

## Informed Consent

Welcome! The following guidelines should answer most of your questions about our policies and procedures.

**Consent to treatment:** All clients are here voluntarily for their mental health care. The practice of therapy is not an exact science and no guarantees can be made as to the results of therapy.

**Limits to Confidentiality:** Confidentiality is an increasingly complex issue. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on April 14, 2003. However, some situations, described in the bullets below, require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following situations:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical Record.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.
- If I am being compensated for providing treatment to you as a result of your having filed a worker's compensation claim, I must, upon appropriate request, provide information necessary for utilization review purposes.

In addition, your insurance company, if you use one, requires a diagnosis be given in order to reimburse you for services rendered. They may also request additional information to authorize mental health services, process insurance claims and facilitate payments for mental health services, and to conduct retrospective reviews for quality assurance purposes. This information will be provided as needed (see the section on Client Records below). Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without either your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If you ask me to disclose parts of the Client Record to a third party to support a disability claim, a civil lawsuit, divorce, or similar legal or quasi-legal pursuit, I may strongly advise you against doing so because of the potential harm to our therapeutic relationship. If, as you read this, you have in mind using any part of the Clinical Record for an upcoming legal or quasi-legal pursuit, please inform me immediately so that, if necessary, I may help find you a clinician who can help you with those concerns.

There are four additional situations in which I am legally obligated to take actions. I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

- If you have expressed ideation, intent and plan to take your life and cannot guarantee your safety I will be required to get you connected to the nearest hospital for further assessment and to keep you safe. I may need to coordinate and communicate with the hospital and law enforcement in such cases.
- If I have reasonable cause to suspect child abuse or neglect, the law requires that I file a report with Child Protective Services. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to suspect the “criminal abuse” of an adult, I must report it to the police. Once such a report is filed, I may be required to provide additional information.
- If there is a threat of physical violence against a reasonably identifiable third person and I judge you to have the apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, their parents and the county Department of Social Services) contacting the police, and/or seeking hospitalization for you.

**Supervision/Consultation:** It is a continuing goal of Integrative Empowerment Group to provide the best possible service to clients. Accordingly, staff members seek, receive, and provide consultation and supervision to each other and outside sources whenever appropriate.

**Record Keeping:** You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records:

One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You have a right to examine and/or receive a copy of your clinical record if you request it in writing, except in unusual circumstances, as follows:

- where disclosure would physically endanger you and/or others,
- when your record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person,

- where others have supplied information to me confidentially.

Because these are professional records, they can be misinterpreted and thus upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your Clinical Records, you have a formal right of review, which I will discuss with you upon request.

The second set of records is Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my assessment of those conversations, and how these conversations affect your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

**Client Rights:** HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which Protected Health Information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**Weapons Policy:** No weapons or firearms of any kind are permitted on the premises.

**Substance Policy:** If you arrive to therapy under the influence of any substance, prescribed or otherwise, that inhibits your ability to meaningfully engage in the therapeutic process, your therapist will end your session and you will be responsible for the late cancellation fee as disclosed in the Fee and Payment Agreement.

**Emergency Accessibility:** A 24-hour voicemail is available for your non-urgent messages. It is checked daily, Monday through Friday, and calls are typically returned by the next business day.

***In the event of an emergency, call your local crisis hot line or emergency care facility (911). If you believe that you may require more extensive access to your therapist between sessions than what is described above, I am probably not the therapist for you. Please let me know and I will be happy to refer you to someone who provides this service. If you have questions about accessibility, please ask.***

**Termination:** I expect that you will provide advance, face-to-face notice of your intention to terminate therapy. Doing so allows us to address the inevitable issues that come up when ending an important relationship.

If you cancel an appointment or fail to show up for an appointment and do not reschedule, I may not be able to hold that regular meeting time open for you. One month from the time of our last face-to-face contact, I will email you asking if you would like to schedule another appointment. If I receive no reply to this email within two weeks of having sent it, I will take this as an indication that you want to end treatment. You are welcome to ask

me for help in finding another therapist, and if you decide subsequently that you want to begin treatment again, I will be happy to see you if there is an available regular appointment time.

Either one of us may decide at some point that our continued working together is not adequately meeting your needs. I am ethically bound not to continue work that is harmful to you or that is less effective than what you might receive from another provider. If this situation arises (or any other unforeseen impediment to our working together, e.g., my becoming ill), I will try to provide as much advance notice as I can and will provide you with appropriate referrals.

By signing below, you agree that you have read this agreement and consent to its terms. It also serves as an acknowledgment that you have been offered the HIPAA Notice described above.

\_\_\_\_\_

Client Printed Name

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness Printed Name

\_\_\_\_\_

Witness Signature

\_\_\_\_\_

Date