Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Welcome!

This questionnaire is to assist me in better understanding your situation/problem. I recognize that there are a lot of questions, so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. I will review this questionnaire and discuss it thoroughly together with you in our first appointment.

Treatment with my office is voluntary and can be terminated at any time without penalty. My goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have any questions, concerns or ways I might improve my services, I would appreciate your input.

I understand that, in all cases, strict standards of confidentiality and professional ethics will be maintained. I strive to protect and preserve the confidentiality of the patient's personal health information. I have a detailed document called the "Notice of Privacy Practices." It contains more information about policies and practices protecting the patient's privacy and is available upon request. I understand that I have the right to read the "Notice" before signing.

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood the Notice of Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

I authorize Stephanie Lacy, LCSW LMFT, LLC to release and / or obtain my records to/from other physicians for the purpose of continuity of care.

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

AUTHORIZATION FOR TREATMENT & PAYMENT

I hereby consent to treatment by the health care provider Stephanie Lacy, LCSW LMFT,LLC

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

Print Full Name

404-345-7062
770-234-5448 (FAX)

LACY THERAPY
Clinical Social Worker • Marriage & Family Therapist

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