

Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Date

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Integrative Emotional Enrichment Services, PC.

781-247-1500 781-247-1100

For our client's security we request you provide your insurance card and a photo ID to avoid insurance fraud.

We strongly believe that part of a healthy working alliance involves staying current with your account here at IEES. This enables us to pay your therapist for services rendered.

To this end, and to reduce the amount of mailings and paper invoices, we ask the person who is responsible for payment here, to register a credit or debit card with us and to select the payment option(s) that best suit you. If the person responsible for payment prefers to pay by check or cash at the time of service, the co-pay or co-insurance will not be run through on the credit/debit card. However, if payment is not made at the time of service, the billing department will process the co-pay or co-insurance on the credit/debit card on file.

If a session is later applied to deductible or there is a missed session or late cancellation fee that is unpaid, that amount will also be put on the credit/debit card. A courtesy call will be made to notify you that we are putting through a charge if there is a large amount owed over \$100.00.

Thanks so much for choosing IEES for you behavioral needs.

****Please indicate your account and payment information below****

Client's Name: _____

Circle Type of Card: Amex Visa Disc MC Expiration Date: _____

Name on Card: _____

Account Number: _____

Preferred Cell Phone Number of Account Holder: _____

Address: _____

City/State/Zip _____

Please charge my credit/debit card for:

_____ Session Co-pay/Co-Ins. Please charge my co-pay for each session

_____ To Deductible Amounts

_____ Missed Session/Late Cancellation (See agreement for services policy)

_____ I prefer to pay by check or cash at the time of the session, but I understand that if my payment is not made at the time of service, my credit/debit card will be charged.

Printed Name of Responsible Party _____

Signature of Responsible Party _____

Relationship to Client _____

Date _____