

**Client Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Ok to leave message? Yes  No

Mobile Phone \_\_\_\_\_ Ok to leave message? Yes  No

Work Phone \_\_\_\_\_ Ok to call at work? Yes  No

Email address \_\_\_\_\_ Ok to send appt reminder? Yes  No

Date of Birth \_\_\_\_\_ Birth Place \_\_\_\_\_

Age \_\_\_\_\_ Male  Female  Other  Social Security Number \_\_\_\_\_

Special Instructions / Other phone numbers: \_\_\_\_\_

Years of Education Completed \_\_\_\_\_ Highest Degree Attained \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

**Insurance Company Information exactly as it appears on your card:**

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Your Relationship to Insured \_\_\_\_\_

Name of the Insured's Employer \_\_\_\_\_

Is your condition related to Employment? Yes  No  Auto Accident? Yes  No  Other Accident? Yes  No

**Referred by**

Name \_\_\_\_\_ May we thank them? Yes  No

**Previous Counseling** Yes  No  With Whom & When? \_\_\_\_\_

Have you billed insurance in the past year for counseling sessions as a client with another provider? Yes  No

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Phone Home** \_\_\_\_\_ **Phone Work** \_\_\_\_\_ **Phone Mobile** \_\_\_\_\_

**Medical Information**

Health Care Provider/Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last Physical Exam \_\_\_\_\_

If you are currently taking any medications, please list: (Use back of form if necessary.)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ condition prescribed for \_\_\_\_\_ by \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ condition prescribed for \_\_\_\_\_ by \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ condition prescribed for \_\_\_\_\_ by \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ condition prescribed for \_\_\_\_\_ by \_\_\_\_\_

Do you have any allergies? Yes  No  If yes, please list: \_\_\_\_\_

General state of health is: Excellent  Good  Fair  Poor

**Please list any significant health problems:** \_\_\_\_\_

**Spouse or Partner**

Current relationship status: Single  Married  Partner  Significant Other  Divorced  Widow/Widower

How many committed relationships have you been in? \_\_\_\_\_ Number of times you have married/partnered \_\_\_\_\_

First (write first name) \_\_\_\_\_ Your Age \_\_\_\_\_ Years Together \_\_\_\_\_

Second (write first name) \_\_\_\_\_ Your Age \_\_\_\_\_ Years Together \_\_\_\_\_

Third (write first name) \_\_\_\_\_ Your Age \_\_\_\_\_ Years Together \_\_\_\_\_

If currently divorced or single, number of years since break-up or divorce \_\_\_\_\_

If applicable, reason for break-ups or divorce(s) (include break-up or divorce dates): \_\_\_\_\_

Describe quality of relationship with your present spouse/partner: \_\_\_\_\_

Current spouse/partner's name \_\_\_\_\_ Number of years together \_\_\_\_\_

**Children**

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Please describe any custody and visitation arrangements for your minor children if they are not living with you full-time:

**Brothers and Sisters**

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

**Parents**

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ If deceased, how old was she when she died? \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ If deceased, how old was he when he died? \_\_\_\_\_

**Activities and Social Interests**

I have:  few friends  many friends. The quality of my relationships with friends is: \_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_ How many hours of sleep do you average per night? \_\_\_\_\_

How many days per week do you think you eat well (nutritious and well-balanced meals/snacks)? \_\_\_\_\_

**Have you ever had?**

	Yes	No	Drug/Alcohol/Addiction Related	When
Suicide Thoughts				
Suicide Plans				
Suicide Attempts				

Please describe any yes answers: \_\_\_\_\_

Have you ever been hospitalized for substance abuse or mental health reasons? Yes  No

If yes, please describe including dates, reason(s) for hospitalization(s), and hospital name: \_\_\_\_\_

Have you ever been diagnosed with a mental health disorder? Yes  No  If yes, what was diagnosis and who diagnosed? \_\_\_\_\_

Do you smoke? Yes  No  If Yes, how many cigarettes per day? \_\_\_\_\_ Have you ever tried to quit? Yes  No

Do you drink alcohol? Yes  No  If Yes, when as your last drink? \_\_\_\_\_ How much did you drink? \_\_\_\_\_

How much do you typically drink per week? \_\_\_\_\_ Do you consider your drinking problematic? Yes  No

Other than prescribed medications and over the counter medications, do you use drugs? Yes  No

Please describe any drug use: \_\_\_\_\_

Has anyone ever expressed concern about your drug or alcohol use? Yes  No  Please describe: \_\_\_\_\_

Have you ever had any legal problems related to drug or alcohol use? Yes  No  Please describe: \_\_\_\_\_

Please check if you have experienced any of the following stressors in the last six months:

- Personal illness       Health problem in family       Death of a friend       Death of a family member
- Lack of employment       Job dissatisfaction       Job change       Retirement
- Financial problems       Inadequate housing       Homelessness       Recent move
- New marriage       New relationship       Relationship discord       Relationship separation
- Divorce       New child       Discord with family       Parenting difficulties
- Physical abuse       Sexual abuse       Unhappy childhood       Victim of crime
- Educational problems       Legal problems       Inadequate healthcare       Discrimination
- Loneliness       Other (please specify) \_\_\_\_\_

What would you like to change in your life and is there anything else you want the counselor to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Informed Consent and Disclosure-Read Carefully**

Thank you for choosing me as your Mental Health Care Provider. I am committed to giving you excellent mental health care. The following is a statement of informed consent and disclosure and includes my financial policy and other office policies, which I require that you read and sign prior to any treatment. If you have any questions about my financial or office policies or anything else, please do not hesitate to ask me.

The laws of the State of Idaho require that all licensed counselors provide clients at the beginning of treatment with accurate disclosure of information concerning their practice, including the right of clients to refuse treatment, the responsibility of clients for choosing the provider and treatment modality, and the extent of confidentiality (Chapter 34, Title 54-3410B, Idaho Code). Licensure of an individual under this chapter does not imply endorsement by the counselor licensing board nor effectiveness of treatment. The Idaho Counselor Licensing Board, through the Idaho Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main St., Suite 220, Boise, ID 83702, is responsible for licensure of counselors within the state of Idaho. Victor Durnil is a licensed clinical professional counselor and holds a Master's of Counseling degree from Idaho State University.

**Confidentiality**

Information disclosed within sessions is confidential and may not be revealed to anyone without your permission. The law provides for certain exceptional situations in which I am required to disclose information including when there is a reasonable suspicion of child abuse, elder or dependent-adult abuse, and when a client threatens violence to an identifiable victim. The law also requires me to break confidentiality when a client presents a danger of harm to others and when a client is likely to harm him/herself unless protective measures are taken. Clear risk of harm to others may include the risk of transmitting a life-threatening illness to an identifiable and uninformed third party. Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., child custody cases), please let me know. As part of my professional responsibility, I may also consult with other counseling professionals. Your name is not revealed. This allows you to receive the benefit of other professionals' expertise.

**Our Professional Counseling Relationship**

A counseling relationship is a professional relationship in which the counselor assists the client in exploring and resolving difficult life issues. Our sessions may be very intimate. However, it is important for you to realize that we have a professional, rather than a personal relationship and our contact will be limited to the paid session you have with me. As a Licensed Clinical Professional Counselor, I will not barter for services or accept gifts or invitations. You will be best served by these professional standards. I am licensed by the State of Idaho to provide counseling services. My ethical code states that sexual intimacy is never appropriate with a client and should be reported to the licensing board. You also have a right to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment. If you have any concerns or questions about my services, I urge you to discuss them with me. You may contact the licensing board at any time by calling (208) 334-3233 or by visiting their website at:

<https://secure.ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=COU>.

Idaho Bureau of Occupational Licenses is located at: 700 W. State Street, Boise, ID 83702.

**Counseling Process**

I am dedicated to giving you the best care that I can. It is my conviction that for counseling to be effective, there needs to be a partnership between the counselor and client. As such, you will be expected to be actively involved in choosing the course of your treatment. It is impossible to guarantee any specific results regarding your goals for counseling or length of treatment. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards of practice as adopted by the American Counseling Association and the Idaho Counselor Licensing Board.

**Risks And Benefits**

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. While I cannot guarantee these benefits, I will do everything I can to work with you to attain your personal goals.

## Counseling Approaches

I work with adults, elders, individuals, couples, and groups. My work with clients is informed by experience and training in trauma issues, addictions (including sex/love addiction and chemical dependency), dual diagnosis, depression, anxiety, grief, loss, relationship concerns (work, family, social, and romantic), anger, and life transitions. My therapeutic orientation is client-centered though I integrate techniques from many treatment modalities including but not limited to cognitive-behavioral, existential, EMDR, behavioral, insight oriented and Emotion-Focused. I provide individualized treatment for each client founded in client-centered principles of congruency, empathy, and unconditional positive regard.

## Client Rights: You have the right to:

1. Request that your records be sent to another professional or agency. Your request will be fulfilled with promptness upon receipt of your written request for transfer of information, provided there is no outstanding balance on your account.
2. Leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others.
3. Participate in developing an individual plan of treatment.
4. Receive an explanation of services in accordance with the treatment plan.
5. Participate voluntarily in and to consent to treatment.
6. Object to, or terminate or refuse any service you do not want, and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notification to that effect could be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.
7. Have access to your records.
8. Receive clinically appropriate care and treatment that is suited to your needs and skillfully, safely, and humanely administered with full respect for your dignity and personal integrity.
9. Be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.
10. Be free to report grievances regarding services or staff to your counselor or the Idaho Bureau of Occupational Licenses.
11. Be treated by staff that is sensitive to your cultural background and beliefs.
12. Be afforded privacy.
13. Be informed of expected results of all therapies prescribed, including possible adverse effects.
14. Request another therapist
15. Request that another clinician review your records for a second opinion.
16. Know that one parent at least must be involved in the therapy of any minor children.

## Professional Fees

\$175 per 60 minute initial intake and new client consultation.

\$130 per 55 minute session for individual, couple, or family counseling.

\$115 per 45 minute session for individual, couple, or family counseling.

\$100 for 30 minute session for individual, couple or family counseling.

\$120 per hour for copying and mailing client records to another professional.

\$120 per hour for written reports, prepared documents, or consultation (over 10 minutes) with another professional at your request, depending on type and purpose.

\$250 - \$450 per hour for preparation and attendance at legal court proceedings, including when called by another party.

\$25 service fee for returned check.

## Fee Change

While I rarely raise professional fees during the course of counseling, there may be an occasion where this will be necessary. If this occurs, I will let you know of the fee change and when it will occur as soon as possible. In any event, I will not raise fees more than once per year so you can be assured that if there is an increase, it won't change again for at least one year (effective Sept. 1 2013).

**Full payment is due at the time of service by cash or check.** Debit or credit cards may be used when service is available. I will bill your insurance company as a courtesy to you, but as your coverage is based on a contract between you and your insurer, you are responsible for any fees or portions of fees not covered by your insurance company. I encourage you to contact your insurance company before the first session and ask them what benefits you may expect. If for any reason your insurance company does not pay for my services as you expect they will, you are responsible for payment in full to me. Insurance companies rarely pay 100% of the fees you incur for my service and you are responsible for paying any co-pays and deductibles at the time of your session. Please confirm with your insurance company their policy related to counseling services provided by a "licensed clinical professional counselor" (LCPC) and your co-pay and deductible amounts for these services. Please remember that I may be required by your insurance company to provide confidential information about you and your case if you choose to use your insurance company for payment for my services.

## **Telephone Calls and Writing**

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**If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.** Phone consultation for check-in calls and reading of writings or messages of 5 minutes or less in duration will not be added to your billing. Consultation calls and reading time longer than 5 minutes will be billed at the normal prorated service rate. If you must get a message to me, the best way is to leave an email or voice message I cannot guarantee a quick reply due to the nature of my practice, but will get back to you as soon as I can. You need to be aware that I do not provide any crisis or emergency services.

## **Special Reports, Services, and Letters**

Occasionally it is necessary for me to write special letters or reports or provide other services on a client's behalf. I am glad to comply with such requests. There is a fee charged based upon the type and purpose as well as the length of time required for the service.

## **Counseling and Technology**

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### **Email**

While email tends to be a good way to get a message to me, email is not totally secure and is sometimes unreliable. Therefore, I use email with caution and urge you to do the same. If you choose to use electronic messages, please be brief and don't include anything you wouldn't want others to read just in case there is a security breach. If you imagine the possibility of you (or me) losing our computer or smart phone and someone else reading your message, you will know the reason to be extra cautious when communicating electronically. In short, email is a good medium for brief messages, but a poor one with which to discuss therapy issues.

### **Phone**

Conversations by cell phone or cordless phones may be picked up by people in the area. The safest phone call is from one old-fashioned corded phone to another. I realize that we rely on mobile and cordless phones so just know that they may not be totally secure. When we have a phone call, be sure that you can't be overheard. **If you need to cancel your appointment within the 24-hour time limit, definitely use the phone so I will get the message right away. Be sure to leave your message on my voicemail, NOT the general office voicemail, as I will not get a general voicemail outside of the office.**

### **Social Networking and Computer Contact**

I usually don't "friend" anyone who is or has been a client of mine to respect your privacy. If you want to show me something on Facebook, on your blog, or any other social media, you can share it with me during our session. I realize some of my clients drive long distances so I will sometimes use the phone or Skype to work with clients but only for very rare and special circumstances on a pre-arranged basis. Again, please know that confidentiality cannot be assured when using this type of technology.

**Litigation Limitation**

I do not do court work (such as, but not limited to, testifying in divorce and custody disputes, injuries, lawsuits, etc...) If you need these services I will give you referrals to forensic psychologists who specialize in these cases. My desire is to protect your counseling from the intrusiveness of legal proceedings.

- 1. Confidentiality – Your counselor cannot release any information about you without your written permission (exceptions to this such as child or elder abuse, danger to self or others are explained in above).
- 2. Confidentiality in Couple’s Therapy – Your counselor cannot release records unless both clients give written permission.

To be in counseling with me you must agree that neither you nor your attorney, nor anyone else acting on your behalf, will call on any counselor at this practice to testify in court or at any other proceeding, nor will a disclosure of counseling or treatment records be requested for legal proceedings.

This is in your best interest because:

- 1. If you place your mental status at issue in litigation initiated by you, the defendant (other side) has the right to obtain your counseling records and/or testimony by your counselor. Your adversary would have the right to know everything you’ve talked about in counseling.
- 2. Forensic psychology (custody evaluations, workers comp, lawsuits, etc.) is not an area of expertise for me.
- 3. If you are involved in legal proceedings, subpoenaing a counselor without forensic expertise to testify could hurt your case more than help. Forensic psychologists do assessments (not counseling or psychotherapy) and are trained as expert witnesses.
- 4. The goals of legal proceedings (winning a case) are inconsistent with the goals of ongoing counseling (exploring conflicted emotions and behavior in a safe, protected place). Whenever possible, counselors are required to avoid dual roles, which may interfere with the client’s counseling.
- 5. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. These fees are listed above.

I understand and agree to this litigation limitation.

Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

**Cancellations and Missed Appointments**

Please make every effort to keep your scheduled appointment. This practice respects my time and allows me to use that time to see other clients who are in need. **Unless I hear from you at least 24 hours in advance, I will, unfortunately, have to charge you the full fee for a missed or cancelled appointment.** Insurance cannot be billed for missed or late-cancelled sessions. When appropriate, telephone sessions can sometimes be done in place of the scheduled in-person session.

**INITIAL HERE** \_\_\_\_\_

My signature below indicates that I understand and agree to these terms and those on the Informed Consent and Disclosure and I am giving my consent for treatment. I understand and agree to comply with these policies and have been given a copy of this policy. I understand that I must call at least 24 hours in advance of my appointment to avoid paying the full fee for a missed or cancelled appointment. I understand I am financially responsible for payment of services rendered to me and will pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection. I am releasing and holding harmless Victor Durnil, LCPC, LLC from any departure from my right of confidentiality that may result.

Print Client Name \_\_\_\_\_

Date \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

**If financially responsible person is different than above, please complete the following:**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Print Financially Responsible Party’s Name \_\_\_\_\_

Date \_\_\_\_\_

Financially Responsible Party's Signature  
**Victor Durnil, LCPC, LLC**  
2500 W. Kootenai St., Boise ID 83705  
ph. 208-908-0500 fax 208-908-0580

Date  
**Effective Date: 03/28/2016**

## Summary Notice of HIPAA Privacy Practices

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

### SUMMARY OF YOUR PRIVACY RIGHTS

**We may use your health information** to treat you, to get paid, to operate the counseling office, to tell you about other health benefits & services, to tell family and friends about you in an emergency, to avert threats to health and safety reasons, for military purposes, for worker's compensation requests, for lawsuits, for law enforcement requests, for national security reasons, for coroner, medical examiner or funeral director use.

**You have the right to** review and get a copy of your medical and billing records (but not psychotherapy notes), change your medical record if you think it's wrong, get a list of with whom we share your health information, ask us to limit the information we share, ask for a copy of our privacy notice, complain in writing if you believe your privacy rights have been violated, request alternative forms of communication.

**COMPLAINTS** - If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region 10: U.S. Department of Health and Human Services, 2201 Sixth Avenue - M/S: RX-11, Seattle, WA 98121-1831

Voice Phone: (800) 368-1019, FAX: (206) 615-2297, TDD: (800) 537-7697

To file a complaint with Victor Durnil, LCPC, LLC contact Victor Durnil, LCPC.

***You will not be penalized for filing a complaint.***

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**I acknowledge receipt** of the Victor Durnil, LCPC, LLC "Notice of Privacy Practices."

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Relation:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_  
(if other than client)

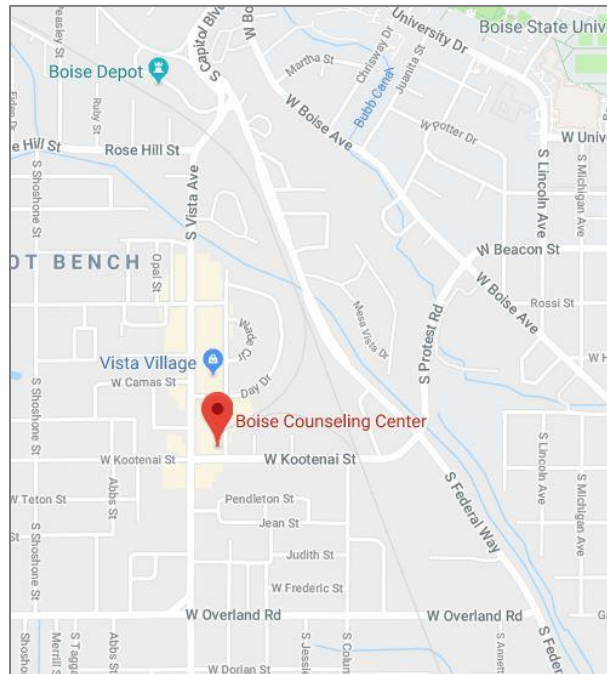
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client declined to sign receipt (staff signature):** \_\_\_\_\_

**Client unable to sign (witness signature):** \_\_\_\_\_



## **Directions to Boise Counseling Center, 2500 W Kootenai St, Boise, ID 83705**



### **From the Freeway**

Go North on Vista and turn right onto Kootenai. Take your first left onto Robert St. and park behind the building. The entrance is on Kootenai.

### **From Broadway**

Turn west onto Beacon. Continue up Protest Hill, which turns into Kootenai. Turn right onto Robert St. just before you get to Vista and park behind the building. The entrance is on Kootenai.

### **From Downtown**

Head south up 9<sup>th</sup> street. Continue onto Capital Boulevard and loop around the Depot onto Vista. Turn left onto Kootenai and take a quick left onto Robert St. The entrance is on Kootenai.

### **Parking**

There is additional parking on Robert St. if needed. The West side of Robert is parallel parking and the East side is angle parking on the gravel area.

### **Upon Arrival**

Please be seated in the waiting area and I will come for you as soon as I can.

# Release



## Consent to Release and/or Obtain Records and Information

Client Name \_\_\_\_\_

Social Security Number or Birth Date \_\_\_\_\_

The client authorizes **Victor Durnil**, LCPC, CSAT of Boise Counseling Center, LLC in Boise, Idaho, to release records and information to, and obtain records and information from, the authorized person(s) and/or organization identified below, for the purpose of continuing counseling, treatment, and referral.

Authorized person(s) and/or organization \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The information to be disclosed is:

All treatment records and information in the possession of the authorized person(s) and/or organization named in this release.

Other (specify) \_\_\_\_\_

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimile of this Authorization shall be considered to be the same as a signed original document. I understand that certain records may be protected from disclosure without my written consent or as otherwise authorized by law under provisions of State and Federal law, including Federal statutes and regulations governing confidentiality of drug and alcohol records (42 CFR part 2.)

X \_\_\_\_\_  
Print Client Name

X \_\_\_\_\_  
Signature of Client and Parent or Legal Guardian, if client is under 18 Date

X \_\_\_\_\_  
Print Name of Parent or Legal Guardian, if client is under 18

\_\_\_\_\_  
Witness Date