Amy E. Brown, MS, CADC, LPC, CCTP
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Informed Consent Agreement for Healthcare Professional Evaluations

Service Agreement

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights regarding the use and disclosure of Protected Health Information (PHI) for purposes of treatment, payment, and healthcare operations.

Your signature on this document indicates that you have read, understood, and agreed to these terms.

I am an approved independent evaluator for the Pennsylvania Professional Health Monitoring Program (PHMP), the Pennsylvania Nurses' Health Program (NHP), and the Pennsylvania Physicians' Health Program (PHP). You have retained me to conduct an independent professional evaluation regarding your safety and fitness to practice as a healthcare professional (HCP), including, when applicable, recommendations regarding treatment, monitoring, or other services related to substance use or mental health concerns.

Purpose, Scope, and Limitations of the Evaluation and Report

- This is an independent professional evaluation. It is not psychotherapy, counseling, or treatment, and our relationship is not a therapist-client treatment relationship. Our discussions are for evaluative purposes.
- You are expected to participate in the evaluation process in a cooperative and professional manner. This includes responding to reasonable requests for information, completing required components of the evaluation, and maintaining appropriate and respectful communication throughout the process.
- I will conduct the evaluation independently and will make reasonable efforts to remain objective and impartial. My findings and recommendations will be based on the information available to me and my professional judgment.
- You will not be provided an opportunity to review, approve, revise, negotiate, or otherwise influence my findings or recommendations before I submit my report to PHMP/NHP/PHP.
- Questions or concerns about the evaluation process are welcome. However, discussion of the process does not include negotiation of my professional conclusions or recommendations.
- My evaluative involvement generally concludes once I submit the final report. You may request a copy of the report after PHMP/NHP/PHP has reviewed the findings and recommendations with you.

Standard Evaluation Process

The evaluation generally includes the following steps:

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- I will review your completed intake materials and other available records and meet with you for a remote clinical interview lasting approximately 45–60 minutes. I may contact you after the interview if additional information or clarification is needed.
- I will contact collateral sources and may request permission to speak with additional individuals when appropriate. If I am unable to reach a collateral contact within five business days, I may ask you to provide a replacement.
- I may communicate with PHMP/NHP/PHP as needed during the evaluation process and will submit my final report directly to the appropriate program.
- My findings and recommendations will be based on the information obtained during the evaluation, including the interview, records and other documentation, collateral information, laboratory or toxicology results when applicable, communications with the referring program, my professional experience and clinical judgment, and relevant diagnostic criteria contained in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* (American Psychiatric Association, 2022).

Payment and Fees

- The fee for the healthcare professional evaluation and report is **$425.00**. Payment in full is due at the time of the evaluation unless other arrangements have been made in advance.
- I accept Zelle, Venmo, Cash App, and credit/debit cards.
- Healthcare professional evaluations are not covered by health insurance. Upon request, I can provide documentation of payment for your records or tax purposes.
- I reserve the right to delay submission of the final report until payment in full has been received.
- If an outstanding balance remains unpaid, I reserve the right to use lawful collection methods, including a collection agency or attorney, when appropriate.
- Fees and policies may be revised periodically. Changes will apply prospectively and will not alter the agreed-upon fee for an evaluation already underway unless otherwise agreed in writing.

Cancellation Policy

I require at least **48 hours' notice** to cancel or reschedule an evaluation appointment. A fee of **$200.00** will be charged for missed appointments or appointments cancelled with less than 48 hours' notice. Exceptions may be considered on a case-by-case basis.

Any late-cancellation or missed-appointment fee must be paid in full before the evaluation is rescheduled.

Professional Records

I maintain records related to the services I provide in a secure manner consistent with applicable professional and legal requirements. I retain a copy of my final report and supporting documentation for at least seven years following submission of the report.

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You may request that a copy of your report be provided to another healthcare provider or other authorized recipient upon receipt of a valid written authorization or Release of Information, subject to applicable law and professional requirements.

Confidentiality

My confidentiality policies and information regarding your privacy rights are described more fully in my separate **Notice of Privacy Practices**, which has been provided to you.

Because this is an independent evaluation rather than treatment, information obtained during the evaluation is intended to be communicated to PHMP/NHP/PHP and may be included in my report when I determine that it is relevant to the purpose of the evaluation.

You are encouraged to ask questions about confidentiality, privacy, and the limits of confidentiality at any point during the evaluation process.

Early Termination of the Evaluation

I reserve the right to discontinue an evaluation before completion if, in my professional judgment, circumstances prevent me from conducting a sufficiently thorough, objective, reliable, or professionally appropriate evaluation. Reasons may include, but are not limited to, insufficient or unreliable information, failure to complete required components of the evaluation, inability to obtain necessary collateral information, significant conflicts of interest, or conduct that materially interferes with the evaluation process.

You also have the right to discontinue your participation in the evaluation before the report is submitted.

If an evaluation is terminated before completion, I will not issue a final evaluation report or professional opinion regarding fitness to practice. **I may, however, notify the referring program that the evaluation was not completed and provide information as permitted or required by the applicable authorization, program requirements, professional obligations, or law.**

Any refund will be determined on a case-by-case basis based on the professional services already provided and expenses incurred before termination. A partial, full, or no refund may be appropriate depending on the circumstances.

Other Rights

You have the right to be treated in a considerate, safe, professional, and respectful manner without discrimination based on race, ethnicity, color, sex, gender, gender identity, sexual orientation, age, religion, national origin, disability, or other status protected by applicable law.

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You have the right to ask reasonable questions about the evaluation process and about my professional qualifications, training, and experience.

Consent

By signing below, you acknowledge that:

- You have read and understand this Informed Consent Agreement.
- You have received the Notice of Privacy Practices.
- You understand that this is an **independent professional evaluation and not psychotherapy or treatment**.
- You understand that information obtained during the evaluation may be reported to PHMP/NHP/PHP.
- You understand that you will **not review, approve, revise, or negotiate the evaluator's findings or recommendations before the report is submitted**.
- You have had an opportunity to ask questions about the evaluation process.
- You voluntarily agree to participate in the evaluation under these terms.

HCP Name (print): _____

HCP Signature: _____ Date: _____

Witness Name (print): _____

Witness Signature: _____ Date: _____

Revised 08/2026

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Release of Confidential Information

Name: _____ Date of Birth: _____

I give Amy E. Brown, MS, CADC, LPC CCTP explicit permission to release my protected health information to the **Pennsylvania PHMP/NHP/PHP** (circle one)

Reason for disclosure: **evaluation purposes**

Specific information to be disclosed: **intake information, evaluation, recommendations, and report**

I understand that I may revoke this authorization in writing at any time by contacting Amy E. Brown My revocation will not apply to information that has already been disclosed in reliance on this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, unless otherwise protected by applicable federal or state law.

I understand that this authorization will expire after one year unless otherwise revoked.

_____

Printed name

_____

Signature Date

_____

Witness printed name

_____

Witness signature Date

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AI-Assisted Documentation Consent Form

To improve the accuracy and efficiency of clinical documentation, I sometimes use an artificial intelligence (AI)-assisted documentation tool integrated with my electronic health record.

Purpose:

With your permission, our session may be audio recorded solely to assist in creating clinical documentation, such as progress notes, assessments, or evaluation reports. The recording is used only to generate a draft note and is not intended for any other purpose.

How AI is Used:

- The session audio is processed using secure, HIPAA-compliant technology.
- The AI system creates a draft clinical note.
- I personally review, edit, and approve every note before it becomes part of your medical record.
- AI does not make clinical decisions or replace my professional judgment.

Privacy and Security:

- Audio recordings are used only for documentation purposes.
- Recordings are handled in accordance with HIPAA and applicable privacy laws.
- Recordings are not used for advertising, marketing, or unrelated purposes.
- Audio recordings are deleted after processing in accordance with the documentation service's retention policies, unless otherwise required by law.

Your Rights:

Your participation is voluntary.

You may:

- Consent to AI-assisted documentation.
- Decline audio recording and still receive services.
- Withdraw your consent at any time. Future sessions will not be recorded once consent is withdrawn.

Choosing not to participate will not affect your access to treatment or the quality of care you receive.

If you have questions about AI-assisted documentation, please ask before signing this form.

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Client Consent to AI -assisted Recording

I have read and understand the information provided above. I have had the opportunity to ask questions, and I voluntarily consent to audio recording of my sessions for the sole purpose of AI-assisted clinical documentation.

☐ **I CONSENT** to AI-assisted audio recording for documentation.

☐ **I DO NOT CONSENT** to AI-assisted audio recording. I understand my therapist will complete documentation using traditional methods.

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how your protected health information (PHI) may be used and disclosed, and how you can access this information. Please review it carefully.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

- Amy E. Brown, MS, LPC, CADC, CCTP may use or disclose your PHI for treatment, payment, and health care operations with your consent.
- Protected Health Information (PHI): Information in your health record that could identify you.
- Treatment: Providing, coordinating, or managing your health care.
- Payment: Activities required to obtain reimbursement for services.
- Health Care Operations: Administrative and operational activities of the practice.
- Use: Sharing or analyzing PHI within the practice.
- Disclosure: Releasing PHI to parties outside the practice.

Uses and Disclosures Requiring Authorization

- Uses or disclosures of PHI outside of treatment, payment, or health care operations require your written authorization.
- You may revoke an authorization at any time in writing.
- Revocation does not apply to actions already taken in reliance on your authorization.

Uses and Disclosures Without Consent or Authorization

- Child abuse reporting as required by law.
- Adult or domestic abuse reporting when permitted or required by law.
- Health oversight activities.
- Judicial or administrative proceedings.
- Serious threats to health or safety.
- Workers' compensation claims.
- Other legal requirements.

Client Rights

- Request restrictions.

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- Request confidential communications.
- Access records.
- Request amendments.
- Receive an accounting of disclosures.
- Receive a paper copy of this notice.
- Restrict disclosure to health plans when eligible.
- Receive breach notifications.

Provider Responsibilities

- Maintain the privacy of your PHI.
- Provide this notice of legal duties and privacy practices.
- Follow the terms of this notice currently in effect.

Complaints

- You may contact Amy E. Brown directly.
- You may file a complaint with the U.S. Department of Health and Human Services.
- You will not be penalized for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective April 14, 2003, and was last revised June 18, 2026.

ACKNOWLEDGMENT OF RECEIPT

My signature below acknowledges that I have received or been offered a copy of this Notice of Privacy Practices.

Printed Name: _____

Signature: _____

Date: _____

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CONFIDENTIAL

Healthcare Professional Evaluation Intake

Please put your name on each page, print neatly or type, and add extra pages as needed

Date:
Name:

DOB/age:
Address:
Email address:
Cell phone number:

License type:
Reason for evaluation:

Case manager:
Date of lab work:
Date of evaluation:

Have you been previously referred to NHP/PHP/PHMP? If so, please provide details.

Substance Use History:

Please include every substance you've **ever** tried (even once), including nicotine and marijuana

Substance	Age of first use	Initial pattern	Recent pattern	Date of last use	Consequences
Example: Alcohol	age 16	2-3 beers on weekends	8-10 beers daily	May 2024	Blackouts, lost job, DUI

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Counseling History:

Have you ever been in counseling for any reason?

Dates	**Provider and location**	**Reason**	**Outpatient/ inpatient?**

Recovery:

Do you identify as a person in recovery?

Have you ever attended recovery meetings?

Did/do you have a sponsor?

Family/Social History:

- Are you adopted?
- Where were you born and raised?
- Who did you grow up with?
- Do any blood relatives have mental health and/or substance use issues?
- Were you raised in a particular religion? Do you practice a religion now?
- How are your current relationships with family members?
- Have you been married or in long-term relationships? If so, please provide details.
- Where do you currently live with and with whom?
- Gender/ages of children and stepchildren:
- Who do you talk to if you're upset or stressed?
- What activities do you enjoy in your free time?

Educational/Military History: **Name of school, city and state, years attended/graduated, degree/ license earned**

- High school:
- College:
- Post-college education:
- Initial licensure year:
- If you are a veteran, please provide years of service, which branch, and nature of discharge. Please also note if you saw combat/were stationed in a war zone.

Employment History: (Please account for the last five years)

For each employer: Name, location, dates, position, attendance/performance issues, reason for leaving

- Current employer:
- Previous employers:

Legal History:

- Have you ever been arrested? If so, please provide details:
- Do you have a pending court date?
- Are you currently on probation or parole? If so, please provide details and the name and contact information for your PO:

Medical History:

Please list any medical problems:

Current Medications:

Name, dose, frequency, reason, and prescriber (i.e.: psychiatrist, PCP, etc.)

1.

2.

3.

4.

Mental Health History:

If you have any past/current mental health diagnoses, please provide the year of initial diagnosis and any current symptoms.

1.

2.

3.

- How is your sleep? Appetite? General energy level?
- Have you ever considered or attempted suicide? If so, please provide details.
- Have any of your family members attempted or completed suicide? If so, please provide details.

- Have you ever considered or attempted to seriously harm someone else? If so, please provide details.
- Did/do you ever do anything to deliberately harm yourself? If so, please provide details.
- Did/do you ever hear or see things that other people don't (when not intoxicated)? If so, please provide details.
- Did/do you struggle with disordered eating and/or purging? If so, please provide details.
- Please describe your mood and stress level over the past few months:
- Please mention any past/current mental health issues not covered above:

Collateral Contacts: **Please list names and cell phone numbers for at least one friend, a work superior and/or co-worker (past or present), and a family member. I will be contacting them to obtain additional information for this evaluation and will not release any of your personal information. Please let your contacts know I'll be texting them soon. Thank you.**

Name and relationship	Cell phone number
1.	
2.	
3.	

Comments/concerns about your upcoming evaluation?

Please **scan** all completed forms back to me at least 24-hours before our appointment: amyebrown.LPC@gmail.com

Thank you!

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Michigan Alcohol Screening Test (MAST)

This test is nationally recognized by alcoholism and drug dependence professionals. You may substitute the words "drug use" in place of "drinking".

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
Circle Answer: YES NO

2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
Circle Answer: YES NO

3. Does any near relative or close friend ever worry or complain about your drinking?
Circle Answer: YES NO

4. Can you stop drinking without difficulty after one or two drinks?
Circle Answer: YES NO

5. Do you ever feel guilty about your drinking?
Circle Answer: YES NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
Circle Answer: YES NO

7. Have you ever gotten into physical fights when drinking?
Circle Answer: YES NO

8. Has drinking ever created problems between you and a near relative or close friend?
Circle Answer: YES NO

9. Has any family member or close friend gone to anyone for help about your drinking?
Circle Answer: YES NO

10. Have you ever lost friends because of your drinking?
Circle Answer: YES NO

11. Have you ever gotten into trouble at work because of drinking?
Circle Answer: YES NO

12. Have you ever lost a job because of drinking?
Circle Answer: YES NO

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
Circle Answer: YES NO

14. Do you drink before noon fairly often?
Circle Answer: YES NO

15. Have you ever been told you have liver trouble such as cirrhosis?
Circle Answer: YES NO

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?
Circle Answer: YES NO

17. Have you ever gone to anyone for help about your drinking?
Circle Answer: YES NO

18. Have you ever been hospitalized because of drinking?
Circle Answer: YES NO

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
Circle Answer: YES NO

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?
Circle Answer: YES NO

21. Have you been arrested more than once for driving under the influence of alcohol?
Circle Answer: YES NO

22. Have you ever been arrested, even for a few hours because of other behavior while drinking? (If Yes, how many times _____)
Circle Answer: YES NO

SCORING

Please score one point if you answered the following:
1. No
2. Yes
3. Yes
4. No
5. Yes
6. Yes
7 through 22: Yes

Add up the scores and compare to the following score card:
0 - 2 No apparent problem
3 - 5 Early or middle problem drinker
6 or more Problem drinker

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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