WILDFLOWER COUNSELING

312 N Elm St.
Suite 112
Grand Island, NE 68801

Ph: 308.216.8018
F: 308.216.8072
mcornelius@mcwildflowercounseling.com

Client Information

Name_____ Soc. Sec. # _____

Date of Birth _____ Sex at Birth: ▢ Male ▢ Female ▢ Intersex Pronouns _____

Gender: ▢ Male ▢ Female ▢ Trans ▢ Nonconforming ▢ Other: _____

Race: ▢ American Indian or Alaska Native ▢Asian ▢ Hispanic/Latino

▢ Black or African American ▢ White/Caucasian ▢ Other: _____

Guardian Name _____ Guardian's SS# _____

Address _____ City _____ State/Zip _____

Home Phone _____ Alternate phone _____

Email Address: _____

Marital Status: ▢ Married ▢ Separated ▢ Divorced ▢ Widowed ▢ Single

Employer _____ Occupation _____

School _____ Grade _____

Emergency Contact _____ Emergency Number _____

Physician Name and Phone Number _____

Please list all current medications _____

_____

Primary Insurance	**Additional Insurance**
Policy Holder's Name_____	Policy Holder's Name_____
Relationship to Patient _____	Relationship to Patient _____
Holder's Birth Date _____	Holder's Birth Date _____
Holder's Soc. Sec. # _____	Holder's Soc. Sec. # _____
Holder's Employer _____	Holder's Employer _____
Insured Co. _____	Insured Co. _____
Insurance Co. Phone # _____	Insurance Co. Phone # _____
Group # _____	Group # _____
Policy # _____	Policy # _____

Release to Insurance

My signature authorizes the release of necessary information to a third-party payer, if applicable, and assigns benefits to MC Wildflower Counseling. Payment is due at the time of service unless prior arrangements have been made. I understand I am responsible for all copays and any charges not covered by insurance. Fees have been explained, and my signature authorizes MC Wildflower Counseling to provide treatment to the named client. Past-due balances may be subject to collection.

_____ _____

Client/Legal Guardian Signature if client is a minor Date

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Client Name: _____ SS# _____

Medical History

How would you describe your physical health? ☐Good ☐Fair ☐Poor
How would you describe your mental health? ☐Good ☐Fair ☐Poor
Have you received any prior outpatient mental health treatment? ☐Yes ☐No
If so, when, where and what was the focus of treatment?

Have you received any prior inpatient mental health treatment and/or been hospitalized for mental health reasons?
☐Yes ☐No
Please list any prior mental health diagnoses:

Do you have problems eating? ☐Too Much ☐Not Enough ☐No
Have there been any noticeable weight changes? ☐Loss ☐Gain ☐No
Do you have problems sleeping? ☐Too Much ☐Not Enough ☐No

Please list any current medications:

List any known medication allergies:

Initial Screening for Self-Harm Potential

Was there a potentially lethal suicide attempt in the past 24 hours? ☐Yes ☐No
Are there statements of intent to self-harm? ☐Yes ☐No
Is there a plan for self-harm? ☐Yes ☐No
Are you unwilling and unable to agree NOT to self-harm? ☐Yes ☐No
Are you experiencing auditory hallucinations that command self-harm? ☐Yes ☐No

---

Self-Administered Screen for Alcohol and/or Drugs

Have you used alcohol or other drugs in the past 12 months? ☐Yes ☐No
Do you feel your use has been excessive or problematic? ☐Yes ☐No
Have you attempted to reduce or stop your use? ☐Yes ☐No
Have you received treatment or support for your substance use? ☐Yes ☐No
Do you experience guilt or distress related to your substance use? ☐Yes ☐No
Have you experienced physical or medical problems related to substance use? ☐Yes ☐No
If so, check all that apply:

- ☐ Blackouts or memory loss
- ☐ Self-injury or accidents while using
- ☐ Seizures
- ☐ Liver disease or hepatitis
- ☐ Withdrawal symptoms (nausea, tremors, anxiety, depression, etc.)
- ☐ Hallucinations or abnormal sensations during withdrawal
- ☐ Injection drug use

List any other drugs you are currently using or have used in the past: _____

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Trauma History
Have you ever experienced any of the following?

Child Abuse and/or Neglect	☐Yes	☐No	☐N/A
Sexual Abuse	☐Yes	☐No	☐N/A
Sexual Assault / Rape	☐Yes	☐No	☐N/A
Sex work and/or sex trafficking	☐Yes	☐No	☐N/A
Physical Abuse	☐Yes	☐No	☐N/A
Physical Assault	☐Yes	☐No	☐N/A
Witnessed domestic violence	☐Yes	☐No	☐N/A
Neglect	☐Yes	☐No	☐N/A
Emotional abuse	☐Yes	☐No	☐N/A
Victim of a crime	☐Yes	☐No	☐N/A
Victim and/or witnessed community violence	☐Yes	☐No	☐N/A
Serious accident and/or injury	☐Yes	☐No	☐N/A
Life threatening medical issue	☐Yes	☐No	☐N/A
Traumatic loss	☐Yes	☐No	☐N/A
War / political violence / torture	☐Yes	☐No	☐N/A
Serious natural disaster (tornado/earthquake/fire)	☐Yes	☐No	☐N/A
Institutionalized	☐Yes	☐No	☐N/A

Community Services Information

Are you receiving case management from Health and Human Services or another agency? ☐Yes ☐No
If so, please list the caseworker's name and contact information:

_____

Will any other person be significantly involved in your mental health treatment? ☐Yes ☐No
If so, who?

_____

Are you receiving court / legal / probation services? ☐Yes ☐No
If so, why (drug court, state ward, probation, other)?

_____

Are you court ordered to receive outpatient mental health treatment? ☐Yes ☐No
If so, who is the primary court / probation contact (name, number, and/or email)?

_____

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INFORMED CONSENT FOR COUNSELING

At MC Wildflower Counseling, your privacy and sense of safety matter. I am committed to creating a therapeutic space where you feel supported, respected, and empowered. All services follow the Ethical Principles and Standards of the American Counseling Association, the National Association of Social Workers, and the licensing laws of the State of Nebraska.

Confidentiality: I understand that everything I share in sessions is confidential and will not be disclosed to anyone outside of MC Wildflower Counseling except under the following circumstances:

- Insurance & Payment: When communication of my diagnosis or other clinical information is necessary for my insurance company to process payment.
- Permission to Share: When I provide written permission for information to be shared with another person.
- Legal Requirements: When disclosure is required by law (for example, when there is reasonable suspicion of abuse involving children or vulnerable adults, or when a court order is issued).
- If I am under 19: My counselor may inform my parent(s) or legal guardian about developments that could significantly affect my health or well-being. In these cases, the specific content of sessions will remain private, but my overall progress may be discussed in general terms.
- Risk of Harm: When I present an immediate risk of causing serious harm to myself or someone else.

Court and Legal Proceedings:

- Therapist Role: My professional role is to provide therapeutic services. This is ***not*** a forensic or legal evaluation. I do not provide reports or testimony for legal proceedings, including child custody, parenting evaluations, visitation or personal injury cases.
- Subpoena or Court Order: If my records are requested or I am subpoenaed to testify by either party, I am legally obligated to comply. However, I will assert professional privilege on your behalf to the extent allowed by Nebraska law. The final decision to release information is determined by a judge.
- Client Financial Responsibility: If I am required to participate in legal proceedings by court order or subpoena, the client is responsible for all time spent. This includes preparation time, travel time and time spent in attendance.
    - My rate for all legal and forensic services is $210 per hour with a minimum of four hours required and all fees are due prior to court involvement. Failure to submit payment may result in the provider declining participation to the extent permitted by law.
    - Insurance will ***not*** cover any fees related to court or legal involvement.

Risks/Benefits:

Counseling and related services (such as EMDR or neurofeedback) can offer many benefits, but no specific results can be guaranteed. These benefits are often increased through honesty, active participation, and consistent attendance. Like any therapeutic process, there are also potential risks, which can be best managed through open communication and by reporting any changes you notice during or after treatment. In rural communities, dual relationships—such as seeing your therapist at shared community spaces—may occur. If this happens, discussing it directly helps minimize risks and ensures it does not negatively impact the therapeutic relationship. Your honest feedback is important, and your counselor will use their professional skills to address concerns and support your wellbeing.

Professional Consultation:

To ensure you receive the highest quality of care, I may at times seek professional consultation. These consultations are a standard part of ethical practice and are conducted without revealing any identifying information about you. All consultants are bound by the same confidentiality standards that guide my work, and no consultation will ever compromise your privacy. If you would like information about the professionals I consult with, you may request this at any time by contacting me directly.

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Client Name: _____ SS# _____

Treatment of Minors:
Consent, Assent and Confidentiality (Minors): State law requires informed consent from a parent or legal guardian for the treatment of a minor (generally under age 19 in Nebraska). By signing below, you confirm that you are the legal guardian and authorized to consent to treatment. In addition to parental consent, the minor's assent and willingness to participate in therapy are required. The therapist will periodically assess the minor's comfort and engagement in treatment. Therapy with minors includes developmentally appropriate confidentiality. While parents/guardians may receive general information about treatment progress and recommendations, specific session content is not routinely disclosed. Information will be shared as necessary for safety concerns, including risk of harm to self or others, or suspected abuse or neglect, which the therapist is legally required to report. Confidentiality limits will be reviewed with both the minor and parent/guardian prior to the start of therapy to support a safe and trusting therapeutic relationship.

Client Rights:
Clients have the right to:

- Be treated with respect, dignity, and fairness.
- Communicate freely with individuals of their choosing, including family members, friends, legal counsel, and medical providers.
- Access their clinical records and authorize the release of information to others through written consent.
- Actively participate in decisions regarding care, including those that support independence, privacy, individuality, and dignity.
- Refuse treatment or services, except when authorized by a legal guardian or mandated by a mental health board or court order.
- Have their privacy protected and all aspects of care kept confidential in accordance with the law.
- Be free from neglect, abuse, exploitation, sexual harassment, or sexual exploitation.
- Participate in the development and ongoing review of an individualized treatment and recovery plan.
- Receive services from providers who practice nondiscrimination.
- File complaints or grievances without fear of retaliation and have concerns addressed in a timely manner. Complaints may be discussed with the provider or submitted to the Nebraska Department of Health and Human Services (DHHS).
- Receive behavioral health services in the most integrated and appropriate setting based on an individualized, person-centered assessment.

Client Responsibilities
Clients are responsible for:

- Treating providers, staff, and others involved in care with respect and courtesy.
- Providing accurate and complete information to support appropriate and effective treatment.
- Supplying necessary information for insurance processing, asking questions about billing, and making timely payment arrangements as needed.
- Communicating any concerns related to fees or financial hardship.
- Informing providers and relevant members of the treatment team of any changes in medications, including those prescribed by other providers.
- Attending scheduled appointments and providing timely notice when cancellations or changes are needed.
- Reporting concerns related to abuse, neglect, or suspected fraud.
- Notifying the provider if the treatment plan is not effective or addressing presenting concerns.
- Actively participating in treatment and following the agreed-upon treatment, wellness, and safety plans.
- Informing the provider if choosing to withdraw from or discontinue services.

Appointments:
Services are by appointment only and generally last 45 minutes. The frequency of appointments will be determined by you and your therapist.

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No Surprises Act:
Mental health services are billed based on session length, regardless of diagnosis. The initial intake is a 60-minute evaluative session. Follow-up sessions are typically 45 minutes but may vary based on clinical need, including 60-minute sessions during periods of increased acuity or 30-minute sessions for younger clients or those with attention-related needs. Treatment frequency and duration are individualized and may range from weekly to multiple sessions per week depending on symptom severity. There is no standard length of treatment. Care is planned in 3-month treatment intervals, with most clients beginning services on a weekly or biweekly schedule.

Cancellations and No Shows:
MC Wildflower Counseling has a 24-hour cancellation policy. Appointments not canceled with at least 24 hours' notice will be charged a $50 late-cancellation fee. Appointments that are missed without prior notice will be charged a no-show fee. These fees are your responsibility and will not be billed to insurance. Services may be paused until outstanding fees are paid or a payment arrangement is made. If three late cancellations or no-shows occur within a two-month period, we may need to discuss possible termination and referral options. Weather and illness will be considered exceptions.

Fees and Financial Arrangements:
MC Wildflower Counseling's fees are as follows: $272 for the initial appointment, $210 for 60-minute individual sessions, and $190 for 45-minute sessions. If additional service fees apply, please inquire prior to your appointment. While we may contact your insurance on your behalf to check benefits, any information provided by your insurance company is not a guarantee of coverage or payment. It is always your responsibility to verify your own benefits and financial obligations. Payment is expected at the time of service. If this creates a hardship, please ask about available payment plan options. All services are non-refundable, even if you are unable—or choose not—to complete the program. **(Initial Below)**
✗____I understand MC Wildflower Counseling's fees and agree to pay any portion not covered by my insurance. I accept responsibility for all charges related to services provided to me or my dependents including late cancel and no-show fees. I understand that if payment is not made, my therapist may pause or discontinue treatment until the balance is resolved. I also acknowledge that all services and materials are non-refundable.

Electronic Communication (Email/Texting):
Electronic communication is not a fully confidential or secure form of communication. You may still choose to communicate electronically with MC Wildflower Counseling, based on your preferred contact method, but you must acknowledge the following risks **(Initial below)**
✗____I authorize MC Wildflower Counseling to contact me electronically for scheduling or appointment-related purposes. I understand that email and text are not confidential.
✗____I understand that counseling will **not** be conducted through email or text. If I send information that is not related to scheduling, my therapist may not reply electronically and will instead bring the information to our next session.
✗____I understand that any electronic communication may become part of my client record.
✗____I acknowledge that MC Wildflower Counseling cannot guarantee that electronic messages will be received or responded to promptly. In the event of an emergency, I am encouraged to call **988**, the **Crisis Stabilization Unit**, or **911**.

Termination:
Please be aware of the following conditions under which therapy may be discontinued. You may be discharged as a client in any of the following situations:

- If your therapist determines that they are not the appropriate provider for your needs—whether due to the nature of your concerns or because the required services fall outside their training or scope. In this case, you will be informed and offered a referral to a therapist who may better meet your needs.
- If you have three consecutive no-shows or same-day cancellations.

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- If you have not attended or kept an appointment for six consecutive weeks, and this is not part of your agreed-upon treatment plan.
- If you commit an act of violence toward, threaten, or harass any staff member or client of MC Wildflower Counseling, treatment may be terminated immediately.
- If therapy is terminated for any reason other than the successful completion of your treatment plan, you will be provided with contact information for other therapy resources. However, this does not guarantee acceptance or availability of further services.

Office Policies and Safety

- Illness Policy: To protect the health of clients and staff, appointments must be canceled and rescheduled if the client is experiencing symptoms of illness (e.g., fever, persistent cough, vomiting). Standard cancellation policies and fees apply unless an exception is approved by the provider.
- Pest / Bed Bug Policy: To maintain a safe and sanitary environment, clients must notify the office of any known or recent bed bug infestation at their home or workplace. If an infestation is suspected, the provider may immediately end the session and require future appointments to occur via telehealth or after written clearance from a licensed exterminator. Clients may be responsible for any remediation costs incurred by the practice.
- Weapons Policy: Weapons of any kind, including firearms (concealed or otherwise), knives, and stun guns, are strictly prohibited on the premises.
- Substance Use Policy: Clients may not attend sessions while under the influence of alcohol or non-prescribed substances. Sessions may be terminated if impairment is observed.
- Smoking and Vaping Policy: The building and surrounding property are smoke- and vape-free. Smoking or vaping is prohibited anywhere on the premises.

Business Hours:
Office hours are Monday through Thursday, 9:00 a.m. to 5:00 p.m. Messages will be returned within 48 business hours.

Crisis Services:
MC Wildflower Counseling does not provide crisis coverage. If you are experiencing a mental health emergency, please contact one of the following resources:

- Call 911 or go to the nearest emergency room
- Mid Plains Crisis Stabilization Unit, 914 Bauman Drive, Grand Island, NE 68803 | 308-385-5250
  - 24/7 Crisis Hotline: 1-800-515-3326
- Richard Young Behavioral Health Center, 1755 Prairie View Place, Kearney, NE 68845 | 308-865-2000
- Mary Lanning Healthcare – Lanning Center for Behavioral Services
  - 24/7 Crisis Hotline: 402-463-7711
- Suicide & Crisis Lifeline: **988**
- National Suicide Prevention Lifeline: 1-800-273-8255

My signature below indicates that I have read, understand, and agree to the statements above. I acknowledge that I have received MC Wildflower Counseling's privacy policies, understand my rights as a client, and know how my information may be used or disclosed. I consent to treatment and authorize consultation regarding my case if needed. I agree to actively participate in my counseling and understand the potential risks and benefits of counseling and other services offered at MC Wildflower Counseling. I also understand that if I have any questions about these statements, associated risks, or my privacy rights, I may speak with my therapist at any time.

Print of patient or parent if minor _____ Date_____

Signature of patient or parent _____Witness_____

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Client Name: _____ SS# _____

HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY MC WILDFLOWER COUNSELING AND HOW YOU CAN ACCESS THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Understanding Your Protected Health Information (PHI):

Your health record contains information about you and the mental health care you receive. Understanding what is included in your record and how your health information is used can help you ensure its accuracy, understand who may access it and why, and make informed decisions when authorizing disclosures. Information that identifies you and relates to your past, present, or future physical or mental health condition and related health care services is known as Protected Health Information (PHI).

When you receive services from us, we maintain a record of your symptoms, progress, diagnoses, treatment plan, and other clinical information. We may also obtain health records from other providers. In using and disclosing PHI, our practice complies with the Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 164. HIPAA permits us to use and disclose PHI without your specific authorization for purposes of treatment, payment, and health care operations, as described below. All other uses and disclosures require your written authorization.

How We May Use and Disclose Health Information About You

For Treatment- Your PHI may be used and disclosed by professionals involved in your care for the purpose of providing, coordinating, or managing your mental health treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Disclosure to consultants outside of this scope will be made only with your authorization.

For Payment- With your authorization, we may use and disclose PHI to obtain payment for services provided to you. Examples include determining insurance eligibility or coverage, submitting claims, reviewing services for medical necessity, or conducting utilization reviews. If collection activities become necessary due to nonpayment, only the minimum amount of PHI necessary will be disclosed.

For Health Care Operations- We may use or disclose PHI as needed to support business operations, including quality assessment, employee review, licensing, and other administrative activities. PHI may be shared with third-party service providers (such as billing or transcription services) only under written agreements requiring protection of your privacy. PHI will be used for appointment reminders and follow-up care, including 24-hour appointment confirmation calls. If you prefer not to receive these communications, please notify our Privacy Officer or indicate this preference on your intake paperwork. PHI used for training or teaching purposes will be disclosed only with your authorization.

Required by Law- We are required by law to disclose PHI to you upon request. We must also disclose PHI to the Secretary of the U.S. Department of Health and Human Services for investigations or determinations of compliance with HIPAA regulations.

HIPAA permits certain uses and disclosures of PHI without authorization, including but not limited to the following categories:

Abuse and Neglect	Judicial and Administrative Proceedings
Deceased Persons	Emergencies
Family Involvement in Care	Law Enforcement
National Security	Public Safety (Duty to Warn)

The following provisions address these categories in a manner consistent with the NASW Code of Ethics.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in limited circumstances. Such uses and disclosures are restricted to the situations described below:

- When required by law, such as mandatory reporting of child abuse or neglect or government audits or investigations (e.g., licensing boards or health departments)
- When required by a court order

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HIPAA PRIVACY POLICY CONT.

- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Disclosures in these cases will be made only to individuals reasonably able to prevent or lessen the threat, including the potential target.

Verbal Permission. With your verbal permission, we may disclose PHI to family members or others directly involved in your care.

With Written Authorization. Any use or disclosure of PHI not permitted by law will be made only with your written authorization. You may revoke this authorization at any time in writing.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, submit a written request to your clinician.

- Right to Inspect and Copy. You have the right to inspect and copy PHI used to make decisions about your care, except in rare circumstances where access would cause serious harm. We may charge a reasonable, cost-based fee for copies. You have the right to receive an electronic copy of records when available.
- Right to Amend. If you believe your PHI is incorrect or incomplete, you may request an amendment. We are not required to agree to all amendment requests.
- Right to an Accounting of Disclosures. You may request an accounting of certain disclosures of your PHI. A reasonable fee may be charged for more than one request within a 12-month period.
- Right to Request Restrictions. You may request restrictions on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to these requests. If you pay cash for mental health services, you have the right to request that services and diagnoses not be submitted to your insurance company.
- Right to Request Confidential Communications. You may request that we communicate with you about health matters in a specific way or at a specific location.
- Right to a Copy of This Notice. You have the right to receive a copy of this Notice of Privacy Practices.
- Right to Breach Notification. You have the right to be notified in the event of a breach of unsecured PHI.
- Right to Opt Out of Fundraising or Marketing Communications. You may opt out of receiving fundraising or marketing communications at any time.

Complaints

If you believe your privacy rights have been violated, you may file a written complaint with your clinician or with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257

There will be no retaliation against you for filing a complaint.

My signature below indicates that I have read and understand HIPAA Privacy Policies offered at MC Wildflower Counseling. I also understand that if I have any questions about these statements, associated risks, or my privacy rights, I may speak with my therapist at any time.

Print of patient or parent if minor _____ Date_____

Signature of patient or parent _____Witness_____

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Telehealth and Technology Consent Addendum

Introduction:
This addendum supplements the Informed Consent and Client Rights Agreement. It outlines specific risks, rules, and privacy expectations for services delivered via telehealth and electronic technologies (e.g., video conferencing, secure messaging, AI-assisted note-taking).

Telehealth Informed Consent (Video/Phone Sessions)
Nature of Telehealth: Telehealth uses electronic communications to provide clinical services when the client and provider are not in the same physical location.
Benefits and Risks:

- Benefits: Improved access, convenience, and continuity of care.
- Risks: Technology failures (interruptions, data loss), potential breaches of privacy/security during transmission, and limitations in responding to emergencies in real-time.

Client Physical Location:

- You agree to share your current physical location at the start of each session.
- The provider is licensed to practice only in Nebraska. If you are outside Nebraska, the session may be terminated immediately.

Client Environment:

- You are responsible for ensuring your location is quiet, private, and free from distractions to maintain confidentiality.

Emergency and Crisis Protocol
Technology Failure:

- If the connection is lost and cannot be immediately restored, the provider will attempt to reach you via your designated phone number.

Crisis Protocol:

- Telehealth is **not** a substitute for emergency services. If you experience a mental health crisis:
  - Do not wait for your provider to respond.
  - Call or text 988 (Suicide & Crisis Lifeline).
  - Go to the nearest hospital or call 911.
- If the provider believes you are a danger to yourself or others, they may contact local emergency services based on your stated location.

Technology and Communication Policies
AI-Assisted Note-Taking:

- MC Wildflower Counseling may use secure, HIPAA-compliant AI technology to assist with administrative note-taking and session summaries.
- AI is used only for administrative purposes and adheres to all privacy and security standards (e.g., encryption, Business Associate Agreements).

Client Recording of Sessions:

- Recording (audio, video, or photographic) by the client is strictly prohibited without prior written consent from the therapist.
- Unauthorized recording may result in immediate session termination and discontinuation of services.

Telehealth Client Acknowledgment
By signing below, I acknowledge that I have read, understand, and agree to the risks, rules, and privacy expectations outlined in this Telehealth and Technology Consent Addendum

Print of patient or parent if minor _____ Date_____

Signature of patient or parent _____Witness_____

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Authorization for Release of Information
Between Psychiatric Medication Provider and Therapist

Client Name: _____ Date of Birth: _____

Primary Care Physician: _____

Clinic Name: _____

Address: _____

Phone Number: _____ Fax: _____

Authorization Details

By signing this authorization, I grant permission for the exchange of relevant treatment information between my therapist and my psychiatric medication provider. This information may include, but is not limited to, diagnoses, treatment plans, progress summaries, and medication information. The purpose of this exchange is to support coordinated, collaborative, and effective care.

Unless otherwise specified, this authorization will remain valid for **one (1) year** from the date of signature. I understand that I may revoke this authorization at any time by providing written notice.

If you wish to set a specific expiration date, please indicate below:

Release of Information Dates: _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Decline Authorization

If you **do not** consent to the release of information, please initial below:
☐ I **DO NOT CONSENT** to the release of information to my psychiatric medication provider.

Initials: _____

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Authorization for Release of Information
Between Primary Care Physician and Therapist

Client Name: _____ Date of Birth: _____

Primary Care Physician: _____

Clinic Name: _____

Address: _____

Phone Number: _____ Fax: _____

Authorization Details

By signing this authorization, I grant permission for the exchange of relevant treatment information between my therapist and my psychiatric medication provider. This information may include, but is not limited to, diagnoses, treatment plans, progress summaries, and medication information. The purpose of this exchange is to support coordinated, collaborative, and effective care.

Unless otherwise specified, this authorization will remain valid for **one (1) year** from the date of signature. I understand that I may revoke this authorization at any time by providing written notice.

If you wish to set a specific expiration date, please indicate below:

Release of Information Dates: _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Decline Authorization

If you **do not** consent to the release of information, please initial below:
☐ I **DO NOT CONSENT** to the release of information to my psychiatric medication provider.

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mcornelius@mcwildflowercounseling.com

Authorization for Release of Confidential Information

Client Name: _____ Date of Birth: _____

By signing this authorization, I grant permission for the exchange of relevant treatment information between the following person / agency below and MC Wildflower Counseling.

Name of Person: _____

Name of Agency / Relationship: _____

Address: _____ Phone: _____

Fax: _____ Email: _____

Purpose of Release:
___ Continuity of Care/Treatment Coordination
___ Insurance/Billing
___ Legal Proceedings

Information to be Release:
___ Initial Evaluation
___ Recommendation / Referral Information
___ Discharge Summary
___ Verbal Information
___ Summary of Treatment
___ Other: _____

Rights and Understanding: This consent is active until _____ , but may be revoked at any time in writing to: MC Wildflower Counseling. If no date is identified, this authorization is valid for one year after the signed date. Refusal to sign will not affect my treatment, payment, enrollment, or eligibility for benefits (unless allowed by law). Information disclosed may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations (HIPAA/42 CFR Part 2).

I have read and understand this Authorization for Release of Confidential Information. I voluntarily authorize the release of the information specified above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

Staff Signature: _____ **Date:** _____

WILDFLOWER COUNSELING

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Suite 112
Grand Island, NE 68801

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Clinician Communication Form

Date: _____	RE: Mutual Patient Care Coordination
To: _____	Client Name: _____
Practice/Clinic: _____	Date of Birth: _____
Fax/Phone: _____	

With appropriate authorization on file, I am writing to introduce myself and to support coordinated care for our mutual patient. I am a licensed psychotherapist in private practice and value collaborative communication with medical and psychiatric providers to ensure comprehensive, ethical, and effective treatment.

Treating Provider Information
Name: Marissa B Cornelius
Credentials: Licensed Independent Mental Health Practitioner #4388, Licensed Independent Clinical Social Worker #2599
Practice Name: MC Wildflower Counseling
Phone: 308.216.8018
Fax:
Email: mcornelius@mcwildflowercounseling.com

Reasons for Treatment / Presenting Concerns

_____

_____

Current Diagnoses (per psychotherapy assessment)

_____

Follow-Up and Coordination Schedule

_____

Request for Records and Clinical Information
With the client's written authorization, I respectfully request the following to support continuity of care:
___Relevant medical and psychiatric history
___Current and past psychiatric diagnoses
___Medication list (current and historical)
___Recent psychiatric evaluations or consult notes
___Laboratory results (if clinically relevant)
___Other pertinent information: _____
Please send records via secure fax or encrypted electronic delivery

Thank you for your collaboration and commitment to integrated patient care. Please feel free to contact me if you would like to discuss treatment planning, progress, or coordination preferences. I look forward to working together in support of our mutual patient.

Sincerely,

WILDFLOWER
COUNSELING

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