LIVING LIFE COUNSELING
Demographic Information

Name _____ Date _____

Address_____

City _____ State _____ Zip _____ ---_____

Date of Birth _____ Age _____

Home Phone _____ Work _____

Cell _____ Allow Text Messages? Yes _____ No _____

Any Calling Restrictions? _____

E-mail_____

Would you like to be on our Email Newsletter list? Yes _____ No _____

Spouse/Partner _____ Age _____

Home Phone _____ Spouse Cell _____

Emergency Contact Name _____

Emergency Contact Phone _____

I give permission for the above person to be contacted in case of emergency.

_____ _____

Signature Date

Referred By: _____

GREGG E. NATKOWSKI P.C.

Notice of Therapist's Policies and Practices to ProtectThe Privacy of Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record could identify you.
- "Treatment, Payment, and Health Care Operations"

-Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
-Payment is when we obtain reimbursement for your health care or determine eligibility or coverage.
-Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administration services, and case management and care coordination.

- "Use" applies only to activities within our clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Law provides the insurer the right to contest the claim under the policy.

III. Use and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If we have reasonable cause t suspect child abuse or neglect, we must report tis suspicion to the appropriate authorities as required by law.
- Adult and Domestic Abuse – If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities – If we receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Counseling, Social Work, or Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to your therapist a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out the threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation – We may use PHI regarding you as authorized by and to extent necessary to comply with laws relating to worker's compensation or other similar programs, established by the law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternate Means and at Alternate Locations – You have the right to request and receive confidential communications of PHI by alternate means and at alternate locations. (For example, you may not want a family member to know that you are being seen here. On request, we will send your bills to another address).
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained I the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from Gregg E. Natkowski P.C. upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will make this new form available for review.

V. Outcomes and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Gregg E. Natkowski, Director at 734-591-6277.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Gregg E. Natkowski, 37677 Professional Center Drive Suite 135-C, Livonia, MI 48154.

You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Policy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14th, 2003.

We reserve the right to change terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by making such a notice available in our waiting room for your review.

Living Life Counseling

Gregg Natkowski, MA, LLP, LPC, CAADC
810-923-5760

37677 Professional Center Drive
Suite 135-C
Livonia, MI 48154

794 West Grand River Avenue
Millpond Parke Office Complex
Brighton, MI 48116

LLP License#6301006475
LPC License# 6401009245
CAADC Cert# C-00329

PROFESSIONAL DISCLOSURE STATEMENT

EDUCATION AND CREDENTIALS

I earned my Master's Degree in Counseling from Wayne State University in 1985 with a specialty in Marriage and Family Counseling. I earned my Bachelor's Degree in Accounting at Eastern Michigan University in 1983. I am dually licensed in the State of Michigan as a Licensed Professional Counselor and a Limited Licensed Psychologist. I am not currently practicing psychology under the scope of my license as a Limited Licensed Psychologist. I am a Certified Advanced Alcohol and Drug Counselor with reciprocal privileges in all 50 states. I am also a Substance Abuse Professional and do evaluations for the Department of Transportation (DOT). I am a member of the American Counseling Association (ACA). I have completed the State of Michigan requirements to be a supervisor and I regularly attend supervision seminars for continued development.

DESCRIPTION OF PRACTICE

As a counselor, I provide individual, relationship and family counseling to adults, and teenagers experiencing mood disorders, anxiety disorders, anger, ADD/ADHD, grief and loss, substance abuse, sexual and gambling addiction, and sexual abuse issues. My counseling approaches include Christian counseling, psychotherapy, cognitive/behavioral therapy and education. If your problem is within my area of expertise and if we mutually feel comfortable working with each other, then we can begin the counseling process. Otherwise, I will refer you to another professional who can better meet your needs. Everything we discuss is confidential (except required by HIPAA law) and will not be disclosed unless you specifically sign a "Release of Information" authorizing me to do so.

EXPERIENCE

My prior counseling experience includes working at the Livonia Counseling Center, Aurora Young Adult Hospital, New Directions Center for Christian Counseling, and Warren Fitzgerald Schools. I have been in private practice since 1993.

COUNSELING SCHEDULE

My standard fee is $150 for a full session (60 minutes). The fee is discussed during the first counseling session and may be adjusted due to individual circumstances. A 24-hour cancellation notice is required without a full fee charge.

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
HEALTH PROFESSIONS DIVISION – ENFORCMENT SECTION
PO BOX 30670 - LANSING, MI 48909
517-373-9196

I received a copy of the Professional Disclosure Statement.

Client Name (Signature) Date

LIVING LIFE COUNSELING

NOTICE OF HIPAA PRIVACY PRACTICES AND PROFESSIONAL DISCLOSURE STATEMENT SIGNATURE SHEET

I acknowledge that I have received for review a copy of the HIPAA Notice of Privacy to Protect Health Information Form and the Professional Disclosure Statement. In addition, this information has been verbally explained to me.

_____ _____

Print Name Date

_____ _____

Signature Date

37677 Professional Center Dr. Suite 135-C Livonia, Michigan 48154
794 West Grand Avenue. Suite 794 Brighton, Michigan 48116
Phone: 810-923-5760

Living Life Counseling
Consent for Assessment and Treatment Form

I am voluntarily seeking treatment from my therapist, Gregg Natkowski MA, LLP, LPC, CAADC at Living Life Counseling. There are no promises or guarantees concerning my treatment outcome. I am consenting to be assessed and evaluated for treatment, and if appropriate, undergo counseling at Living Life Counseling. If my problem requires a higher level of care, I will be referred to a better suited therapist/clinic.

The fee for a full therapy session is $150 (60 minutes). All fees are to be paid at the beginning of each session (Check or cash, no credit cards) as well as scheduling the next therapy session. A 24-hour cancellation notice is required (phone call or text only), should you need to cancel your appointment. No-shows and less than 24 hours cancellation notice will be charged $150.00. Services performed outside of therapy (letters, reports, copying, phone calls) that exceed 5 minutes are prorated at the hourly rate of $150.00.

I agree to allow my therapist permission to contact and submit claims to my insurance company. If my therapist is an in-network provider, and for my therapist to be reimbursed directly by my insurance company. I will be responsible for all charges not reimbursed to my therapist (deductibles, co-pays, co-insurance). It is my responsibility to verify insurance benefits before therapy begins. If my therapist is a non-network provider with my insurance company, I will be responsible for payment at the beginning of the session. My therapist will provide me a receipt to submit to my insurance company in the event I may be reimbursed.

All personal information is considered confidential and can only be released/exchanged with my written authorization. HIPAA guidelines limit my confidentiality, which was explained in the Notice of Privacy that I received. I agree to waive my confidentiality, if my account is ever delinquent and turned over to a collection agency, small claims court, and/or the Attorney General Fraudulent Check Department. If my check is returned for non-sufficient funds (NSF), I will be charged $30.00 and the future payments must be made by cash or money order.

Recordings of any kind during the therapy sessions (in person or online) and phone calls are prohibited unless mutual consent in writing is agreed by both parties.

My case will be automatically discharged from LLC after 2 weeks, if I have not made any contact with my therapist to reschedule my next appointment.

My signature below indicates that I agree with the above Consent for Assessment and Treatment.

Name (signature) _____ Date _____

Name (print) _____

Gregg E. Natkowski, MA, LPC, CAADC
DBA/Living Life Counseling

37677 Professional Center Dr. Suite 135-C Livonia, Michigan 48154
794 West Grand Avenue. Suite 794 Brighton, Michigan 48116
Phone: 810-923-5760

Client Responsibility Agreement to Pay for Services

In the event that my Health Plan, _____,
(Print name of Health Plan)
Does not pay for the services that I receive for therapy, I understand that I will be responsible for the payment to Gregg Natkowski P.C./DBA Living Life Counseling for all psychological and counseling services.

It is therefore very important for you to know your exact insurance coverage and to be in compliance with the referral and authorization requirements of your specific Health Care Insurance Plan. We are requiring all to sign this waiver prior to treatment.

_____

Print Name of Client Signature of Client/Guardian/Parent

☐ I have reviewed this form and information with the client

Therapist: _____

LIVING LIFE COUNSELING
RELEASE/EXCHANGE OF CLIENT INFORMATION

I _____ hereby authorize Gregg Natkowski his/her director or designee Living Life Counseling to release information contained in my client records to the following individual(s) and /or organization, and only under the conditions listed below:

1. Name of person(s), organization, and address to whom release/exchange is to be made:

_____

_____

2. Specific type of information to be released/exchanged: (Client initials next to each checked box)

❑ ___ Diagnosis ❑ ___ Drug/Alcohol History ❑ ___ Treatment Summary/Reason for Closing

❑ ___ Attendance ❑ ___ Mental Status Exam ❑ ___ Recommendations

❑ ___ Progress ❑ ___ Physical Examination ❑ ___ Other: _____

❑ ___ Prognosis ❑ ___ Discharge/Summary/Date _____

3. The purpose and need for such release/exchange: (Clinician check appropriate boxes)

❑ Continuity of Treatment ❑ Aftercare Planning ❑ Referral

❑ Contact w/ Referring Supervisor ❑ Family Involvement

❑ Other:/Job Stability/Union Representation _____

_____

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME. IF NOT PREVIOUSLY REVOKED THIS CONSENT WILL TERMINATE UPON: (Specific date, event or condition)

/ /
_____
Date

Event: _____

Condition: _____

_____ / /
Client (Parent/Guardian) Signature Date

_____ / /
Witness Date

The client information release authorization form is prepared in accordance with the authority specified in Public Act 56 of 1973 and is in compliance with Title 42 of the Code of Federal Regulation, Part II. Authorized disclosure is inclusive of mental health and alcohol or drug abuse information as specified.

As of this date, I hereby revoke the consent provided on this authorization forth.

_____ ___/___/___
Client (Parent/Guardian) Signature Date