David Levingston, M.A., LMFT
Licensed Marriage and Family Therapist LMFT 100-0000054
139 Main Street, Suite 404 Brattleboro, VT 05301 415.717.0918 dlevingston@gmail.com

Welcome!

Introductory Questions

Today's Date:

Name:

Phone:

Home:	OK to leave a message?	Yes ☐	No ☐
Work:	OK to leave a message?	Yes ☐	No ☐
Cell:	OK to leave a message?	Yes ☐	No ☐

Email:

Address:

Age: Birthdate:

Gender:

Counselor Use Only
Dx for Insurance:

_ _ _ _ _ _ _ _ _ _

1st Session Date: _ _ _ _ _

Insurance Company and Policy Number:

Emergency Contact (Name, Address, Phone):

PCP (Doctor): Consent to contact? Yes ☐ No ☐

Family constellation [small family tree of immediate relations, including pets you may have]:

How did you hear about me? Who referred you?

Reason for coming to therapy:

How do you imagine things can be better for you?

How do you imagine we'll be using the time in our therapy sessions to help you?

Current physical health issues, conditions, limitations – anything affecting your capacity to function and enjoy life as fully as you would wish:

Struggles with Mood? Anxiety? Suicidal thoughts, plans, or actions (pls elaborate)?

Current medications:

Allergies:

Diet:

Exercise:

If you are a couple with children, do you get your 1 hr/wk alone time? Yes ☐ No ☐

Sleep (difficulty falling ☐, staying ☐, or getting up ☐):

Past and present drug use – including substances such as alcohol, marijuana, uppers, downers, all–arounders, entheogens, as well as what might be considered “process addictions”, such as internet, working, gambling, sex.
Include type, amount, and frequency:

Socially acceptable drugs:
Nicotine use:

Caffeine consumption:

Sugar consumption:

Past medical issues (significant problems, accidents, hospitalizations):

Existential / circumstantial limitations, challenges, struggles, stressors – such as finances, living situation, legal issues, family, education:

Trauma or abuse, past and/or present – including physical, emotional, verbal, or sexual abuse:

Counseling you have done in the past – and was it helpful or not:

Anything else you think would be helpful for me to know about you and your situation, including what you might consider to be your strengths and/or your personal interests:

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~ Signature Page For All Forms ~

Informed Consent, "No Secrets" Policy, Patient Bill 'o Rights, HIPAA

I/we have read, understand and agree to the information and policies described in the Informed Consent Form.

I/we have read, understand and agree to the cancellation policy.

I/we understand that if I/we miss a scheduled session and I/we don't provide at least 24 hours' notice or if the absence is not due to an emergency, I/we agree to pay the full payment for the missed session, which is $80.

I/we acknowledge receipt of the Patient Bill of Rights.

I/we acknowledge receipt of the HIPAA and Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you can get access to this information.

If the "Client" consists of more than one party, I/we have read, understand and agree to the "No Secrets" Policy for Family Therapy and Couple Therapy.

____
Print Name

____
Signature

____
Date

____
Print Name

____
Signature

____
Date

______________________ I give permission to be contacted by David Levingston in writing if necessary, and/or to be sent a feedback survey sometime after therapy has ended.
Initials

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Informed Consent Form

Complimentary quote from a person I worked with: *"Thank you for making me feel human."*

Welcome. This psychotherapy disclosure form will answer many of your questions about my therapy services. Please feel free to ask questions if you need clarification or more info.

What is therapy about? I am open to how therapy can take different possible forms (including walking outside or making art). In the end, I hope it serves your needs to connect better to yourself and others, to feel less isolated or down, and to connect to your own capacity to change your experience – whether it's your mood, or how you react to situations and people. Sometimes it is about coming to see reality as it is, and finding ways to be more at peace with it all. I encourage you to try and be open and honest with yourself. Allow for times when things might not be so comfortable. You might face aspects of reality more directly and possible choices that you have been avoiding, and this might be upsetting or hard to be with. Perhaps you already know this on some level. Also allow for some time. Sometimes change can happen quickly and sometimes change can take a while. Sometimes what changes is our desire to change things.

Our relationship. My style is interactive. I welcome discussion of any feelings you may have about our work together. Using the relationship itself can be an important part of the process in therapy.

Consider this: The word "therapist" derives from the Greek language. One meaning of the word *therapeuein* is "to attend."

My qualifications and experience. I began counseling in a professional context with the UCSF AIDS Health Project of San Francisco in 1999. In September 2001, I began the Integral Counseling Psychology program at California Institute of Integral Studies (CIIS) in San Francisco. I graduated with a Master's degree in December 2003, and I earned my Marriage and Family Therapist license for the State of California in January, 2007. This was granted reciprocity for the State of Vermont in October 2007.

Professional regulations. My practice is governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online at http://vtprofessionals.org/

A copy of the statutory definition of unprofessional conduct (3 V.S.A. ' 129a and 26 V.S.A. ' 4042 for licensed marriage and family therapists) can be found here:
http://vtprofessionals.org/opr1/allied_mental_health/
http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=26&Chapter=076

Information on the process for filing a complaint with, or making a consumer inquiry to, the Board, may be found here: http://vtprofessionals.org/opr1/allied_mental_health/

Confidentiality. With very few exceptions, the information discussed during your therapy session and all documentation (written or in any other medium) is kept private and confidential. Some very important exceptions to this rule are:

1. If there is a court order for the therapist to appear, or to produce the client's chart.
2. If your insurance company is involved, some information will be given after you sign the release of information part of the insurance form.
3. If the therapist learns that there exists a serious threat to any person.
4. If there is evidence of child or dependent adult or elder abuse.

Parents & Children: Children need to know that their parents have a *right* to know what goes on in therapy, but rather than reporting back *what* is said, I may discuss *how* things are going. I want both the child and the parent to know that it's important for the child to feel like what he or she is saying will be kept private.

Couples & Families: I encourage you to share any thoughts or feelings directly in our group sessions rather than privately with me.

Groups: As with individual therapy, I will hold confidential anything disclosed in groups. Group members are asked to agree to not share things with individuals outside the group.

Managed Care Organizations: Please be aware that any and all treatment records may be requested by the MCO in exchange for allowing treatment and billing for services.

Attendance. A regular weekly time together can make a difference in the kind of experience you have and progress you can make.

If you are running late, as long as you call to let me know, I'll wait and hold the time slot for you. Unless you call to let me know, I will wait for a 15 minute window after our appointed time, after which I will consiuder it a missed session and I may choose to leave the office to attend to other things.

If you happen to forget to appear for a scheduled session (and also forget to call in advance to let me know) two times, I may (at my discretion) provide you with a referral for other counseling opportunities that might be able to accommodate your situation.

Time. Sessions are generally 50 minutes long, starting at 10 minutes after the hour and ending on the hour. Longer sessions can be scheduled if we agree that it will be helpful. I will let you know when there are 5 minutes left in the session. We need to end on time because other people are scheduled to use the room.

Fees. Fees will be discussed and set by the end of the first session. My standard fee is $80/session. If you are using insurance, the first session is $120 to cover the time for insurance-required matters. Please let me know if your current financial situation would make it difficult for you to afford my standard fee, so that we can talk about possible alternatives. Payment is to be made at the beginning of each session or the beginning of each month, and may be by cash or check. I do not bill. Fees will be reviewed yearly and may be raised approximately $10 per year. A 30 day notice will be given of any changes to fees.

Insurance. If you wish to utilize health insurance to pay for services, please tell me the name of your plan, so that we can determine the extent to which our visits can be covered by your plan.

The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. Although I am willing to help determine the terms of your policy, you should also be aware that you are ultimately responsible for verifying and understanding the limits of your insurance coverage.

If I am a contracted provider for your insurance company, I will discuss the procedures for billing your insurance.

If I am not a contracted provider and you would like to submit a bill to your insurance company to be reimbursed for our sessions, I will be happy, as a courtesy, to provide you with an insurance form at the end of each month. You are responsible for the payment for our services regardless of what the insurance company does or doesn't ultimately do. Although I may be willing to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you.

Please know that when any agency (such as health insurance) is involved, your confidentiality will be affected. Please know that for the sake of determining insurance coverage, the services rendered will be *Outpatient Mental Health*, and my license is an *LMFT (Licensed Marriage Family Therapist*). Even though my license has the word "marriage" in its title, the services are not to be considered "marriage counseling." Please know that most insurance will not cover marriage counseling but will cover outpatient psychotherapy.

Please discuss any questions or concerns that you may have about this with me.

Cancellation policy. I will be reserving the time and the room for you, so please give me as much notice as possible if you won't be able to make it for your appointed session. If you need to cancel, I require thay you do so by phone rather than by email, because email is not reliable. My voice mail is available 24 hours a day to receive messages. If you don't provide at least 24 hours' notice of a cancellation or if it is not an emergency, you agree to pay for a missed session. Your health plan does not cover payment for missed appointments; therefore, you agree to be responsible for full payment, which is $80 per session. Likewise, if I fail to give 24 hours notice of a cancellation, your next appointment is at no charge to you.

Contact and after hours emergencies. My usual business hours are weekdays between 9:00 AM and 6:00 PM. If I am unable to answer the phone, please leave me a message. I check my messages during business hours and I will return your call as soon as I can. You are welcome to leave a voice mail at any time, but I may not be able to retrieve your message until my business hours.

I am not available after hours for emergencies. For after-hours emergencies or if you need immediate assistance, call the 24hr local crisis team at 1-800-622-4235. If you are feeling very out of sorts and need a soft place to land, you can also contact your medical group or your primary care physician, or visit the emergency department of your local hospital, and they will help direct you. If you are feeling suicidal, please call 1-800-622-4235.

Regarding Emailings, except for matters of scheduling, it is best to save interpersonal sharings for scheduled sessions. Also, please know that regarding confidentiality, electronic communications are not 100% secure. If you need to cancel a session on sudden notice and it is less than 24 hrs before the session, please call rather than email to assure that I will receive your message.

Outside contact. Respecting your preferences for privacy, we will discuss how we shall handle contact by phone and contact outside the therapy context, if we happen to run into each other in public.

Drug use. Please come to therapy sessions not under the influence of mind/mood-altering drugs (except for prescriptions), whatever that may mean for you. I see our work as about learning to be with reality as it is.

Notes. Sometimes I may take notes while we talk. It helps my work with you.

Exchanges and bartering. We will discuss the ethics of exchanges such as bartering of services or giving of gifts.

Touch. "*Talk* therapy," is different than hands-on body work, but can include directing one's awareness towards the body. While different cultures may include gestures of touch such as handshakes and hugs, I wish to respect and defer to your preferences. We will discuss the issue of contact and how we shall handle scenarios such as greetings and goodbyes.

Ending. Your participation in therapy is voluntary and you have the right to end therapy whenever you want. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session together. I ask that you allow for two final sessions for us to have an ending together, to review what we've done and to offer feedback to each other. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

- -

Please sign this form and keep a copy for yourself for future reference. Should you have any questions at any time, please ask.

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Patient Bill of Rights

You have the right to:

Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.

Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.

Receive respectful treatment that will be helpful to you.

A safe environment, free from sexual, physical, and emotional abuse.

Ask questions about your therapy.

Refuse to answer any question or disclose any information you choose not to reveal.

Request that the therapist inform you of your progress.

Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.

Refuse a particular type of treatment or end treatment without obligation or harassment.

Refuse electronic recording (but you may request it if you wish).

Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment

Report unethical and illegal behavior by a therapist.

Receive a second opinion at any time about your therapy or therapist's methods.

Request the transfer of a copy of your file to any therapist or agency you choose.

Source: California Department of Consumer Affairs

http://www.calpsychlink.org/resources/patientbillofrights.htm

Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at:
http://www.themissingexperience.com/forms/HIPAA_Notice_of_Privacy_Practices.doc.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment**. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you’re being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. **For health care operations**. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care

services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.

4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement**. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities**. For example, I may have to report information about you to the county coroner.
3. **For health oversight activities**. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes**. In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm**. In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions**. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes**. I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services**. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any com-plaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

David Levingston
Phone: (415) 717-0918
Address: 139 Main St. Ste 404, Brattleboro, VT 05301
Email: dlevingston@gmail.com

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

David Levingston, M.A., LMFT
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"No Secrets" Policy for Family Therapy and Couple Therapy

This "No Secrets" Policy is for situations where I am working with more than one person as part of a group. It explains how confidentiality works differently, to keep the therapist out of a triangle (i.e., being used as a recipient for allegations of "he said.." and "she said.."), and to further the goal of helping the group work out their issues more directly together. The legalese is elaborated below:

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatmet unit) to be the client. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-client privilege on behalf of the client (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple as a whole unit, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the client (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will not be able to help you as I see necessary, and we may need to revisit your goals in relation to my methods, and if necessary, end our therapeutic process together and explore other possible referrals.

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Consent to Release Confidential Information

[If you wish to grant permission for therapist to share any info with a 3rd party]

I, (Client name) ____, D.O.B. _______________

do hearby authorize:

David Levingston, M.A., LMFT,

to receive from, release to, or exchange with:

____

Name/Agency

____

Address/Phone Number

The following information:

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

____

For the purpose of:

(check all that applies):

________ The development of a treatment / service plan
________ Coordination of care with family/behavioral health or medical providers
________ Ongoing treatment / continuing care
________ Insurance or employment
________ Other (Specify): ____

I understand that information disclosed above is protected by Federal Regulation 42CFR, Part 2, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is no longer than one year unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying David Levingston in writing, except to the extent that action has been taken in good faith on my consent.

Client Signature ____ Date _____________

Parent/Guardian/Legal Representative Signature __________________ Date _____________

THIS CONSENT WILL AUTOMATICALLY EXPIRE IN ONE YEAR or as specified ____________________