Exhibit A- ASAP

# Margie Smith and Associates, LLC

Today's Date: ________/________/________ Your Email Address:_______________________

Last Name: ___________________________ First Name: ____________________ MI : _________

Address: Street: _______________________________ City: ______________________ State: ______

Zip Code: ______________

Home Phone#: ________________________ Date of Birth: ______/______/________

Soc. Sec. #: ____________________________ Gender: M___ F___ Race: ________

Marital Status: S ___ M ___ Sep. ___ Div. ___ Wid. ___

Employer: _________________________________Occupation: ________________________________

Cell Phone: ___________________________ Work Phone: ___________________________

A. We have a legal duty to protect health information about you.
B. We may use and disclose Protected Health Information about you in the following circumstances:
1. We may use and disclose Protected Health Information about you to provide health care treatment to you.
2. We may use and disclose Protected Health Information about you to obtain payment for services.
3. We may use and disclose your Protected health Information for health care operations.
4. We may use and disclose Protected Health Information under other circumstances without your authorization.
5. You can object to certain uses and disclosures.
6. We may contact you to provide appointment reminders.
7. We may contact you with information about treatment, services, products or health care providers.
C. You have several rights regarding Protected health Information about you:
1. You have the right to request restrictions on uses and disclosures of Protected Health Information about you.
2. You have the right to request different ways to communicate with you.
3. You have the right to see and copy Protected Health Information about you.
4. You have the right to request amendment of Protected Health Information about you.
5. You have the right to a listing of disclosures we have made.
6. You have the right to a copy of this notice.

I understand that therapy offers no guarantees. By working with my therapist, I have the opportunity to get help with the problems and concerns I bring to therapy. I understand that I will benefit in proportion to the effort I put into making changes and acting in new and different ways. I will develop these new choices in cooperation with my therapist. This effort will not be limited to the time in a session but will include being committed to making the effort in between sessions. If I do not do these things outside the office, I understand that the effectiveness of the therapy will be limited.
I agree to collaborate with my therapist or to discuss with him or her the reasons why I cannot. I agree to ask

any questions I have to clarify my therapeutic goals and to monitor progress towards them.
I understand that therapy will end when the goals of the therapy are met. I also understand that I can terminate my therapy at any time I wish. I agree to notify my therapist if I choose to end the therapy before the goals are met. I also understand that my therapist can end therapy if we do not make progress, or if our relationship working together does not produce results, or if I am no longer able to pay for therapy. If therapy is terminated early, my therapist will make every effort to refer me to another appropriate
source of therapy or assistance.
Patients have the right to be treated with dignity and respect.
Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
Patients have the right to have their treatment and other patient information kept private.
Only in an emergency, or if required by law, can records be released without patient permission.
Patients have the right to information from staff and providers in a language they can understand.
Patients have the right to have an easy-to-understand explanation of their condition and treatment.
Patients have the right to know all about their treatment choices, regardless of cost or if they are covered by insurance or not.
Patients have the right to get information about MSA's services and role in the treatment process.
Patients have the right to provider qualification information.
Patients have the right to share in the formation of their plan of care.
Patients have the responsibility to give providers the information they need. This is so they can deliver the best possible care.
Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
Patients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
Patients have the responsibility to treat those giving them care with dignity and respect.
Patients should not take actions that could harm the lives of employees, providers or other patients.
Patients have the responsibility to keep their appointment. Patients should call their providers as soon as possible if they need to cancel visits.
Patients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
Patients have the responsibility to let their providers know about problems with paying fees.
Patients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the patient and the provider.

________________________________________________________

Client Signature Date

________________________________________________________

Counselor Signature Date

# Margie Smith and Associates, LLC

Date_______________________________________________

I hereby authorize and request Margie Smith and Associates to furnish:

Case Manager's Name _______________________________________

Address Capital Area ASAP
4915 Augusta Avenue
Richmond, Virginia 23230

With such information as may be desired from my medical and/or other records.

Signed________________________________

Address______________________________

_____________________________________

Witness__________________________________________________