

Patient Name: _____

Date: _____

RICBT

Cognitive Behavioral Therapy and Coaching

1130 Ten Rod Road, Suite E305, North Kingstown, RI 02852

400 Massasoit Ave. Suite 305, East Providence, RI 02914

Phone: (401) 294-0451 • Fax: (401) 294-0461 • Receptionist@RICBT.com

www.RICBT.com

Information and Registration Forms for New Patients

This document consists of four main sections.

- Section I, the RICBT Welcome Guide, is a brief and informal overview of the practice, the services we offer, and our policies.
- Section II is the Initial Evaluation Questionnaire, in which we ask you to write down all sorts of information about yourself and your problems. This helps greatly in making our first meeting with you at RICBT as productive as possible.
- Section III is our more formal Services Agreement, which details a wide range of our policies, including confidentiality. We ask you to sign this agreement to indicate your understanding and acceptance.
- Section IV, Permission to Exchange Information to Better Coordinate Care, contains our form allowing us to communicate with other health and mental health providers you have seen so that we may coordinate your care and obtain records from other care providers.

Please print out this document, read and complete each section, and bring the entire packet with you to your initial evaluation at RICBT.

Reviewing and completing the sections of this document will take some time (perhaps between 20 and 60 minutes). Though we sincerely appreciate your efforts, we also do not want this process to be a barrier to care. If you need help with any of the above, please feel free to bring the packet to session and your clinician will help you.

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SECTION I: Welcome Guide to RICBT

This brief guide is intended to welcome you to the practice, to inform you about our services, and to cover topics that are not detailed in the more formal Services Agreement (found in Section III).

Introduction

RICBT (formerly known as "The Rhode Island Center for Cognitive-Behavioral Therapy") is a group psychotherapy practice that strives to offer state-of-the-art, scientifically-informed treatment for a wide range of adult mental health concerns. We help individuals with many different issues, including depression, anxiety, panic, shyness, phobias, obsessive-compulsive disorder, recent and past trauma, grief and bereavement, low self-esteem, anger, eating disorders, and relationship problems. In addition, we help individuals with personal growth work, coaching them on improving work performance, family life, and relationships.

We offer individual, couple, family, and group therapy. We use treatments that have been shown by research studies to be effective and we help set measurable goals so that signs of progress are clear to all. We strive to create therapeutic relationships that are personal and collaborative, and that enable discussion of even the most difficult issues.

Our group workshops are an important aspect of the practice. They help individuals learn concrete strategies and tools, while also getting support from peers. Participants in group often feel for the first time that they are truly not alone in their issues and in their desire to improve their lives. Hearing about the accomplishments of other group members is often extremely motivational.

By coming to the practice you are joining a community. We think about the clinical staff, administrative staff, and the clients we serve as part of a community dedicated to improving the effectiveness by which we all lead our lives. We try to create a warm, inspiring, and informative environment. We invite you to share your ideas with us about how to better live up to these ideals.

Group Workshops

There are currently a number of ongoing groups and groups in formation. These are detailed on the web and include groups on mood management, social anxiety, communication skills in relationships, stress reduction, depression, emotion regulation for people with intense emotionality, women's issues, and bereavement. Though people are sometimes apprehensive about joining a group, they are most often impressed by the power of group. Please ask your therapist for more information, or contact our receptionist & intake coordinator. Also, please let us know if there are topics that you would like to see covered in a group workshop.

Reception Room Notebooks

On the table in the waiting room we have a number of different notebooks organized by topics. Topics include problems like depression and anxiety, as well as treatment approaches like "Schema Therapy." In each of these notebooks we have placed relevant newspaper and magazine articles, handouts, and resources. Please let your therapist know if you would like a copy of anything in a notebook. In addition, please bring in articles or web sites you come across that might be helpful additions to this library.

Bookstore

We have selected a number of books, videos, and audiotapes that we believe are consistent with our approach to treatment and made them available for purchase at RICBT. We also offer a number of specialized therapy workbooks that help us to take clients through well-researched treatments for several different problems and disorders. If you would like to purchase a book or tape on display in the waiting room, please take the item and a purchase form to your therapist or to the receptionist. We encourage "bibliotherapy" – reading the right materials can greatly facilitate progress in therapy.

Web Site

The practice has a web site – www.RICBT.com. There are a number of resources available on the site, such as links to other sources of mental health information, descriptions of staff members, and descriptions of group workshops. We encourage you to visit the site and share any comments or suggestions you might have for expanding it.

Credit Card and Payment Issues

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The practice accepts cash, checks, and credit cards (MasterCard and Visa) as payment for services not covered by insurance. Checks can be made out to RICBT. If you would like to reduce the number of checks you are writing in a month, you can make a payment at the beginning of a month and have your clinician draw from that balance. Receipts are available from your therapist or from our receptionist (receptionist@RICBT.com) to aid in record keeping and submission to insurance companies, if relevant. Payment is expected at each session. Overdue balances are subject to a billing fee of \$25 per month.

Referrals of Other Clients

We take the referral of a friend or family member as the highest compliment. Please direct people you would like to refer to contact our receptionist & intake coordinator.

Rescheduling Appointments and Our No-show/Cancellation Policy

To reschedule an appointment please contact our receptionist at (401) 294-0451 or by email at receptionist@RICBT.com. If you are canceling an appointment on the day of the appointment, please also leave a message directly on your clinician's voicemail. Please try to provide as much advance notice as you can if you need to cancel or reschedule. Because of the nature of therapy, each appointment accounts for a significant percentage of a therapist's time. In addition, because of the great number of patients needing service, every open slot will be filled with enough notice. The practice charges the full session fee if a missed appointment is not cancelled at least twenty-four hours prior to the scheduled time. This allows us time to call other patients who are on a cancellation list waiting to be seen. We acknowledge that situations out of an individual's control do arise that may prevent them from keeping an appointment and giving 24-hours notice. Though we understand that issues come up at the last minute, we also expect reimbursement for time that had been reserved.

Feedback About Your Treatment Experience

You are welcome to share feedback about any aspect of your experience at the practice with the director of RICBT, Ben Johnson, Ph.D. (BenJohnson@RICBT.com) or with the Practice Manager, Judy Johnson (JudyJohnson@RICBT.com). We greatly appreciate your compliments, as well as any suggestions for improvement. We truly hope that your work at RICBT helps you to accomplish your most ambitious goals.

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Part 2: Current Problems and Life History

Please leave blank the sections reserved for clinician comments and notes that will be made during and after your first meeting.

I. Current Problems

Please describe the key problems for which you are currently seeking treatment, and when they began. Please feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Additional Comments/Notes by RICBT Clinician:

II. Your Living Environment

With whom do you currently live?

Do you live in a house, apartment, etc.?

Who are the most emotionally supportive people in your life?

How would you describe your friendship network? Do you have friends you feel close to? Do they live locally?

What are typical things you do for pleasure or enjoyment, and how often?

Are there any other environmental factors that contribute to your difficulties (e.g., financial difficulties)?

Additional Comments/Notes by RICBT Clinician:

III. Medical History

Patient Name: _____

Date: _____

Please describe your current physical health:

Please describe any significant past medical problems and treatments (e.g., surgeries):

Do you currently have a primary care physician?
If not, would you like a referral to a primary care physician?

Primary Care Physician's Name, Address, and Phone (if applicable):

Please let your therapist know if you would like him or her to consult with your medication prescriber at any point in treatment.

Please list any psychiatric and nonpsychiatric medications you are currently taking using the categories below.

Psychiatric:

Medication _____ Dosage _____ Prescriber/Doctor _____ Reason for taking (e.g., antidepressant)
Check here if you are on NO psychiatric medications: _____

Nonpsychiatric:

Medication _____ Dosage _____ Prescriber/Doctor _____ Reason for taking (e.g. to lower cholesterol)
Check here if you are on NO nonpsychiatric medications: _____

Which psychiatric medications have you been on in the past?

IV. Mental Health Treatment History

Please describe your past experiences in outpatient treatment using the categories below:

Therapist or *Dates of treatment* *Approx.* *Type of treatment* *Reasons for*

Patient Name: _____ Date: _____
counselor (start – end dates) # of sessions (individual, etc.) seeking treatment

Please describe your past experiences in inpatient or day hospital programs:

<i>Facility/program (start – end dates)</i>	<i>Dates of treatment</i>	<i>Type of program</i>	<i>Reasons for seeking treatment</i>
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V. History of Suicidal Feelings

Many people think about suicide on occasion. Have you had times in life where you were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Additional Comments/Notes by RICBT Clinician:

VI. Other Symptoms

How is your concentration?

How is your memory?

How is your appetite?

Have you gained or lost weight recently?

Is your appetite affected by emotional issues?

Do you have trouble falling asleep?

Do you wake up frequently during the night?

Do you wake up earlier in the morning than you would like?

Approximately how many hours of sleep do you get per night?

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Are there any sexual issues that cause you concern that you would like to note?

Additional Comments/Notes by RICBT Clinician:

VII. Substance Use and Addictive Behaviors

How often and how much do you drink alcohol?

Do you believe your alcohol use may be a problem?

Do you believe you have ever had a problem with alcohol use? If so, when?

How often and how much do you use other nonprescribed drugs?

Do you believe your drug use may be a problem?

Do you believe you have ever had a problem with drug use? If so, when?

Do you struggle with other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

Additional Comments/Notes by RICBT Clinician:

IIIX. Psychosocial and Developmental History

Where were you born and raised?

Can you briefly describe your family growing up?

What was your school experience like? What were your relationships with peers like?

Were you sexually, physically, or emotionally abused at any point in your life?

Have you had any other significant life changing events or traumas that affected you either negatively or positively?

Does anyone in your family struggle with mental illness? If so, please describe.

Additional Comments/Notes by RICBT Clinician:

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IX. Other Things Your Clinician Should Know

Please describe anything else that is important to know in understanding your life and your difficulties.

Thank you for completing this Questionnaire. We expect it will be very helpful in developing an organized and effective treatment plan.

Items Immediately Below for RICBT Clinician:

MSE:

I:

II:

III:

IV:

V:

Treatment Targets & Plan:

Additional Comments/Notes by RICBT Clinician:

Clinician Signature:

Patient Name: _____

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SECTION III: Psychotherapist-Patient Services Agreement

This Agreement contains important information about our professional services and business policies.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you talk with your clinician about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Your first few sessions will often involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of how therapy might proceed, if you decide to continue. You should evaluate this information along with your own comfort working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about the procedures, you should discuss them with your therapist whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

During your first few sessions your therapist will decide if he or she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, your therapist will usually schedule one or two 50-minute sessions per week at a time you agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay the full session fee for it unless you provide 24 hours advance notice of cancellation. We realize that situations arise that can make late cancellations or missed appointments unavoidable. Though we understand that issues come up at the last minute, we also expect reimbursement for time that had been reserved. We hope you understand and appreciate this policy. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

PROFESSIONAL FEES

Each therapist charges an hourly fee. In addition to weekly appointments, they charge this amount for other professional services you may need, though they will break down the hourly cost if they work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of them. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of their professional time, including preparation and transportation costs, even if they are called to testify by another party. Because of the difficulty of legal involvement, we charge \$200 per hour for preparation and attendance at any legal proceeding. Also, all fees are generally reassessed and increased if needed each January.

CONTACTING YOUR THERAPIST

Due to the nature of the work, therapists are often not immediately available by telephone. When therapists are unavailable, their telephone is answered by voice mail. Therapists will make every effort to return your call within 24 - 48 hours, with the exception of weekends and holidays. In emergencies, please call and listen to your therapist's voice mail (401 294-0451) for instructions. Most often you will be instructed to call Dr. Johnson, the director of the practice, listen for instructions on how to contact him, leave him a message with the nature of your situation, and await a call back. If you are unable to reach your therapist and feel that you can't wait for someone to return your call, contact your family physician or the nearest emergency room. If your therapist will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization for specific information to be released to specific individuals or institutions. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, your therapist will make every effort to avoid revealing the identity of their patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless they feel that it is important to your work together.
- You should be aware that your therapist practices with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative

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purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If you threaten to harm yourself, your therapist may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the psychotherapist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order, or a subpoena of which you have been officially notified and failed to inform us that you are opposing the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against a therapist or the practice, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, information that is directly related to that claim must, upon appropriate request, be provided to the Workers' Compensation Commission.

There are some situations in which your therapist is legally obligated to take actions to attempt to protect others from harm. They may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If they have reason to know or suspect that a child has been abused or neglected, or has been a victim of sexual abuse by another child, the law requires that they file a report with the Department for Children, Youth and Families. Once such a report is filed, they may be required to provide additional information.

If your therapist believes that a patient presents a risk to a person or his/her family, your therapist may be required to take protective actions including warning the potential victim(s), contacting the police, or seeking hospitalization of the patient.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and they will limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

OFFER TO RECEIVE THE NOTICE OF OUR PRIVACY POLICIES

The Rhode Island Notice Form describes our policies and practices to protect the privacy of your health information, as mandated by a federal law called the Health Insurance Portability and Accountability Act (HIPAA). Signing the Services Agreement indicates that you have been made aware that a copy of this Form is available in the waiting room, is posted on our web site (RICBT.com), and will be given to you at any point if you request it.

PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we charge a copying fee of \$25 per page.

PATIENT RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) provides you with rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the Notice of Privacy Policies form. Your therapist can discuss any of these rights with you.

FOR PATIENTS SCHEDULED WITH OUR GRADUATE STUDENT OR POSTDOCTORAL PSYCHOTHERAPISTS, ANNE FERNANDEZ, M.A., ELIZABETH REICHERT, M.A., JESSICA LIPSCHITZ, M.A., CERISSA BLANEY, M.A., ELISE CLERKIN, Ph.D., OR TONY WELLS, Ph.D.: NOTICE THAT YOUR THERAPIST IS IN TRAINING AND WORKS UNDER SUPERVISION

The master's level trainees are currently enrolled in graduate school to become psychologists and are practicing at RICBT to further their training. They conduct therapy under the close supervision of Dr. Benjamin Johnson or Dr. Wendy Ossman, who are licensed psychologists. They will be consulting regularly with Dr. Johnson and Dr. Ossman about your treatment and working with them to develop a treatment plan. The postdoctoral trainees (with Ph.D.s) are postdoctoral fellows at RICBT, working towards hours for their

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psychologist license. They works under the supervision of Dr. Benjamin Johnson. You are welcome to speak with Drs. Johnson or Dr. Ossman at any point if you have any questions or concerns (401.294.0451).

MINORS & PARENTS

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, your therapist will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Your therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless your therapist feels that the child is in danger or is a danger to someone else, in which case, he or she will notify the parents of their concern. Before giving parents any information, your therapist will discuss the matter with the child, if possible, and do their best to handle any objections he or she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that allows or requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Overdue balances are subject to a billing fee of \$25 per month. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Our office will call to determine your mental health benefits at the outset of your treatment. If you are seeing a therapist who is out-of-network for your insurance, your signature at the end of this document authorizes us to submit claims and receive payments on your behalf. However, you (not your insurance company) are ultimately responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will call the company on your behalf. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that your therapist provides to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your therapist will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described.

Your signature below indicates that you have read the information in this Agreement and agree to abide by its terms during our professional relationship. **Your signature also indicates that you understand and accept our policy regarding charging for late cancellations and missed appointments.**

Patient Name: _____ Signature: _____ Date: _____

Patient Name: _____

Date: _____

**SECTION IV: Permission to Exchange Information to Better Coordinate Care
(Authorization for Use and Disclosure of Protected Health Information)**

Date of Birth: _____

Please check next to one of the appropriate statements.

I do NOT wish any information to be exchanged with any of the above individual's other healthcare providers.
OR

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization. I therefore authorize RICBT, 1130 Ten Rod Rd, E305, N. Kingstown, RI 02852 and 400 Massasoit Ave. #305, East Providence, RI 02914 to:

Release to: OR Request from: OR Exchange Information with:

Type of Provider: Primary Care Physician/Internist/OB-GYN Psychiatrist/Medication Prescriber
 Psychologist/Psychotherapist Family members/Friends Other: _____

Agency/Practice/Institution Name (If applicable): _____

Provider Name (First and Last): _____

Street Address: _____

City/State/Zip Code: _____

Phone # _____ Fax #: _____

It is okay to send a Coordination of Care Letter to this provider, describing that I have been evaluated at RICBT and what preliminary diagnosis/diagnoses I have been given and the broad nature of the treatment plan.

- If you would like information exchanged with multiple providers, either enter all relevant information above or print out another copy of this form. The following information in this authorization applies to all providers listed. This authorization will have a duration of consent for the duration of active treatment or until notified that consent is revoked. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email (with confidentiality statements and reasonable precautions in place).
- Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Information you do not want exchanged (if any): _____. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care unless indicated otherwise here: _____.
- I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke or cancel this authorization at any time. I understand that to revoke this authorization, I must contact RICBT and put my revocation/cancellation in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that if I authorize RICBT to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by RICBT may no longer be protected by the federal rule on the privacy of medical records.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed name of Authorized Representative (if not patient): _____

Relationship of Authorized Representative to Patient (if not patient): _____