentioned above:

Signature of parent or legal guardian:_____ Date: _____

Please Refer to Grace Jones Family Therapy, LLC Professional Disclosure and Consent for Treatment Form

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Client Insurance Information Form

*Complete this form **ONLY** if you are planning to utilize your BlueCross BlueShield (BCBS) insurance benefits for therapy.*

☐ **I am a self-pay client and will not be utilizing benefits from an insurance company**

Client Full Name: _____ New Client? ☐ Client Update? ☐

Address: _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number: N/A _____ Date of Birth: _____ Gender: ☐ M ☐ F

Home Phone: _____ ☐ Y ☐ N
May I leave a message?

Home Phone: _____ ☐ Y ☐ N
May I leave a message?

Other Phone: _____ ☐ Y ☐ N
May I leave a message?

Client Marital Status
☐ Single ☐ Married ☐ Other

Client Employed?
☐ Yes ☐ No

Client Student Status
☐ Full Time ☐ Part Time

Email: _____ May we text your cell phone? ☐ Y ☐ N

How Did You Hear About My Practice? ***Please be as specific as possible.***

Name: _____ ☐ Former/Current Client ☐ Website ☐ Print Media

☐ Healthcare Professional ☐ Mental Health Provider ☐ Insurance Company ☐ Word of Mouth

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please complete any information that differs from the client.***

☐ Same as Above

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____
Street or PO Box

_____ Relationship to Client: _____
City State Zip

Insurance Information ***Information in this section should pertain to the Primary Person listed on the insurance card. Please complete any information that differs from the client.***

Insurance Co: _____ Insurance Phone#: _____

Insured's Name: _____ ID#: _____

Group#: _____ Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____ Home Phone: _____
Street or PO Box

_____ Insured's SSN: N/A _____
City State Zip

Insured's DOB: _____ Gender: ☐ M ☐ F Insured's Employer: _____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature: _____ Date: _____

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Consent to Release Protected Health Information

Patient Name _____ **Date of Birth** _____

I _____ (full legal name) authorize **Grace Jones Family Therapy, LLC** to disclose or obtain my protected health information with the following person(s) and/or facility:

Name of Person, Provider or Facility: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Fax: _____

Scope

☐ All information regarding assessment, diagnosis and treatment of patient.

☐ Billing Information

☐ Emergency contact

Purpose for Release

☐ Coordination of care

☐ Billing activities

☐ Other _____

Exclusions

☐ Specify _____

I understand the following:

- Unless otherwise specified by law, Grace Jones Family Therapy, LLC will release only that information that has been created by our facility. Records created by and available from other providers, hospitals or other facilities must be obtained directly from those other providers or facilities.
- This authorization is voluntary and I may refuse to sign this authorization. Such refusal will not affect my ability to obtain treatment except to the extent that the information being requested may assist my healthcare provider in determining appropriate treatment. I also understand that if I do choose to sign this form, I have the right to request and receive a copy of this form.
- I may revoke this authorization at any time by submitting a written request to this facility or provider. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
- Grace Jones Family Therapy, LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules. Grace Jones Family Therapy, LLC is not responsible for the actions of others who may be provided with information released as a result of this authorization.
- This authorization is valid as of the date of my signature below and will expire one year from said date or upon discharge.

_____ _____

Signature of Patient or Legal Guardian *Date*

_____ _____

Signature of Witness *Date*