LOOKING UP COUNSELING, LLC

BILLING INITIATION FORM

(Note: This form is used to initiate billing.)

Intake Date: _____ Clinic: _____ Therapist: _____
Case Manager: _____

Client name, exactly as it is shown on his or her Medicaid card:

Last Name: _____ First Name: _____ MI ____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMAIL: (for a digital handbook)_____

Medicaid Number: _____ Phone Number: _____

Primary Diagnosis *(from DMS-V)*: _____

Does this person qualify for rehab services? YES ☐ NO Qualifier: IEP Testing Disability Inpatient

Are you interested in having a Psychological Assessment (Testing) completed? Yes No

EMERGENCY CONTACT INFORMATION

****For minors: Please list someone other than child's primary guardian. ****

Name: _____ ____ Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Special Instructions for Contact: _____

Name of Pharmacy Used: _____ City: _____

Looking Up Counseling, LLC
Therapist Intake Packet Checklist

Client Name_____ Milan #_____

Date Opened_____

Counselor_____

Legal:

Consent for Treatment	Pg. 3	_____
Consent for Follow-up Contract	Pg. 4	_____
HIV/AIDS Prevention	Pg. 5	_____
Clients Rights	Pg. 6-7	_____
Notice of Privacy Practice (HIPAA)	Pg. 8-9	_____
Grievance Procedure	Pg. 10	_____
Treatment Advocate Form	Pg. 17	_____
Professional Disclosure	Pg. 19	_____

Financial/Medical Information

Billing Initiation	Pg. 1	_____
Client Orientation Check List	Pg. 12	_____
Fee schedule agreement	Pg. 13	_____
Signature Page	Pg. 18	_____

Clinical Information

Psycho-social Evaluation		_____
Discharge Summary		Milan

Optional Needs Forms

Permission to Transport	Pg. 14	_____
No-Harm Contract	Pg. 16	_____
Consent for Release of Confidential Information	Pg. 11	_____

Client Name:_____

CONSENT FOR TREATMENT

Consent extended to Looking Up Counseling, LLC

1. I, We (Parent, Legal Guardian if applicable) authorize **Looking Up Counseling,LLC** (hereinafter referred to as **LUC**) and representative **Qualified Mental Health Providers (QMHP)** of their chance to administer treatment to me and to continue such treatment as deemed professionally necessary.
2. I/We do hereby authorize psychiatric, psychological, diagnosis or treatment by a physician, therapist and / or authorized qualified mental health provider by **LUC.** Treatment may be rendered to said client under general, specific or special consent of **LUC,** whether such diagnosis or treatment is rendered at the office of the psychiatrist, therapist, or **QMHP**. It is understood that this consent is given in advance of any specific diagnosis of treatment being required, but it is given to encourage and authorize those persons, (physicians, **QMHP**) to exercise their judgment as to the requirements of such diagnosis or psychotherapeutic treatment.
3. I / We further agree to be actively involved in the treatment plan as prescribed by the treatment team of **LUC**. while the aforementioned client is in treatment. I / We understand that included in such treatment plan would be my / our involvement in regular family, individual, or group therapy sessions, scheduled in accordance with State, Federal and / or pay source guidelines.
4. No guarantees or assurance have been given by anyone to the results that may be obtained.
5. I / We consent to be contacted following discharge for purposes of obtaining information of assistance in efforts to improve the quality of care (i.e. client satisfaction surveys, etc.

This consent shall remain in effect commencing on the date of admission to Looking Up Counseling, LLC., unless sooner revoked in writing and delivered to said physician, therapist, or QMHP of Looking Up Counseling,LLC.

1. I / We understand Looking Up Counseling, LLC provides these services regardless of the client's ability to pay. If able, I/We agree to pay when services are rendered and charged.
2. I / We have read the Consent for Treatment form, understand all of its content and sign my / our name(s) hereunder freely, voluntarily and without coercion.

I / We agree to give 24-hour notice of cancellation if not participating in planned services and understand that not showing up for planned services, the treatment plan may be reviewed by treatment staff to determine the appropriateness of continued treatment or discharge.

I / We have provided the information in the Initial Intake Packet and, upon review, find it to be accurate to the best of my / our knowledge.

I / We have read and received the Privacy Practice Notice Forms and they have been discussed with me. I understand how my health information will be handled and used through Looking Up Counseling,LLC.

I / We have read and received the Client Grievance Policy and Procedure Form and this form has been discussed with me, and I / We understand that is there is a grievance, I may file a complaint with the LUC Privacy Officer.

_____ _____

Signature of Parent/Guardian **Date**

_____ _____

Signature of Client (If 14 or older) **Date**

_____ _____

Signature of Staff **Date**

Client Name:_____

Looking Up Counseling, LLC

Consent for Follow Up and Explanation of Patient Rights

Exceptions to Confidentiality General Statement

Looking Up Counseling, LLC (LUC) shall meet the requirements of all applicable state and federal laws, rules and regulations.

All staff must have general knowledge of the provision of Public Law 99-401, which amends the federal confidentiality laws to remove any restriction on compliance with state laws mandating the report of child abuse or neglect. This statute requires that cases involving suspected, actual or imminent harm to children must be reported to child protection agencies and therefore are not covered by confidentiality requirements. This provision applies only to initial reports of child abuse or neglect and not requests for additional information or records. Thus, court orders are still required before records may be used to initiate or substantiate any criminal charge against a client or to conduct any investigation of a patient.

Client records are considered confidential and will not be released to other individuals or agencies without your expressed written consent, except upon receipt of a legitimate subpoena, in the event of a valid medical emergency, to meet the requirements of state law that child / elderly abuse be reported or in the event you present an imminent danger to yourself or others.

Since part of the cost of treatment is paid by federal, state or local sources, these sources have the right to review the client files on periodic basis to verify that such services have been delivered appropriately. Also, an insurance company may need to review parts of a file to verify diagnosis and treatment procedures so as to process payment claims. This review is done for accounting access to your file by LUC staff, consultants, and accountants. (See Client Rights Form).

I / We have received a copy of the Client Rights form.

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Client (If 14 or older) Date

Consent for Follow Up

I (Client, Parent, or Legal Guardian if applicable) authorize Looking UP Counseling,LLC to contact me by phone / mail / in person for the purpose of evaluation of treatment progress, client satisfaction and other information as deemed necessary by the staff in order to enhance the quality of care.

_____ _____

Client/Guardian Signature Date

Client Name:_____

A.I.D.S. PREVENTION CLIENT EDUCATION

WHAT IS A.I.D.S.?
Acquired Immune Deficiency Syndrome (AIDS) is a group of life threatening symptoms, infections, or illnesses, which occur because a person's immune system, the body's natural disease fighting mechanism, is weakened or damaged by infection with Human Immunodeficiency Virus (HIV).

WHAT DOES H.I.V. DO TO THE BODY?
The virus weakens the body's immune or disease fighting abilities so that the body cannot fight off infections or destroy cancer cells. Eventually, the diseases may cause death in an HIV infected person.

HOW DOES A PERSON "GET" A.I.D.S.?
When bodily fluids, especially BLOOD or SEMEN, from an infected person get into another person, the second person becomes infected with the virus.
This can happen by:

- Sexual intercourse (vaginal, anal, or oral) with an infected person
- Sharing needles with an infected person
- Blood products / transfusions (prior to 1985)
- An infected pregnant mother passing the infection to her baby

HOW DO I KNOW IF I HAVE A.I.D.S.?
Long before any symptoms appear, the body will produce antibodies to attempt to fight off the HIV infection. These antibodies can be detected in an infected person's blood by a blood test, the HIV antibody test.

Many symptoms of A.I.D.S. or A.I.D.S. Related Complex (ARC) are similar to symptoms cause by many illnesses. Only a physician or certified Oklahoma State Health Department HIV testing site can determine whether or not you have A.I.D.S. or are infected with HIV.
WHAT IS THE NATURAL COURSE OF A.I.D.S.?

High Risk Behaviors = INFECTION - HIV Antibodies - ARC - A.I.D.S.
(Weeks to Months) (HIV Positive)

Any infected person, male or female, is ALWAYS infectious.

WHAT CAN BE DONE ABOUT A.I.D.S.?
There is no cure. PREVENTION IS THE ONLY ANSWER AT THIS TIME.

Do not engage in "high risk" behaviors, such as those listed above, which put you at risk for HIV infection.

If you decide to engage in "high risk" sexual activity, protect yourself and your partner. USE A CONDOM.

If you are using IV-Drugs, DO NOT SHARE NEEDLES. If you do share needles, clean the "works" with household bleach; rinse with fresh water before using.

_____ I have received HIV/AIDS Prevention Education / Information.

_____ I have received referral information regarding HIV Testing, which shall be accompanied by pre-test and post-test counseling.

_____ My spouse and sex partner(s) have been offered said information / services.

For any Sexually Transmitted Disease including HIV/A.I.D.S. testing and screening can be done at the local Health Department.
Appearance of this form in the client record indicates that Looking Up Counseling, LLC, client has received basic HIV/AIDS prevention education.

_____ _____ _____
Parent/Guardian Signature Client Signature (If 14 or older) Date

_____ _____
Staff Signature Date

Client Name:_____

CLIENT RIGHTS

Each consumer has the right to be treated with respect and dignity.

Furthermore:

Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;

To be free from unnecessary, inappropriate, or excessive treatment; To participate in consumer's own treatment planning;

To receive treatment for co-occurring disorders if present;

To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and

Client Name:_____

To not be discharged for displaying symptoms of the consumer's disorder.

Every consumer's record shall be treated in a confidential manner.

No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

ODMHSAS Advocacy Division 405-248-9037 1-866-699-6605 (toll-free) Advocacydivision@odmhsas.org 2000 N. Classen Blvd. Ste. E600 Oklahoma City, OK 73106

ODMHSAS Inspector General; 405-248-9037 or 1-866-699-6605 (toll-free)

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

CLIENT SIGNATURE (IF 14 OR OLDER) DATE

_____ _____

STAFF SIGNATURE DATE

Client Name:_____

LOOKING UP COUNSELING, LLC
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.
PLEASE READ CAREFULLY.

Looking Up Counseling (LUC) is required to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and relates to our past, present, or future mental health condition and related health care services. This notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment, or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes our rights with respect to PHI about you.

LUC is required to follow the terms of the Notice. We will not sell your name and address or identifying information for any purpose. We will not disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice to make the Notice effective for all PHI we maintain, upon request, we will provide any revised Notice to you. The complete law which sets out how information that identifies a patient can be used and disclosed is the Health Insurance Portability and Accounting Act of 1996 (HIPAAA) Title 45, Code of Federal Regulations (CFR), Parts 160 and 164 & title 42 (CFR) (part 2).

Effective date: This Notice is effective as February 1, 2016.

Your health information rights: you have the rights with respect to PHI about you.

Obtain a paper copy of the notice upon request: you may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy by written request by mailing such request to 114 S 1st St. Madill, Ok 73446 from your respective Counselor or the Administrative Assistant. You will receive a paper copy of the Notice at your first visit after February 1,2016.

Request a restriction on certain uses and disclosures of PHI: you have the right to request additional restrictions on our use or disclosures of PHI about you for treatment, payment, health care operations, communication with individuals involved in your care or by business associates by submitting a written request for the restriction. You may submit your request in person to your respective counselor or mail the request to 114 S 1st St. Madill, OK 73446. We are not required to agree to those restrictions.

Inspect and obtain a copy of PHI: You have the right to access and copy PHI, about you contained in a designated records set for as long as we maintain the PHI. To inspect your copy of PHI about you, you must sign a written request. You may submit your request in person or by mail to the above address. We may charge you a fee for the cost of coping, mailing and supplies that are necessary to fulfill your request. We may deny your request and copy in certain limited circumstances. If you are denied access to PHI about you, you may request the denial be reviewed.

Request an amendment of PHI: If you believe that PHI we maintain about you is incorrect or incomplete, you may request that we amend it. You may request an amendment for as long as we maintain PHI. To request an amendment, you must send a written request to your office at the above address. You may include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the Clinical Director and we may give you a rebuttal to your statement.

Receive an accounting of disclosure of PHI: You have the right to receive an accounting of disclosure we have made of PHI about you after February 1, 2016, for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosers made directly to you, disclosures you authorize, disclosures to friends or family members involved in your case, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing. Your request must specify the time period, but may not be longer than (6) years. The first accounting you request within a 12 month period will be provided free of charge, but you

Client Name:_____

may be charged for the cost of providing additional accounting in the same 12 month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
Request communication of PHI by alternative mean or at alternative locations: For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you by alternative means or at an alternative location, you must submit a request in writing. You may submit your request in person or by mail to LUC at the above address. Your request must state here or where you would like to be contacted. We will accommodate all reasonable requests.

Special Requirements of Psychotherapy notes: Psychotherapy notes are afforded special privacy protection under this regulation. You are not entitled to receive a copy of the psychotherapy notes from this office and exclude from the provisions of this law that gives clients that right to see and copy their health information. Further, these records are kept separate from a client's other records. A specific written client authorization will be required before these psychotherapy notes will be disclosed to anyone. The definition of psychotherapy notes exclude medication prescriptions and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests and summary of the following items, diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
Exceptions from consent, authorizations, or opportunity to object: Under certain circumstances, a covered entity may use or disclose protected information with our written consent or authorization and without providing a notice to the individual, as follows:

- Uses and disclosures required by law.
- Uses and disclosures for public health activities.
- Disclosures about victims of abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities.
- Disclosures for judicial and administrative proceedings.
- Disclosures for law enforcement purposes.
- Uses and disclosures about decedents.
- Uses and disclosures for cadaver organ, eye tissue donation purposes.
- Uses and disclosures for research purposes.
- Uses and disclosures for advert serious threat to health or safety.
- Uses and disclosures for specialized governments functions.
- Disclosures for worker's compensation.

Other uses and disclosures of PHI: LUC will obtain written authorization before using or disclosing PHI about you other than those requested by you or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon request of the written revocation, we will stop disclosing PHI about you except to the extent that we may have already taken action in reliance on the authorization.

For more information or to report a problem: If you have questions or would like additional information about LUC's Privacy Practices, you may write the Program Coordinator of LUC at the above address. If you feel your rights have been violated, you can file a complaint with LUC's CEO, Program Coordinator or the Department of Mental Health and Substance Abuse Services (ODMHSAS) by contacting the Consumer Advocacy Division either by telephone or in writing. Contact ODMHSAS Consumer Advocacy Division at: 1-866-699-6605 or Consumer Advocacy Division, P.O. Box 151, Norman, OK 73070.
The signature below is acknowledgement that you have received this Notice of our Privacy Practice:

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date
_____	_____	_____
Client Printed Name	Client Signature (if 14 yrs or older)	Date

Client Name:_____

Looking Up Counseling
THIS FORM MUST BE COMPLETELY FILLED OUT

Grievance Process

*****You may report a specific complaint or contact ODMHSAS at any time during the process.

1. You have the right to discuss the complaint with your counselor. Your counselor will have 72 hours to resolve your grievance.

2.Should you not be successful in resolving your complaint with your counselor, the grievance / complaint report should be completed and forwarded to the counselor's supervisor.

3.The supervisor has 72 hours to provide a solution. If not resolved at the supervisor level, you have the right to request a face - to - face meeting with the CEO of the agency. The CEO shall have 72 hours to provide the meeting and a resolution.

4.If you are not satisfied with the results, a written request for review may be made to the Board of Directors. The Board of Directors will review the complaint / grievance during the next scheduled board meeting. The decision of the Board of Directors shall be final and must be given to you within seventy two (72) hours after the Board review has been completed.

5. If you are not satisfied with the decision of the Board of Directors, you may contact the following person / agencies:

The Office of the Advocate General
2000 N Classen Blvd. Ste. E600
Oklahoma City, Ok 73106
(405) 522-3877

OR

Local Advocate and Grievance Coordinator
Office Manager
(580)795-5949

Decision Maker
Angie Wright
(580)282-0077
The Office of the Advocate General
405- 248-9037

_____ _____
Client/Guardian signature Date

Client Name_____

Looking Up Counseling, LLC

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I_____

Participant'sName

DOB_____SS#_____

agree that the staff of LUC can exchange information about me and about my participation in services (such as HIV information, psychiatric information, medical information, etc.) including:

_____

Type of Information to be Disclosed

*To:*_____

SPECIFIC NAME OF RECEIVER/S

in order to:_____

Reason for the Disclosure - Be specific as Possible

If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services..

Kind of communication allowed: *(Mark all that apply)* ☐ All Types ☐ Electronic ☐ Written ☐ Verbal

I understand that my records are protected under federal and state regulations governing the confidentiality of mental health, alcohol and drug abuse patient records. These regulations ensure that information cannot be given to anyone without my written consent except for very unique and special situations which are explained within these regulations (Part 42 Section 2). The release of information form has been explained to me and the consent has been given of my own free will.

This release is good until

_____

Specific Date, Event or Condition

and may be revoke in writing at any time except for information that has already been released.

_____ _____

Parent/Guardian Signature Date

_____ _____

Client Signature (If 14 or older) Date

_____ _____

Signature of staff requesting release Date

I hereby revoke this consent to disclose confidential information on the date of my signature below. I acknowledge that this revocation has no bearing on information that has been previously disclosed.

_____ _____

Parent/Guardian Signature Date

_____ _____

Client Signature (If 14 or older) Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION

Client Name:_____

Looking Up Counseling, LLC.
Statement of Acknowledgement Regarding Orientation

During the Intake process I received adequate explanation of the forms I have signed and have been given a copy of

- Rights of Persons Served
- Complaints, Grievances, and Appeals information sheet
- Complaint / Grievance Form
- Notice of Privacy Practices
- Statement of Professional Disclosure
- Information Sheet for Persons Served
- Any other documents I requested a copy of

I have had an opportunity to ask questions regarding my care and treatment while receiving services at Looking Up Counseling and my questions have been satisfactorily answered.

Parent/Guardian:_____Date:_____

PersonServed:_____Date:_____

Therapist:_____Date:_____

Client Name:_____

Looking Up Counseling, LLC.

Fee Schedule Agreement

I understand that I am expected to pay the agreed upon fee at the time services are rendered.

Proof of income may be required. (Copy of income tax return or recent pay stub.)

I will talk to my therapist if I am unable to, for any reason, abide by the above regulations.

I understand that I am expected to pay my insurance co-payment in the amount of $_____ at the time services are rendered.

I/We agree to the (adjusted) fee of $_____.

Client has SoonerCare and will not be responsible for any co-pays____

_____
Parent/Guardian Signature & Date

_____
Client Signature (If 14 or older) Date

_____
Staff Signature Date

Client Name:_____

Looking Up Counseling, LLC

Permission to Transport

This form is optional and to be used if needed

I, _____, give my permission to transport _____ by Looking Up Counseling staff for any outings provided by LUC.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Client (If 14 or older) Date

_____ _____
Signature of LUC Staff Date

Client Name:_____

Looking Up Counseling, LLC

No Harm Contract

Optional form to be used for applicable clients

I, _____, agree to give

_____ of Looking UP Counseling, LLC., one counseling session, face to face, before I harm myself in any way. If I cannot contact anyone at Looking Up Counseling, LLC. I will seek any other available resources before harming myself is any way.

Office Phone Number 1-405-300-8588

Therapist: _____ Cell No.:_____

County: _____ Sheriff Phone No.: _____

City: _____ Police Phone No.: _____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Client (If 14 or older) Date

_____ _____

Counselor Signature Date

Client Names:_____

Looking Up Counseling, LLC
Treatment Advocacy Designation Form

*This form is required for all **adult c**lients*

I / We, _____ chose to ( ) or not to ( )
(Client/Guardian)
name a Treatment Advocate.

We choose _____ as our Treatment Advocate.
(Treatment Advocate Legal Name)

I, _____, do ( ) or do not ( ) intend to
(Treatment Advocate)
serve client according to their specifications.

As the Treatment Advocate, I agree to comply with all privacy standards regarding the above mentioned client.

_____ _____
Client Signature/Parent or Guardian Date

_____ _____
Treatment Advocate Signature Date

Client Name:_____

Client Name: _____Client Payor ID: _____

Provider Number: _____ Date Completed: _____

I / We (client / guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I / We have the following response:

_____

_____

I / We (☐ Agree) (☐ Disagree) with this service plan.

_____ _____

Client Signature, 14 or older Date Parent / Guardian Signature
Date

_____

_____

Witness Signature Date Relationship to Client

If client is unable to sign, document the reason:

_____

LBHP signature indicates completion of the face to face assessment to determine medical necessity and appropriate level or care including the evaluation of all pertinent information by the other service practitioners and the client as well as a review of the current service plan.

_____ _____

Responsible LBHP Signature, Degree/License/Under Supervision Date

Physician Credentials Date
☐ Physician signature not required

Type of Service	Frequency (per week or month)	Print Staff Name & Credentials
Ind Psy		
Int Psy		
Fam Psy		
Grp Psy		
P/S Reh-G		
P/S Reh-I		
Psy Test		
Med T/S		
C/M		
BH Aid		
Fam Support		

THIS PAGE IS A REMINDER TO ADD YOUR OWN PERSONAL

PROFESSIONAL DISCLOSURE