Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC
Counseling, Coaching & Consulting

Disclosure of Professional Practices

Please allow me to provide you with some information regarding my professional services so that you can make an informed decision about working with me for your health, wellness, personal growth, professional development or organizational needs. Please note that I am a holistic provider, meaning that I take into consideration the whole person when considering treatment needs and plans. I am interested in helping my clients be well, not just treating symptoms of an 'illness" without investment in a desired outcome. To that end, I offer 3 very different levels of service depending upon your needs: Counseling, Coaching & Consulting.

Hopefully, you will find my approach unique and refreshing especially if you have worked with other mental/behavioral healthcare providers. I have a specialty in Process Experiential Theory which includes traditional in the office "talk" therapy and/or experiential sessions in nature that may include yoga, mindfulness, meditation, culturally sensitive spiritual practices and/or animal based interventions for adults, children, adolescents, families and groups. Additionally, as an Integrative Behavioral Healthcare provider, I work with traditional medical professionals when possible especially when we are treating an 'illness' (Professional Counseling). Regardless of the level of service, I utilize an evidence-based, multi-species approach offering dynamic options in which my clients heal body, mind and spirit while learning critical relationship skills with humans and the natural world when desired. Please allow me to explain the key components of my services as you consider your options and make an informed decision to consent to services.

What is Integrative Behavioral Healthcare?

In the simplest terms, "integrative behavioral healthcare" means integrating medical services with psychotherapy whenever necessary. Evidence based practice states that in the treatment of a mental/emotional/behavioral illness an integrative approach with your primary care physician and/or a specialty psychiatric provider is the most efficient approach to treatment. Through a relationship with LightHorse Psychiatry, LLC, your primary care physician and/or other local providers of behavioral health and/or wellness services, I can offer you an integrated and efficient experience leading to total health and wellbeing.

What is Professional Counseling?

Professional counseling is a medical service performed by a state licensed mental health professional that requires the therapist perform an assessment, determine the diagnosis of a specific illness (emotional, mental and/or behavioral), develop a treatment plan and keep records of the progress of the treatment. Professional Counseling ***is*** reimbursable under most health insurance plans and meets the criteria for tax deductible medical expenses. In short, Professional Counseling is a treatment service provided for an illness. Licensed in the states of Florida and Georgia, if your need is treatment I can help. I accept assignment and am an in-network provider for most commercial health insurance plans. If you plan to use your insurance for services, Professional Counseling is the service you are seeking.

However, my approach to Professional Counseling goes beyond the treatment of an illness, as I am focused on facilitating your wellness. Sometimes, there is a place where someone wants their quality of life to be better but does not meet the criteria for a clinical diagnosable illness. For some who have participated in professional counseling this comes when they are no longer clinically 'sick' but want to continue the relationship in order to continue to be well. For others, they may be seeking services of a trusted guide to improve their quality of life and relationships but never were

clinically 'sick' in the first place. For individual who meet these criteria, I offer a Personal/Life Coaching service which goes beyond just treating someone's illness.

What is Personal or Life Coaching?

Life Coaching is defined as partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and/or professional potential. Professional coaches provide an ongoing partnership designed to help clients produce fulfilling results in their personal and professional lives. Coaches help people improve their performances and enhance the quality of their relationships. Coaching can be performed by a clinically trained therapist with specialized training in a solution focused counseling/coaching approach leading to insight development and behavioral change. Coaching is not a medical treatment and thus not covered by private insurance. An affordable cash pay fee scale is available for those desiring coaching services instead of/or after Professional Counseling (therapy) is concluded.

What is Clinical Consulting*?*

Clinical Consulting is a service that can range from professional development, supervision and/or training for up and coming mental health professionals who are interested in my particular style and theory of practice or it can be providing forensic assessments for court and/or custody proceedings involving children or persons with mental illness involved in the legal system. Organizational consulting with businesses, advocacy groups and others involved in the provision of human services is an area of specialized practice for which I am highly qualified as is providing expert witness testimony in legal proceedings when the testimony of a licensed mental health professional can be helpful in educating judges and/or juries about issues specific to mental illness, child and or adult human development and the nature of specific categories of mental illness. The fee schedule for clinical consulting is negotiated based upon the duties and time required and is different from the fee schedule established for Professional Counseling or Personal Coaching as identified in this document. .

Summary of Services Offered

Dr. Taylor is:

- Licensed & Board Certified to practice Professional & Clinical Mental Health Counseling in Georgia & Florida
- Specially trained in Process Experiential Theory & other Evidence Based Practices to provide effective clinical treatment for mental, emotional and/or behavioral disorders.
- Specially trained in a solution focused coaching approach to personal growth and wellness.
- Focused on promoting your and/or your family's health and wholeness by assisting you in developing into your highest and best self.
- Qualified an expert witness, clinical supervisor and organizational consultant in Georgia & Florida

Her Services Include:

- Traditional Evidence Based "Talk" Counseling & Psychotherapy
- Experiential Psychotherapy utilizing Creativity & Art
- Equine Facilitated Psychotherapy
- Animal Assisted Therapy with canine partner, Eli
- Spiritual/Christian Counseling
- Yoga Therapy
- Nature Based Therapeutic Experiences
- Personal and/or Professional Life Coaching to promote overall health & wellness
- Clinical training for Therapists, Coaches & Equine Specialists in Mental Health
- Specialized clinical or non-clinical experiential services for groups

Practice Locations

Main Office
314 Osborne Street
St. Mary's, GA 31558
(912) 673-1801 Phone
(912) 882-0726 Fax

LightHorse Healing, Inc.
Therapeutic Farm
5035 Clarks Bluff Road
Kingsland, GA 31548
(Phone & Fax the Same)

Swann Building
1 North 4th Ave, #204
Fernandina Beach, FL 32034
(Phone & Fax the Same)

Use of Patient Portal

Dr. Taylor utilizes a patient portal system where you can request an appointment change or cancel an appointment if needed. Please make sure you pay attention to service location in the patient portal. Appointments can be made up to 8 weeks in advance. When you are registered with this practice, you will be sent an email welcoming you to the patient portal. Please log in and create a user account so that you can efficiently manage your appointments when needed. Please add appointmentreminders@therapyportal.com to your address book so that your email reminders do not go to your spam folder. The Patient portal link is : https://www.therapyportal.com/p/drcarlene/

Office Hours & Communication

Dr. Taylor's office hours are by appointment only. Appointments may be scheduled at either location, however, **communication with her is all done through her Main Office in St. Mary's.**

For advance appointments, schedule changes, non-emergency needs:
Call (912) 673-1801 and leave a message. Your message will be emailed to Dr. Taylor wherever she is and she will respond back to you within 1 business day. Fax records requests or correspondence to: (912) 882-0726.
For same day appointments, same day schedule changes or emergency need:
Text (preferably) or call (912) 674-3346 on the day of your appointment

When arriving for your appointment at either location:
Dr. Taylor does not utilize a receptionist or traditional medical lobby. All services are concierge services and she is personally awaiting your arrival. **When you arrive and at either location, please text her at (912) 674-3346 when you park your car and she will be out to greet you as the designated meeting location.**

Designated meeting location for Main Office:
Park in public spaces on Osborne Street, the office is the **BLACK** door to the right when you are facing the house. Dr. Taylor's office is in the Historic Jackson-Clark House in downtown St. Mary's. Enter through the gate on the right, come up the steps and have a seat on the porch. Dr. Taylor will greet you at the **BLACK** door. Please remain on the porch until greeted the remainder of the house and grounds is private property.

Designated meeting location for Fernandina Beach:
Entrance door on 4th Street next to the 4th Street Deli, will escort up-stairs to the office.

Designated meeting location for LightHorse Healing, Inc. Therapeutic Farm:
Picnic table under the oak tree adjacent to the entrance gate in the board fencing.

Your Rights as a Client

You have the right to ask questions about anything that happens in the therapeutic/ consulting process. Dr. Taylor is always willing to discuss how and why she suggests courses of intervention and to encourage you to consider alternatives that might work better if you desire an alternative. Additionally, out of respect for you and my ethical responsibility as a licensed professional my clients have the following rights:

- The right to be treated with consideration & respect for personal dignity, autonomy and privacy;
- The right to service in a respectful setting that offers the greatest possible freedom of choice.
- The right to be kept up-to-date on current/suggested services or treatments and of alternatives.
- The right to accept or reject any service, treatment or therapy after you have been given a full explanation of the risks and benefits;
- The right to a current, written, individualized treatment/service plan addressing mental and physical health, social and emotional needs, and describing who will provide these services and how they will be provided in a way that meets your needs if you are seeking treatment.
- The right to active and informed participation in all areas of the treatment/service plan, including the plan's writing, review, and rewriting to meet your needs;
- The right to freedom from too much or unnecessary medication, seclusion or restraints for those seeking mental health treatment services.
- The right to be informed of and to refuse any unusual or dangerous treatments or procedures;
- The right to be told about and to refuse to be observed through one-way mirrors, photographed or taped (audio or visual);
- The right to absolute confidentiality (as best it can be provided in an experiential setting) unless court ordered or unless you sign a Release of Information form permitting disclosure of all or part of your records or acknowledgement of the limits of confidentiality in the experiential setting.
- The right to see *all* parts of your records, including psychiatric and medical records. Access can be restricted *only* for clear treatment reasons, meaning that reading the records will likely cause you severe emotional damage resulting in the immediate risk of dangerous behavior toward yourself or someone else.
- The right to advance notice if a service is to be discontinued, and to be actively involved in planning to meet your needs when the service is discontinued;
- The right to have a clear explanation when any services are denied or discontinued.
- The right not to be discriminated against in the provision of service based on race, color, creed, religion, sex, national origin, age, lifestyle, physical or mental handicap or developmental disability;
- The right to have open financial discussions about the anticipated costs of your services and have services tailored to fit your financial circumstances when possible.
- You have the right to be informed of any grant/donation funded services available if a clear financial need is present.
- The right to be fully informed of all your rights;
- The right to exercise all rights without being threatened or punished in any way, including being denied services.

Based upon the above explanation of services and the foundation of these rights, if you wish to receive services from Dr. Carlene Taylor, please complete the following pages, initialing where indicated and signing the signature page. Please keep pages 1 – 4 for your records and return the remaining pages to Dr. Taylor via email or fax 24 hours prior to your appointment. Please call (912) 673-1801 if you have any questions or need help completing the package of information. If your appointment is in less than 24 hours, please bring completed documents to your appointment time and arrive 15 minutes early.

General Client Information

Name:_____DOB:_____Age:_____ S.S.#_____

Email:_____Sex: ___M___ F

Phone:_____(c)_____ (h) _____(o)

Address:_____City:_____ ST_____Zip _____

Emergency Contact:_____

Phone: _____Relationship:_____

Martial Status: Married Single Divorced Separated Widowed N/A – child

Employment Information

Company:_____Phone: _____

Address: _____City: _____State: _____ Zip: _____

Referral Information
Where or from whom did you hear of our services?_____

Primary Care Physician or Referring Provider:

Name: _____ Phone: _____

Guarantor Information (If patient is a minor or dependent adult)

Name of Guarantor: _____

Address: _____City:_____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____Cell/Pager: _____

Primary Insurance Information (Limited commercial insurances accepted for services medically necessary services reimbursable by insurance)

Insurance Company:_____Phone:_____

Address: _____

Policy ID#: _____ Group#: _____Group Name: _____

Policy Owner's Name: _____ Phone#:_____DOB:_____

Policy Owner's Address _____

Social Security #:_____Authorization #:_____Deductible: $ _____

Co-Pay: $_____Patient's Relationship to Policy Owner: Self Spouse Child Other

Please include a copy of your insurance card, front and back with this package so that we may verify your benefits and be able to have information available about costs at your first appointment. Secondary Insurance is not billed by the provider. You may request a superbill that you can submit to your secondary insurance carrier for reimbursement of copayments or deductibles if you have secondary insurance.

Confidential Consent for Treatment

Explanation of Consent Form

This treatment consent form covers all procedures that are not of a nature to require a special consent, i.e. forensic (court related) services, experiential therapy services, organizational consulting or clinical training/supervision. The services listed above have additional special releases that must be completed prior to the service provision. This form provides protection for the procedures

performed by Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC in her outpatient private practices in both Florida and Georgia. This form documents that you are consenting to treatment with Dr. Taylor, including but not limited to, assessment, psychotherapy and counseling and/or personal or professional coaching as deemed appropriate and desired. Information about the specific services she provides has been given to you in writing and discussed with you. Your agreement to consent to services and signature on this form allows Dr. Taylor and her professional staff to provide services to you. This form provides evidence that no guarantee is made by Dr. Taylor or any professional staff working with her as to the outcome of treatment. There is no guarantee that treatment or services provided will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by Dr. Taylor and/or her staff. If you have any questions concerning this or any other matters, it is your responsibility to ask Dr. Taylor. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form and supporting documents.

Consent to Treatment

I,_____for _____
(Print your name) *(Print the patient's name, if minor)*
do hereby voluntarily consent to care and treatment by Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC and her designated clinical staff as specifically authorized below. I am aware that the practice of medicine, psychiatry, clinical psychology, clinical social work, professional counseling and other therapy or coaching by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

For those seeking Personal/Professional Coaching and/or other wellness services apart from primary treatment services: I understand that patients requesting non-treatment services MUST not be in acute distress or in need of medically necessary services. If clients arrive in acute distress, they will be assessed and treated in accordance with traditional mental health treatment approaches until such time as the acute distress has subsided. Traditional mental health treatment may include: psychiatric evaluation and/or medication recommendations, psychological evaluations, and/or in the case of risk of harm to self or others, inpatient crisis stabilization. Non-treatment coaching/wellness services are recommended to be used complimentary with other traditional outpatient services and all coaching clients are strongly encouraged to have an ongoing relationship with a behavioral healthcare provider(s) covered by their primary insurance or for whom an acceptable self-pay arrangement has been negotiated. Coaching/wellness clients are welcome to have clinical relationships with other licensed mental health providers if they choose.

I am aware that I am an active participant in the counseling process and that I share responsibility for treatment and the outcome of my services. My responsibilities in treatment include informing Dr. Taylor of any information that may be relevant to the problems or conditions being addressed, assisting in setting goals for services, following therapeutic advice to the best of my ability, and ending services in a responsible way.

If I am consenting to service for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them. Children in joint legal custody must have both parents/guardians listed to be involved in treatment unless otherwise directed by a court of law.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

[ ] **Clients Initials HERE signifying you have read and agree with this consent.**

Confidential Consent for Family Involvement in Treatment

I consent to have the family members listed below involved in the planning and delivery of the services that I shall be receiving from this practice for this period of service. I understand that, without this consent Dr. Taylor nor her covering colleagues at this practice will be allowed even to acknowledge to any family member that I am a patient receiving services. (List additional names on the back if necessary, or leave blank if not family is to be involved).

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

[ ] **Clients Initials HERE signifying you have read and agree with this consent.**

Financial Policies & Statement of Financial Responsibility

Insurance Reimbursement & Ancillary, Court or other Non-Insurance Covered Services

Although Dr. Taylor and her covering colleagues are in network providers for clinical mental health services for most insurance plans and accept insurance assignment for traditional outpatient clinical mental health counseling services, this practice provides an array of services for wellness or personal/professional development that are not under the scope of traditional health insurance plans. Non-clinical ancillary wellness or coaching/personal growth services are ***not*** covered by insurance. However, these services maybe provided by or under the supervision and direction of a licensed mental health professional as part of a clinical/medical treatment plan, and thus can be considered clinically legitimate medical expenses. These services may be covered under a Health Savings Account (H.S.A.) and/or be tax deductible medical expenses even if not reimbursable through commercial health insurance. Clients should consult their financial professionals for advice on deductions and uses of health savings funds for ancillary or wellness services provided by this practice.

Also any services required for an action of a civil or criminal court are not covered by insurance plans. Likewise, professional training, clinical supervision, organizational consulting and/or personal or professional coaching services are not covered as a medical expense as they have no medical diagnosis meeting the requirement for treatment.

The strict requirements of in-network insurance plans often limit how often a client can be seen per week for outpatient services and limits the length of sessions. Insurance companies often limit services to techniques and/or treatments that can be helpful in treating illness but not necessarily fully effective on their own when a person seeks a higher level of wellness. It is the practice of Dr. Taylor to assess your needs based upon your primary concerns and reasons seeking service and provide you with comprehensive choices that will help you be well rather than just provide an insurance reimbursable treatment that may treat your 'illness' but not necessarily make you well. Clients are always encouraged to 'take what you need/want and leave the rest' of whatever services are offered. Every effort will be made to make recommended beneficial but non-insurance reimbursable services affordable based upon your individual financial situation.

Statement of Financial Responsibility

Many insurance companies require an authorization for mental health coverage. The insured is generally responsible for obtaining that authorization. This practice files insurance claims as a courtesy, and will accept the assignment of insurance benefits in lieu of payment if the insurance has been verified/authorized ***prior to service***. All services not covered by insurance and/or any insurance copayments or deductibles must be paid for at the time of service or have an agreed upon financial plan on file following the initial visit. Agreed upon financial arrangements must be kept current once a service and financial commitment is made. If there is an outstanding balance on your account, you will be notified by an email statement. Payments are due within 15 days of receiving a statement unless other arrangements are made with Dr. Taylor. A late fee of 10% will be assessed for statement balances beyond 15 days from the statement date.

This practice accepts payment in the form of cash, check, Visa, MasterCard and/or American Express credit or debit cards. A fee of $40 will be assessed for returned checks or charges, and unpaid balances over 30 days may be referred to a collection agency for assistance in collecting any past due amounts. Appointments are made to reserve time especially for you. Cancellations require 48 hours notice. Appointments cancelled with less than 48

hours notice, or missed appointments without notice, will be billed at $50.00 per appointment.

Clients are asked to leave a credit card on file to authorize charges for copayments and/or late cancellations or "no shows". Excessive cancellations or no shows may result in termination of service by the provider with 30 days' notice. Most importantly, if you are having financial difficulty, please communicate with your provider. Every effort will be made to accommodate your needs and help you continue on your path to health and wellness based upon your financial situation.

Dr. Taylor's fees range from $225 for an intake assessment to $150 for a 60 minute counseling session or $50 for a group counseling session. Insurance plan negotiated rates are accepted. Non-treatment coaching or consulting fees are similar depending upon the level of complexity. A sliding fee scale based upon your ability to pay may be available for counseling or coaching services. Ask for details.

Assignment of Insurance:
I hereby direct my insurance company to pay by check made out and mailed to my individual clinical provider, Dr. Carlene H. Taylor, LMHC, LPC or to pay by direct deposit to the provider for the professional and/or medical expenses, benefits allowable and otherwise payable to me under my current insurance policy and as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee. I have agreed to pay in a current manner any balance of professional service charges over and above the insurance payment. A photocopy of this assignment shall be considered as effective and as valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf in the event the insurance company does not honor their contract to pay for your medical services as agreed.

I have read and understood/had explained to me these financial policies and by initialing below, I agree to accept these terms of service for myself and/or for my guarantee (if applicable). I agree to have my insurance benefits assigned to my provider and agree to accept financial responsibility as outlined above for any balances due beyond my insurance benefits.

[ ] **Clients Initials HERE signifying you have read and agree with this consent.**

Credit Card Authorization or Declaration of Payment

Client/Guarantor: _____

I hereby authorize Dr. Carlene H. Taylor, LMHC, LPC to charge the credit card listed below for copayments and or associated fees for treatment services provided to the above listed client from the date of this letter forward until this authorization is terminated by me in writing. I agree to pay the credit card company for fees for services for which I have contracted to receive.

Name of Card Holder: _____

CC Number: _____

Exp Date:_____Security Code on the Back:_____Billing Zip Code: _____

Signature of Card Holder:_____ Date Authorized: _____

Release for Coordination of Care and Emergency Services

To ensure that the best care possible for you, this practice utilized cross coverage for vacations and emergencies and rely on cross coverage in the absence of your provider. Unless specifically restricted, your information will be accessible to the clinical providers within this practice and to our practice management staff, on a need to know basis, to ensure smooth operation of office practices as well as clinical coverage for emergencies and case consultation for review and support or coverage when your provider is unavailable. The clinical providers who share cross coverage for Dr. Taylor are:

Debra Tait, LPC – in Georgia
Colleen Shane, LCSW – in Florida

Professionals with whom your protected information may be shared on a need to know basis are: our clinical and administrative staff for billing or record keeping purposes, Professional Counseling Interns and Licensed Associate Professional Counselors contracted to provide support services for this practice. Information will be shared on a level of medical necessity need to know basis only. By initialing below, you certify:

____ I have no conflicts with my information being available to the above listed clinical associates

OR

____ I have a conflict and desire my information not be shared with the above listed clinical associates and understand that in the event of an after-hours emergency, Dr. Taylor may not be available to assist without the agreement for cross coverage with covering colleagues.

Patient Acknowledgement and Consent for Primary Care Physician Notification

In an effort to provide the best integrative care possible, Dr. Taylor may send a notification to your family doctor or primary care physician informing him/her that you are receiving medically necessary services **if you wish to have primary care involvement or if your insurance plan requires it for reimbursement**. Patients with concurrent medical conditions that complicate treatment must have signed an authorization for Primary Care Manager involvement in treatment. If you change to another physician during your term of care with Dr. Taylor, please complete another form with the updated information. The authorization can only be revoked upon giving us written notice that you no longer wish for your primary care physician to be contacted.

Doctors Name: _____Practice Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone Number: _____ Fax: _____

I acknowledge that my initial below on this form gives my consent to Dr. Taylor and my clinical providers to obtain from and release to the primary care physician listed above, all pertinent information associated with my treatment necessary for my ongoing care.

[ ] **Clients Initials HERE signifying you have read and agree with this consent.**

Automated Appointment Reminder System (AARS) Acknowledgement

In an effort to provide the highest quality of care, Dr. Taylor provides an automated appointment

reminder system as part of client services. The automated appointment reminders system is proven to improve client satisfaction in the way clients communicate with his/her provider. Dr. Taylor is providing automated appointment reminders through text, email and phone, if text or email is not available. We understand how busy life can get. Our client reminder system will notify you three business days prior to your appointment. This gives you time to reschedule if necessary within the 36 hour window. Additionally, through our appointment reminder system, we will be able to send you other important news on occasion. Your personal and health information is of utmost importance to us and is never provided to a third party for this service.

[ ] **Clients Initials HERE signifying you have read and agree with use of the AARS.**

Acknowledgement of Receipt for
Notice of Privacy Practices & Professional Disclosure Forms

In an effort to help protect the environment, the Notice of Privacy Practices and the Professional Disclosure Statement can be found on our website at www.drcarlenetaylor.com or a laminated copy can be viewed at your appointment. You may request a hard copy of these documents for your own records if you desire.

[ ] Yes, I have received a copy or had the opportunity to read the Professional Disclosure Agreement & Notice of Privacy Practices Document

Informed Consent, Professional Practices Disclosure & Notice of Privacy Practices Signature Page

By signing below, I acknowledge that I have received or reviewed a copy of this practices Notice of Privacy Practices and this Professional Disclosure/Informed Consent agreement for myself and/or for anyone of whom I am the legal guardian requesting services. I acknowledge that my signature below indicates that I have read the information in both documents, have asked any questions needed, and am aware of the privacy practices of Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC. and the risks and benefits associated with behavioral healthcare services. I agree to abide by the terms and conditions stated in both of this Professional Practices Disclosure and the Privacy Practices Documents.

This section concludes the Informed Consent and Notice of Privacy Practices process as required by law prior to the provision of clinical mental health or professional counseling services. By signing below, the client (or parent or guardian) acknowledges that having read these consents and notices, initialed the sections affirming my agreement or indicated my wishes fully and wish to have services provided by Dr. Carlene Taylor, LMHC, LPC, CPCS, NCC.

_____	_____	_____
Client's Signature	Participant's Printed Name	Date
_____	_____	_____
Parent or Legal Guardian Signature	Printed Name of Parent/Guardian	Date

Releases of Information & Disclosure of Confidential Information

In general counseling, mental health treatment and any service provided by a licensed mental health provider is considered to be "confidential" and thus part of your Protected Healing Information. In the earlier documents, we provided you with explanations of the areas where by the nature of our outdoor facility some of your PHI may be compromised due to being out side for services. Also, we have given you the opportunity to give us authorization to share some of your information (A/K/A a photo release if you want to have your picture taken with the animals). However, we take your confidentiality seriously and we want to inform you of our responsibilities to your confidentiality and your confidential records.

As licensed professionals, we are mandated by law and ethics to keep your records and your information confidential except for 4 very specific circumstances:

1. **We have reason to be concerned that you are a risk to harm yourself or someone else.**

   In the event we have clinical reason to think you or someone else is at risk from your we are required to seek help and that may mean calling medical, law enforcement, child protective services and/or your emergency contact information you have listed in this paperwork.

2. **We have reason to believe a child or dependent adult or elderly person is being abused or neglected.**

   In the event we have clinical reason to think that there is a child who is at risk to harm or neglect, we are required to notify law enforcement and/or child protective services. Likewise, for dependent adults or the elderly we are required to notify law enforcement or adult protective services

3. **We have been court ordered to release your information.**

   Sometimes courts rule that PHI is necessary for court proceedings, if we are court ordered to release your information, we use the utmost of discretion while complying with any orders of the course. We are careful in our documentation to record what is necessary to meet clinical documentation standards but does not disclose information that is not necessary for the recording of the clinical session.

4. **You have signed a release authorizing us to release your information to someone.**

   We can release your records to anyone you want your records released to. The following pages are 2 very specific release forms. The first is for us to obtain information from other providers, schools, attorney's or other persons who are helping you or have helped you in the past so that we can better coordinate your care. The second form is for us to release any information from our records to anyone you want your records to be shared with. In general, it is a good idea for us to share records with your primary care doctor and/or any treatment psychiatric provider you are seeing so that we can work together in an integrative fashion. However, this is not necessary. Please consider your options, discuss with your provider and complete the necessary releases to meet your needs for use or restriction of your information.

Consent for Release of Information to Dr. Carlene H. Taylor, LMHC, LPC

I, _____, DOB: _____

Hereby authorize: _____
Name or Practice Name Information

_____
Address City Sate Zip

_____
Phone Fax Email

To release the following information from my medical, psychiatric, mental health and substance abuse (if applicable) records:

_____Discharge Summary
_____Psychiatric Evaluation
_____Medical History & Physical
_____Educational Records
_____Lab Reports
_____Correspondence
_____ Psychological/Neurological Testing
_____ Consultations
_____ Diagnosis
_____ Social History/Assessments
_____ Progress Notes
_____ Legal

To be sent to: Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC.
314 Osborne Street, St. Mary's, GA 31558
Secure Fax: (912) 882-0726

For the purpose of: ( ) Continuity of Care ( ) Other:_____

Information released is not to be further disclosed or used for any other purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me, and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility or person named herein for the stated purpose.

This authorization is valid until:_____
Expires One Year from Date Signed Unless Otherwise Specified

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

Consent for Release of Information from Dr. Carlene H. Taylor, LMHC, LPC

I, _____, DOB: _____
Authorize Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC

Dr. Carlene H. Taylor, LMHC, LPC, CPCS, NCC

Correspondence Address: 314 Osborne Street, St. Marys, GA 31558

Phone: (912) 673-1801 Secure Fax: (912) 882-0726

To release the following information from my medical, psychiatric, mental health and substance abuse (if applicable) records:

_____Discharge Summary
_____Psychiatric Evaluation
_____Medical History & Physical
_____Educational Records
_____Lab Reports
_____Correspondence
_____Psychological/Neurological Testing
_____Consultations
_____Diagnosis
_____Social History/Assessments
_____Progress Notes
_____Legal

To be sent to: _____
Name or Practice Name to release information

_____
Address City State Zip

_____
Phone Fax Email

For the purpose of: ( ) Continuity of Care ( ) Other:_____

Information released is not to be further disclosed or used for any other purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me, and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility or person named herein for the stated purpose.

This authorization is valid until:_____
Expires One Year from Date Signed Unless Otherwise Specified

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date