420 Dividend Dr., Suite C
Peachtree City, GA 30269
www.lifeswitch.life

LifeSwitch
ADDICTION COUNSELING
The best days of your life are just ahead.

Office: 678-568-9049
Cellular: 404-295-7076
LaTella.Mike@ gmail.com

2023 New Client Intro

Welcome to LifeSwitch!

Thank you for trusting me in guiding you to forge a new path, a new perspective, and a new existence. What lies ahead is a purposeful, fearless and regret-free life that clears the hurdles that serve to prevent most of us from even understanding our true potential, much less reach it. It is true that the goals of our work together include living without drugs and alcohol; *but* ***it's so much bigger than that!*** Freeing oneself from the ball and chain of alcohol and drugs is a necessary and impactful beginning that no doubt offers many positive results all by itself. But our short journey together can also be the catalyst towards a new life that is so rich and rewarding it defies even your greatest imagination. In the words of Dr. Seuss, "***Oh the places you will go****!"*

Over 85% of the clients who have completed the LifeSwitch 14-week Program are still drug and alcohol free today; most with multiple years of continuous sobriety. ***Honesty***, with yourself and me is the most important attribute to carry with you in this journey. Having an ***open-mind*** and being ***willing to change*** is also important. While it may be difficult to corral right now, eventually your ***enthusiasm for success*** will play an important part. I will provide the road map but you are the driver and there are many tempting diversions and exits that will take you off the path and over the cliff. Sometimes these spoilers come in the form of another human being, but more often than not the cause of failure in our attempts to be free and sober come from within. ***Fear*** is the lying beast that leads the parade of self-destructive emotions that undermine our success manifesting itself as low self-esteem and lack of confidence. ***Resentment***, defined as unresolved anger, is another emotion that will trip us up time and time again. ***Ego, pride*** and ***self-righteousness*** cloud our vision and make it hard to see what the right path is. **Self-justification**, which is just another word for ***selfishness*** always hangs around just waiting for an opportunity to get us off track.

Above all, please remember this: *the problem of drug and alcohol abuse and addiction resides in our own brain.* Physical dependence comes later but it is our innate and baffling ability to fool ourselves, to practice self-deception - that is at the root of all of our problems. Therefore keeping an open mind, taking direction and being willing to try changes create the **key** that opens up the door to your new life.

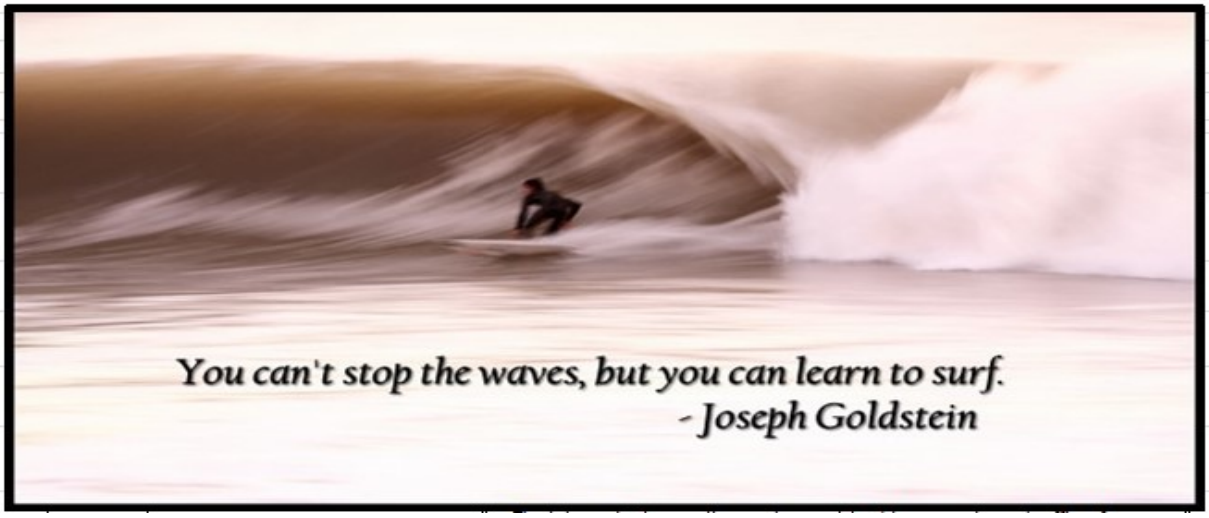
So take a deep breath, clear your mind of preconceptions that have thwarted progress before, and get ready for a journey that promises to change your life.

2023 LifeSwitch ADDICTION COUNSELING 2024

The best days of your life... are just ahead!

NEW CLIENT PACKET - LIST OF CONTENTS & INSTRUCTIONS

PAGE #	Description	Instructions
1	Welcome Letter	*Have the right mindset for success*
2	Document List & Instructions (*this page*)	*Follow the instructions on this page to complete and submit your paperwork correctly.*
3	Initial Intake Form	*Please Fill Out Completely*
6	Personal Overview	*If the questions on this form make you uncomfortable, just let me know and we can discuss without a written record*
9	Informed Consent	*Please read carefully and sign electronically*
14	HIPAA Rights & Acknowledgment	*Please read carefully and sign electronically*
17	Inbound Release	*The inbound release allows other entities (doctor, mental health professionals, psychiatrists, rehab centers, etc) to share their records and notes with LifeSwitch. Any previous information that offers insight into your past struggles with substances is very helpful.*
18	Outbound Release	*Your authorization on the outbound release allows me to share with whomever you designate information about your care. Usually this is a close family member... a spouse or parent. This doesn't mean I will share every detail of our sessions; in fact I won't. But this is valuable if I see you heading for disaster or if you stop showing up; at least I can reach out and make sure you are okay.*



LifeSwitch ADDICTION COUNSELING

2023 INTAKE FORM

420 Dividend Dr., Suite C
Peachtree City, GA 30269
Office: 678-568-9049
www.LifeSwitch.Life

CLIENT NAME: **LAST** _____ **FIRST** _____ **MIDDLE** _____ **DATE** _____

Do you have a preferred name different from your first name? **YES** ◯ **Preferred**_____ **NO** ◯

Are you under 18 years of age? **YES** ◯ **NO** ◯ *If **YES**, what is your current age***?** _____ *Student?* **YES** ◯ **NO** ◯

How did you hear about LifeSwitch? _____

ENGAGEMENT PURPOSE

Please describe the primary problem for which you are seeking help _____

_____

_____

Do you have any secondary concerns or issues that you are hoping to resolve? _____

_____

_____

GENERAL INFORMATION

DOB_____ Sex _____ Last 4 SS# _____ Birth City_____ State _____ Country _____

Current Address _____ City _____ ST ____ ZIP _____ *live w/parents?* **YES** ◯ **NO** ◯

Email: _____ Cell Phone _____ Home Phone _____

EMERGENCY CONTACT: First Name _____ Last Name_____ Relation _____

City _____ ST _____ Cell Phone _____ Email _____

Your Employment: ◯ **Full-Time** ◯ **Part-Time** ◯ **Student** ◯ **Retired** ◯ **Disabled** ◯ **Unemployed** ◯ **Other** _____

Employment Title _____ **How long at this job?** _____ **briefly describe your job role below:**

_____

FAMILY DETAILS

Marital Status: ◯ Engaged ◯ Married ◯ Divorced ◯ Widowed ◯ Single

About My Partner (*spouse, fiancé, boyfriend, girlfriend, significant other-if none put NA)* First Name _____ Age _____

In relationship for Yrs _____ Mos _____ His/Her Occupation _____ Has children not yours Y/N? _____# _____

Your Biological Children *First name, Sex, Age* (*If deceased, please write "deceased" and age when they died)*

1. _____ *2.* _____ *3.* _____

4.. _____ *5.* _____ *6. .* _____

House Mates: *Please list all persons currently living in the same dwelling as you (First name, Sex, Age, Relation)*

1. _____ *2.* _____ *3.* _____

4.. _____ *5.* _____ *6.* _____

7. _____ *8.* _____ *9.* _____

Of the people living in the same dwelling as you, please identify which ones have or may have substance use issues and their drug of choice (first name only please) _____

_____

ALCOHOL AND DRUG USE INFORMATION

My Drug of Choice is ◯ **Alcohol** ◯ **THC Products** ◯ **Opiates** ◯ **Other _____**

Please fill out the information forms below for alcohol, THC products and opiates/opioids if you have used them even once in the past six months regardless of whether they are your primary drug of choice.

Please complete the following sentences regarding Alcohol. Honesty and accuracy are extremely important.

◯ I drink alcohol ◯ I do not drink alcohol (move on to the next section i.e.. Marijuana)

The last time I had alcohol was _____ and I drank (qty) _____ over a period of time of _____.

In general, I drink alcohol ◯ Most of waking hours ◯ DAILY ◯ 4/5X a Week ◯ 2/3X a week ◯ 1X week ◯ < 1x week

When I drink, my preferred beverage(s) are: 1. _____ 2. _____ 3. _____

Considering that ONE DRINK = one 12 oz. beer, 5 oz of wine or 1.25 oz whiskey (shot), how many drinks do you you usually have on the days that you drink _____

*In terms of drinking, my **partner** (spouse, fiancé, boyfriend, girlfriend, etc if none then closest family member/friend) usually drinks:*

◯ *A lot more than me* ◯ *somewhat more than me* ◯ *about the same as me* ◯ *Less than me* ◯ *A lot less than me*

*In terms of drinking, most of the time my **partner** tells me:* ◯ *I am an alcoholic and need help* ◯ *Sometimes I drink too much but I do not need professional help* ◯ *My drinking is normal & not problematic* ◯ *I should relax and drink more*

Please complete the following sentences regarding Marijuana and THC. Honesty and accuracy are extremely important.

◯ I smoke pot or take THC ◯ I do not smoke or intake THC products (move on to the next section i.e. Opiates.)

The last time I had MJ/THC was _____ and I took (qty) _____ over a period of time of _____.

In general, I smoke/take THC ◯ Most of waking hours ◯ DAILY ◯ 4/5X a Week ◯ 2/3X a week ◯ 1X week ◯ < 1x week

When I take THC, my preferred substance is: 1. _____ 2. _____ 3. _____

*In terms of MJ/THC, my **partner** (spouse, fiancé, boyfriend, girlfriend, etc if none then closest family member/friend) usually takes:*

◯ *A lot more than me* ◯ *somewhat more than me* ◯ *about the same as me* ◯ *Less than me* ◯ *A lot less than me*

*In terms of smoking Pot or taking THC products, most of the time my **partner** tells me:* ◯ *I am dependant and need help* ◯ *Sometimes I smoke/take too much but I do not need professional help* ◯ *My smoking/THC use is normal & not problematic* ◯ *I should relax, quit worrying about it and smoke or take more*

Please complete the following sentences regarding OPIATES or OPIOIDS. Honesty and accuracy are extremely important.

◯ I use Opiates/Opioids ◯ I do use opiates or opioids (move on to the next section)

The opiate/opioid I use most often is in the form of (pill, powder, etc) _____ via (swallow, snort, needle) _____

The last time I used was _____ and I took (qty) _____ over a period of time of _____.

In general, I use the drug ◯ Most of waking hours ◯ DAILY ◯ 4/5X a Week ◯ 2/3X a week ◯ 1X week ◯ < 1x week

*In terms of opiates, my **partner** (spouse, fiancé, boyfriend, girlfriend, etc if none then closest family member/friend) usually takes:*

◯ *A lot more than me* ◯ *somewhat more than me* ◯ *about the same as me* ◯ *Less than me* ◯ *A lot less than me*

*In terms of using opiates/opioids, most of the time my **partner** tells me:* ◯ *I am dependant and need help* ◯ *Sometimes I smoke/take too much but I do not need professional help* ◯ *My smoking/THC use is normal & not problematic* ◯ *I should relax, quit worrying about it and use more*

If you have a primary drug of choice other than alcohol, THC products, or opiates/opioids, please use the form below to specify the substance and your frequency of use.

Currently, my drug of choice is _____

The last time I used it was _____ and I took (qty) _____ over a period of time of _____.

In general, I use this substance ◯ Most of waking hours ◯ DAILY ◯ 4/5X a Week ◯ 2/3X a week ◯ 1X week ◯ 1-2x month ◯ 3-5x month ◯ 1-2x month

When I use it my preferred method of intake is, my preferred substance is: 1. _____ 2. _____

This habit started approximately _____ yr(s) and _____ mo(s) ago.

Over time, my use has (gotten less, stayed the same or increased) until now _____

Comments: _____

If there are any other substances you have used in the past six months for the primary purpose of altering your state of mind, regardless of legal status, or if prescription or over the counter, please list them here along with how many times used in the past six months.

_____

List any previous treatment for Substance Use Disorders

1. **Instigating Event** _____ **Provider** _____ **Length** _____ **Dates** _____
2. **Instigating Event** _____ **Provider** _____ **Length** _____ **Dates** _____
3. **Instigating Event** _____ **Provider** _____ **Length** _____ **Dates** _____

NICOTINE: Please select which of the following nicotine products you currently use *(This is for profile information only. LifeSwitch does not currently offer a smoking cessation program).*

☐ *Cigarettes* _____ *Pks/ Day* ☐ *Cigars* _____ *per day* ☐ Pipe _____ bowls/ day ☐ *Chew Tobacco* _____ *wads/ day*
☐ *Snuff/Dip* _____ *cans/ day* ☐ *SNUS/Pouches* ☐ *Vape- Usage is* ◯ *low* ◯ *med* ◯ *High* ☐ *Other* _____

COEXISTING (COMORBID) CONDITIONS

Many times, alcohol and drug abuse are tied to other mental conditions and disorders. It is important to identify these and discuss in detail so that we make sure we are addressing any underlying issues. Please check any of the conditions below that have existed in the past six months.

☐ **Anxiety** ☐ **Panic Attacks** ☐ **Low self esteem** ☐ **Depression** ☐ **Suicidal thoughts** ☐ **Sleep Issues**

Have you ever been diagnosed by a Psychiatrist or mental health professional with any mental condition or disorder? ◯ **Yes** ◯ **No**

If "YES" please list disorder/condition and approximate date the diagnosis was made

_____

SIGNATURE BOX

By signing below I attest to the accuracy of the information contained herein and understand that lack of honesty and transparency about my life and alcohol and drug use reduce the chance of my recovery. I further understand that the information contained on this form is **highly confidential** and that without my written permission cannot be shared with anyone outside of my counselor and limited staff members of LifeSwitch on an as needed basis.

☐ Client is under the age of 18

_____ _____
Client Name (Please PRINT) Parent/Guardian Name (Please Print)

_____ _____ _____ _____
Client Signature *electronic signature line** Date Parent/Guardian Signature *electronic signature line** Date

**I, agree and understand that the electronic signature above is the legal equivalent of my manual/handwritten signature and by executing it I consent to be legally bound by the stipulations as written _____ <---- please initial).*

PERSONAL OVERVIEW

The following questions are at the heart of what you will discuss with your counselor during sessions. Providing this overview now allows your counselor to get a head start on what you are currently going through, the emotional pain you are experiencing and the current challenges and obstacles that are in the way of being free of your addiction. You may not want to complete this right now; you may prefer to share only in the privacy of your counseling sessions. There might be a privacy concern at home or describing these sensitive issues is too painful to do by yourself. It is completely your decision. You can complete it, submit what is comfortable to share or leave it blank.

In terms of alcohol and drug use, how long have they been negatively affecting your life? _____ yr(s) _____mo(s)

Please describe how the use of alcohol and drugs has affected the following areas:

- **Relationships (Marriage/Intimate)** _____
- **Relationships (Children)** _____
- **Relationships (Other Family)** _____
- **Relationships (Friends)** _____
- **Career/Work** _____
- **Finances** _____
- **Health** _____
- **Legal/Criminal** _____
- **Other Areas** _____

If you had never used alcohol or drugs, how do you think your life would be different today?

_____

_____

_____

Using the guide below, please answer how these areas of your life are today

(1) It couldn't be worse (2) Bad but not hopeless (3) okay but needs improvement (4) really good but not perfect (5) It's Awesome!

Overall Happiness	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Hope for a Bright Future	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Spiritual Life	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with God	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Marriage	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
OR						
Intimate Relationship	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with My Children	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with spouse's Children	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationships with Friends	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with my Parents	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with my sibling(s)	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Relationship with Co-workers	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Career/Work Situation	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Financial Situation	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Health	◯ N/A	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

If I had to choose a "Spiritual Status" I would say I am

◯ ***Atheist*** *(I do not believe in God)*
◯ ***Agnostic*** *(not sure if God exists*
◯ ***Spiritual with uncertainty*** *(believe something is out there but I have no real relationship with it*
◯ ***Very connected Spiritually*** *with "God" but without any significant religious dogma*
◯ ***I am religious*** *under the affiliation selected below but a lot of the time I feel like I am missing appropriate Spirituality*
◯ ***I am Religious and have strong Spirituality*** *through my affiliation as indicated below*

◯ *Christian* ◯ *Islam* ◯ *Jewish* ◯ *Hinduism* ◯ *Buddhism* ◯ *Other* _____

I attend church ◯ *At least weekly* ◯ *1-2X a month* ◯ *once every couple of months* ◯ *A few times a year*

COMMENTS _____

_____

Describe how your life would improve if you were to be free from drugs and alcohol for the next 12 months. What would change? How would you feel? Be specific! _____

If you have gotten to here, good work! I know it was exhausting. Take this last section below to tell me anything you feel like you haven't gotten out yet. Anything at all whether related to your alcohol or drug use or not. Problems, challenges and fears? Your greatest hope?

LifeSwitch ADDICTION COUNSELING

②

LAST UPDATED 6/01/2020
Mike LaTella
Addiction Counselor
latella.mike@gmail.com
770-629-4726

Counseling Agreement and Informed Consent Form

Welcome!

I am very pleased you are here and am excited to start working together. To give us the greatest opportunity for success, I want to make sure I have shared with you the parameters of our relationship, what your rights and obligations are and what you can expect of me. Please read this carefully. We will review it together in our first session. If you have any questions or concerns, please note them so we can discuss.

OVERVIEW

Scope of Services

LifeSwitch is a private counseling practice focusing on drug and alcohol use, abuse and addiction. *The primary goal is to help you overcome addiction and the mindset that life is not worth living without a mind-altering substance so that you can live a productive and happy life*. Teaching you the tools necessary to avoid drugs or alcohol is certainly a part of the program. It is where most recovery plans stop. But that objective alone misses the target. The permanent solution and the real miracle occurs when drugs and alcohol are no longer used, not because you have learned a list of rules of what to do and what to avoid, but rather because using drugs and alcohol are no longer consistent with the person you have become. To that end, the services that I offer include initial screening, testing and assessment, treatment planning, individual, family and group addiction counseling, case management, crisis intervention, and client education.

Qualifications

Certified Alcohol and Drug Counselor, Level II (CADC-II)
Internationally Certified Alcohol and Drug Counselor (ICADC)
Electronic Communication (Internet) Certified Alcohol and Drug Counselor (E-CADC)
Certified Advance Alcohol and Drug Counselor (CAADC) (pending testing)
Georgia State Certified Drug and Alcohol Evaluator (*authorized for all city, county and state courts and entities to use for evaluations with legal ramifications*)

COUNSELING

Assessment – Counseling - Treatment

The first goal in our work is to gain a comprehensive understanding of the unique characteristics of your circumstances with drugs and/or alcohol including your past experiences and current challenges that may impact that use. This understanding will be accomplished through a battery of tests and an assessment interview. Secondly we will develop a plan of action (a path) with the goal of leading you to a new dimension in life; one that is free from alcohol, drugs and their obsession. Finally we will implement that plan measuring key milestones along the way to make sure we are making progress. *Keep in mind you will take part in developing the success plan and are accountable for following through on the commitments made*. The most important player in this work is you.

Length of Treatment

14 Weeks. Most clients are learning and healing through a 14 week program that can vary in intensity from one 60 minute session per week to three 90 minute sessions per week. I have found that clients prefer to be on a program (with a begin date and end date with a set of measurable goals) than the old counseling model of lying on the couch week after week whining about life. The client can extend that program time as long as there is a stated objective for the additional sessions and it is achievable. The point is that it is important we have an established path with a destination and that we are making progress towards that destination.

LifeSwitch Beliefs and Likely Applications

Theoretical Platform. From a psychological perspective, generally employed are the concepts of client-centered therapy and cognitive behavior therapy, especially those that are highlighted in motivational interviewing. This simply means that the prevalent idea at LifeSwitch is that you will be more successful in your recovery if you help shape its direction. We will work collaboratively on deciding what is best for you to do and provide necessary support, direction and guidance.

Twelve-Step Facilitation. LifeSwitch operates under the belief that the **12 Step Program of Alcoholics Anonymous** (adopted by Narcotics Anonymous and over 100 other groups of various objectives) is the most effective method for achieving long-term sobriety. Usually (but not always) **The 12 Steps** are the basis for the LifeSwitch Recovery Program. The Steps are simple in design but many times complex in execution. Through actual experience of successfully working the 12 steps for personal alcohol addiction and having lead dozens of others through them with equal success I know them to represent ones best chance at recovery. Through my Masters Degree in Addiction Counseling I know and understand the other models as well and am quick to employ them when I see they can affect successful change.

Spirituality. LifeSwitch believes that having a relationship with God and experiencing the accompanying spiritual experience that accompanies finding God are necessary elements of a successful recovery. While Christian beliefs are the foundation of LifeSwitch's spiritual leanings (as are A.A. and N.A.) we are fine with your own concept of God and how He exists. LifeSwitch does not try to convert anyone to any religion, including Christianity. People recover with the 12 steps under every religion known to man and with no religion at all. God is essential in doing the 12 Steps; how you envision Him is up to you Even if you aren't sure who God is, all that we ask for is have an open mind. The current circumstances that led you here should be proof enough that you need to be open to seeing things differently.

Honesty

There is perhaps nothing more important in our success in working together than mutual-trust. That trust develops with complete honesty. I will be honest with you. You must be honest with me. We can manage almost anything if we maintain that trust. We can accomplish little without it.

Commitment

Second to honesty in your success recipe will be commitment. If we can have complete honesty and you give this your best commitment, a good portion of the battle is already behind us. Commitment means you are actively participating in your own treatment. It means showing up on time clean and sober for the appointment, coming with willingness and openness to discuss your triumphs and difficulties.

Risks and Limitations of Therapy

By its nature, therapy comes without any guarantees of specific outcomes. My expectation is that, at minimum, by the end of our work together you will be better able to regulate your own emotions, have more mindfulness about your difficulties, possess a new set of tools to overcome those difficulties, and know how to set goals and meet them.

Over the course of our time together some tough topics will probably be discussed. Uncomfortable emotions such as shame, guilt, hopelessness, or sadness may arise as a result of our work. I will always do my best to offer you support in managing these feelings.

Referrals

In some case there may be a need to refer you to another treatment professional so that you may get the best care possible. If that need arises, we will discuss in detail.

Advanced Discounted Payment

For the 14 week programs offered by LifeSwitch I offer a significant discount for those clients who can pay in advance. The caveat is that if you decide to end therapy sooner than the end of the program, or must end it due to illness, incarceration, or due to actions or inactions on your part that make treatment unworkable whether inside or outside your control, you will have that credit on the books for a period of one year after the initial treatment date to continue sessions. No refunds are given however.

PROCEDURES

24-Hour Clean and Sober Policy

I ask that you come to each session with at least 24-hours of clean and sober time. This is important to treatment because it is difficult to discuss important issues while you are intoxicated or high. If you do come to a session under the influence of drugs or alcohol I will end the session early and payment for the session will be forfeited.

Cancellation and No-Shows

During a 14 week period with weekly sessions, I will allow one emergency cancellation within 24 hour period of appointment, provided I am called as soon as you find out about the emergency. For twice-weekly session clients I will allow two such emergencies. After that, if you are more than 20 minutes late without calling, if you show up high or inebriated, or you don't show up at all without appropriate notice, I have no choice but to charge you for the missed session. Communication is the key here. I will give you every benefit of the doubt but I need for you to communicate with me so that we can stay on the same page. Making

your sessions is important for continuity and progress, but If you must cancel an appointment, please provide me a 24 hour notice so I can plan that time. For habitual tardiness or absences, LifeSwitch reserves the right to terminate counseling services.

Vacations & Holidays

There will be times where I have planned days off for professional conferences or personal engagements. When those occur I will give you at minimum a two week notice and reschedule your time so as to create as little inconvenience for you as possible. You too will have other plans from time-to-time that will keep you from making a planned appointment. If you could allow me a two-week notice when possible that would be appreciated.

VIDEO-BASED COUNSELING

LifeSwitch is a certified provider of telehealth services – that is, conducting counseling sessions via video conferencing. We use HIPAA-approved platforms to have maximum protection of your confidentiality. While exceptions may be made, as a general rule LifeSwitch requires at least 50% of sessions be completed face-to-face. For video-conferencing to be affective, there needs to be very little distractions during our time together. Paramount to that is having a strong internet connection that will provide the bandwidth necessary to manage streaming video. The preference is for clients to have a desktop or laptop computer followed by an I-Pad. Sessions via cell phone are difficult and distracting but exceptions may be made for special circumstances. If you have questions about it or are not comfortable with the technology but would like to have this option, please let us know. We can help you determine if you have the necessary specs to successfully engage in Video-Conferencing and give you a free training session so you will be comfortable.

CONFIDENTIALITY

Guiding Rules of Confidentiality

Generally everything that you say in therapy is confidential. Usually, anything discussed in therapy will only be released to others if you sign an authorization form giving me your consent to release such information to specified people. However, there are some limitations to that confidentiality.

Limits to Confidentiality

While these limits to confidentiality do exist it is rare that they arise. If you have any concerns regarding them please discuss them with me.

- *If a client threatens to harm himself/herself I may need to seek hospitalization to ensure the safety of the client or to contact family members of the client or others who can help provide that protection.*
- *If a client makes a serious threat to harm another person I may need to seek hospitalization both to protect the client and the potential victim. I may be obligated to warn the victim, contact someone else who could help protect the victim, and or contact the police.*
- *If you chose to pay using insurance I may be required to release information about your diagnosis for reimbursement.*
- *I may need to disclose your name and the nature of services offered to insurance or a collections agency if there are unpaid or overdue fees.*
- *In cases of criminal or civil liability I may be ordered by the court to release some information. If a client files suit against me I may release minimal information in order to defend myself.*
- *I am required by law to report any cases of sexual or physical abuse where the person is unable to protect themselves (i.e. children, elders, and dependent adults).*

HIPAA

In my practice I comply with all HIPPA regulations. For a detailed description of how these effects our therapy please read the "HIPPA for Clients" document attached to this informed consent. If you have any questions, please ask me.

OUT-OF-SESSION INTERACTION

Seeing each other outside of therapy

In order to protect your confidentiality, if I see you in public any acknowledgement of you will be void of how we know each other. It is best if we keep any conversation to a minimum especially when others are around. If we see each other in an AA meeting, CARTA meeting, or at any other gathering of those in recovery, I will keep our relationship confidential. You however are free to discuss and reveal it at your discretion. Your confidentiality is my concern and it is protected by law.

Contacting Me

It is important to remember the best way to have serious communications about your situation is when we are in session; this is where your confidentiality is most secure. If we have conversations outside of that parameter I will do my best to protect your confidentiality but it does become more difficult. Please limit the personal information you share with me via **phone, text, or email**. **If you are in physical or emotional danger and cannot reach me, please call 911.**

Phone, Text, Email

I recommend you keep a notepad where you can jot down things you want to ask me or put ideas that come to mind. Keeping a daily diary describing how you feel as you go through the day is a great idea. However, if you need to talk or share something with me between meetings, *please feel free to reach out*. That is what I am here for. When you do need to talk, the best way to reach me is via text. I check those relatively frequently. If your message requires more information than can be explained in a text, call me and leave me a message. If it is something with even more detail but lacks urgency, emails are fantastic.

DRUG AND ALCOHOL SCREENINGS

LifeSwitch offers drug and alcohol screenings to clients at their discretion for a nominal fee ($6 to $12 each). The results are part of confidentiality and will not be shared with anyone else based on the conditions of confidentiality previously listed without your express permission. I will ask you as we begin treatment if you want to have random testing. It is a tool for holding you accountable more than anything else. It may be the reason you pass on using or drinking on any given day. If you choose to opt-in for random screening there is no "opt-out" during treatment.

TREATMENT COSTS

Fees and Insurance Reimbursement

Payment is expected in advance, or at the time of appointment unless arrangements have been made otherwise. ***I do not take insurance.*** You may be able to file for reimbursement as using an out-of-network provider. I can provide you with my NPI (National Provider Identifier) number and other information to help you with that. If you have a balance due that is over 60 days late I reserve the right use a collections agency or file a claim in small claims court in order to seek compensation.

END OF TREATMENT

Inevitably the therapy relationship will end… and that is a good thing. We have goals to accomplish and when they are finished or when you can handle them yourself, there is no reason to keep you paying for therapy. When we are coming to a close of our time together I will discuss with you when and how we will end therapy. I ask that we terminate therapy in a mutually respectful way. If you decide to end our relationship prior to the completion of the program, I simply ask that you speak with me so I can provide you with guidance on how to maintain your newfound sobriety beyond what work we have done together

GRIEVENCES & COMPLAINTS

Over the course of therapy if you have any grievances with me or something is bothering you, please bring it to me so we can discuss. It can be difficult to talk to a therapist about what they are doing that is not working for you. Even though it is hard, I ask that you bring any issues to me so that I can address them and figure out how to best serve your needs as a client. I am far from perfect and the "science" of recovery is far from exact. I try to be insightful and alter my approach as I get to know you better and as you change and develop. If I misstep please bring it to my attention. I can't fix it if I don't know about it.

PLEASE SIGN THE NEXT PAGE ACKNOWLEDGING THAT YOU HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT. IF YOU HAVE ANY QUESTIONS PLEASE BRING THEM TO MY ATTENTION.

RETURN ONLY THE LAST SIGNATURE PAGE TO ME AND KEEP THE DOCUMENT ITSELF FOR YOUR RECORDS.

SIGNATURES NEXT

I have received a copy of the informed consent. I realize that it is my responsibility to bring up any questions with my counselor. By signing this document I am agreeing to the terms of treatment and I am acknowledging my responsibility to know the facts contained in this document.

_____

Client Print Name

_____

Client Signature *electronic signature line**

Date _____

Mike LaTella – CADC-II

_____

Counselor's Signature

Date _____

**I, agree and understand that the electronic signature above is the legal equivalent of my manual/handwritten signature and by executing it I consent to be legally bound by the stipulations as written (<---- please initial).*

③ Patient Notification of Privacy Rights

Notice of Mike LaTella, DBA LifeSwitch Addiction Counseling
to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION 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

I may use or disclose your **Protected Health Information (PHI)** for treatment, payment, and health care operations purposes with your consent. *"PHI"* refers to information in your health record that could identify you. "Treatment, Payment and Health Care Operations"

"Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

"Payment" is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. **I will also need to obtain an authorization before releasing your Psychotherapy and Counseling Notes.** "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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 authorizations (or PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse.** If I have a reasonable cause to believe that a child has been abused, neglected, or exploited, I must report that belief to the appropriate authority.
- **Adult and Domestic Abuse.** If I have a reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authorities.
- **Health Oversight Activities.** If I am the subject of an inquiry by the Georgia Board of Examiners of Psychologists (the Board), I may be required to disclose protected health information regarding you in proceedings before the board
- **Judicial and Administrative Proceedings**. If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will

not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for 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 I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- **Worker's Compensation**. I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties.

Patient's Rights:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your written request, I will send your bills to another address).

Right to Inspect and Copy. You have the right to inspect and obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, i will discuss with you the details of the amendment process.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of the notice from me on request, even if you have agreed to receive the notice electronically.

Counselor's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect. If I revised my policies and procedures, I will provide you with a revised notice by mail or at your next appointment.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me for further information. You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

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

This notice will go into effect April 15, 2003. I will not limit the uses or disclosures that I will make.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Reference

Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 CFR. parts 160 and 164).

LifeSwitch
ADDICTION COUNSELING
Mike LaTella – Addiction Counselor CADC-II, ICADC
420 Dividend Drive
Peachtree City, GA 30269

HIPAA Notification Confirmation Form

The Health Insurance Portability and Accountability Act (HIPAA) established patient rights and protections associated with the use of protected health information (PHI). HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and the storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, I will do all I can do to protect the privacy of your mental health records. Please contact me if you have questions regarding matters discussed in this Patient Notification. Please print, sign, and date this form below to acknowledge that you have familiarized yourself with LifeSwitch Addiction Counseling's HIPAA practices.

I, _____, have been provided a copy of the LifeSwitch *Patient Notification of Privacy Rights*. My signature below indicates that I had opportunity to review this document prior to signing it.

_____
Client's Printed Name

_____ _____
Client's Signature *electronic signature** Date

**I, agree and understand that the electronic signature above is the legal equivalent of my manual/handwritten signature and by executing it I consent to be legally bound by the stipulations as written _____ <---- please initial).*

If you have had previous mental health treatment, this form authorizes your previous provider to release records to me which will be helpful in our work. Use a separate form for each provider and return to LifeSwitch.

INBOUND INFORMATION REQUEST ④

2023 AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION 2023

I authorize and request the disclosure of protected health information from:

Name/Organization | Address | Phone

to release health information about the following patient:

Patient Name (first)_____ (middle)_____ (last)_____

Date of Birth:_____ Telephone#:_____ Last 4 of SS#_____

Street Address_____ City_____ State____ Zip Code_____

You are authorized to release the above records to the following: ☐ Myself/Patient to above address

☒ Name/Organization LifeSwitch Addiction Services ℅SP Mike LaTella, CADC II, ICADC, E-CADC

Phone 404-295-7076 Email: latella.mike@gmail.com

Street Address 420 Dividend Dr.. Suite C City Peachtree City State GA Zip Code 30269

I expressly request that information be disclosed for the following categories:

☐ **All records regarding myself/patient, or**

☐ *Records regarding the evaluation and/or treatment of mental health*

☐ *Records of infectious or contagious diseases (including HIV/AIDS confidential information)*

☐ *Records of drug or alcohol abuse or treatment of same*

☐ But only for treatment during the following dates: _____

Disclosure of this information either to myself, 3rd party or both is for the purpose of continuing care:

By Delivery Method: ☐ Pick-up ☐ Mail US Postal Service ☐ Electronic Media

My Rights and My Authorization:

I understand that authorizing the disclosure of this patient health information is voluntary decision. I understand that unless expressly limited by me in writing, I am **specifically authorizing** the release of any sensitive medical information that may appear in my medical record including records for pain management, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I can revoke this authorization at any time, except to the extent information has been released in reliance upon this authorization. Revocation must be signed and dated later than the date on this authorization and submitted to the provider of the information requested in this document. The revocation will not affect any actions taken before the receipt of the written notification. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. **This authorization will expire in 90 days** from the date of execution of this authorization unless another date or event is entered here:

Patient Signature or Legal Authorized Representative * | Date | Time

Print Name | Relationship to Patient, if not signed by patient

**I, agree and understand that the electronic signature above is the legal equivalent of my manual/handwritten signature and by executing it I consent to be legally bound by the stipulations as written (_____ <---- please initial).*

This form allows LifeSwitch to release information about your treatment and condition to other individuals or entities that you name. Examples are the legal authority that required you be here (probation, court, attorney), your primary doctor, your spouse or parents.

OUTBOUND RELEASE 5

2023 AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION 2023

I authorize and request the disclosure of protected health information from:

LifeSwitch Addiction Services	420 Dividend Dr., Suite C	PTCity, GA 30269	404-295-7076
Name/Organization	Address		Phone

to release health information about the following patient:

Patient Name (first)_____ (middle)_____ (last)_____

Date of Birth:_____Telephone#: _____ Last 4 of SS#_____

Street Address_____City_____State_____ Zip Code _____

You are authorized to release the above records to the following:

Name/Organization _____

Phone_____Email: _____

Street Address_____City _____ State _____ Zip Code _____

I expressly request that information be disclosed for the following categories:

☐ **All records regarding myself/patient, Or**

X *Records regarding the evaluation and/or treatment of mental health*

☐ *Records of infectious or contagious diseases (including HIV/AIDS confidential information)*

☐ *Records of drug or alcohol abuse or treatment of same*

☐ But only for treatment during the following dates: _____

Disclosure of this information either to myself, 3rd party or both is for the purpose of continuing care:

By Delivery Method: ☐ Pick-up ☐ Mail US Postal Service ☒ Electronic Media

My Rights and My Authorization:

I understand that authorizing the disclosure of this patient health information is voluntary decision. I understand that unless expressly limited by me in writing, I am **specifically authorizing** the release of any sensitive medical information that may appear in my medical record including records for pain management, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I can revoke this authorization at any time, except to the extent information has been released in reliance upon this authorization. Revocation must be signed and dated later than the date on this authorization and submitted to the provider of the information requested in this document. The revocation will not affect any actions taken before the receipt of the written notification. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. **This authorization will expire in 90 days** from the date of execution of this authorization unless another date or event is entered here:

_____ _____ _____

Patient Signature or Legal Authorized Representative * | Date | Time

_____ _____

Print Name | Relationship to Patient, if not signed by patient

☐ Legal authorized patient representative proof obtained and attached to this authorization_____ Staff signature

**I, agree and understand that the electronic signature above is the legal equivalent of my manual/handwritten signature and by executing it I consent to be legally bound by the stipulations as written (<---- please initial).*