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TREATMENT CONSENT FORM

Please read the following information carefully and feel free to discuss with your counselor any questions you might have. Then please sign the form at the bottom signifying that you have read the information regarding confidentiality and acknowledge the extent of information that must be shared for supervisory or training purposes.

1) **Clients are expected to pay for services at the time of each visit.** Insurance or other billing arrangements should be made prior to the session and are the responsibility of the client. If needed, you will be provided a receipt for services with all the necessary information to file on your own for out of network benefits or apply towards FSA/HAS benefits. Returned checks will be subject to a $45.00 fee and may require future sessions paid in cash or in advance.

2) Your set appointment is a contract whereby you have the exclusive use of the counselor's time for your scheduled appointment. **You are therefore held responsible for the fee for all cancelled appointments.** If you are unable to keep your appointment, you must cancel as soon as possible. If this is done at least 48 hours in advance of your appointment time, there will be no charge for the cancellation. A minimum charge of $50.00 will apply for missed sessions. This cannot and will not be charged to your insurance or your EAP and is the personal responsibility of client, and must be paid prior to next session.

3) The counselor is a consultant and resource professional only, whose intervention may be freely accepted or rejected by the client. Therefore, **decisions made during and after counseling are the responsibilities of the client.**

4) **CONFIDENTIALITY:** Information shared with a counselor is protected by professional ethics and federal and state law and will not be disclosed without your written permission. There are exceptions and limitation to confidentiality if the following occurs: a) There is a clear and serious indication of doing self-harm b) There is a clear and serious indication of danger to someone else. C) My primary counselor receives a subpoena of which I have been properly notified and have failed to inform her that I am opposing the subpoena or court order. D) There is indication that a child, person with a disability, or elderly person has been abused, exploited, or neglected. E) My account is in delinquent status. Appropriate billing and financial information will be released to a collection agency. No clinical data will be released. F) I send my counselor an email containing private information. Emails may be read/accessed by other people unless sent via secured portal; G) In cases of minors, parents are by law privy to their information unless the parents and the primary counselor have agreed to other alternatives in providing services. Additionally, in an effort to facilitate professional development and quality counseling, we submit ourselves to ongoing supervision. Your signature below grants me permission to disclose information from our counseling sessions for the purpose of professional supervision (ongoing training) to peer or supervisory professionals without any personal identifying information. Any other disclosure to third parties will be specified in writing through another document.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW HEALTH, MEDICAL, AND PSYCHOTHERAPY INVORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A) Disclosure – Your counselor may be "In Network" or "Out of Network" for your insurance or EAP benefits. It is your responsibility to verify benefits. You are responsible for all charges not paid by your insurance or EAP company. If you choose to pay for services through insurance or EAP benefits, information about your diagnosis and treatment **may** be given to the insurance company, your employer, their agent, or the national insurance database for payment, and health care operations. We are permitted or required to disclose protected health information for other purposes without your written consent or authorization, such as when there is danger of actual physical harm to your self or someone

else, when physical or sexual abuse or neglect of a specific minor child or elderly person becomes known. **Information may be discussed openly if you are seeing a counselor with your relationship or family partner,** or in legal cases, your clinical records and/or the counselor may be subpoenaed by a judge. Other uses and disclosures will be made only with your written authorization and you may revoke such authorization in writing any time. By my signature below, I authorize my counselor to bill my EAP and/or insurance on my behalf for services provided. If I choose NOT to use EAP or insurance benefits, I will notify my counselor and sign a waiver for same.

B) Patient's Rights – With respect to protected health information (PHI), you have the following rights:

a) The right to request restrictions on certain uses and disclosures of protected health information
b) The right to receive confidential communications of protected health information.
c) The right to inspect and copy, at your cost, protected health information, or to have PHI provided to your new mental health provider, at the discretion of this counselor.
d) The right to amend or annotate protected health information.
e) The right to receive an accounting of disclosures of protected health information to others.
f) The right of a patient, including a patient who has agreed to receive the notice electronically, to obtain a paper copy of the notice from the practice upon request.
g) The right to request restrictions on the use of disclosure of your health information, such as to ask us not to give any information to your family, and that would be a restriction we would try to honor.

(**PLEASE NOTE: Electronic communications (email or text) are NOT protected PHI data nor is confidentiality ensured due to the nature and vulnerability of these communications. For this reason, no counseling services will be provided via emails or text. Should you wish scheduling confirmation provided via email or text message, and understand and agree to this exemption to confidentiality, please initial here _____).

3) Practice Responsibilities – We are required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect; and, in case we may wish to make a change in our privacy policies, we reserve the right to change the terms of your notice and to make the new notice provisions effective for all protected health information. We will provide you with a revised notice by mail to your latest known address.

4) Complaints – We have a policy for filing an official grievance. For further information please contact the provider as listed under "5. Contact". A formal grievance can be filed with the office of Civil Rights in Washington, DC or the Florida Department of Health.

5) Contact – The person to contact for further privacy related information or regarding any grievance is:

Anna Lively, LMHC
Post Office Box 752
Balm, FL 33503
813-928-5335

If you have concerns about confidentiality, please discuss with your counselor the degree to which your confidentiality will or will not be protected and what steps we might take to preserve your privacy. Your signature below gives consent to the above.

I have read and understand the information presented in this form. I consent to receive treatment from Anna Lively, M.S., LMHC (If you are signing on behalf of your dependent, please print his/her name, and your relationship to the client.)

I understand that I have the right to terminate treatment or refuse treatment at any time; I will give counselor notice of my intent to terminate. In the event that I do not communicate with my counselor regarding my absence or in not following up for sessions for a period in excess of 21 days, my file will be closed and I will be considered discharged. I may return and resume counseling services by contacting my counselor.

I realize that all sessions are based on a 50 minute time frame, unless otherwise specified.

I UNDERSTAND THAT FEES FOR SERVICES ARE EXPECTED AT THE TIME THAT SERVICES ARE RENDERED, IF EXTENUATING CIRCUMSTANCES PREVENT PAYMENT, I WILL DISCUSS WITH MY COUNSELOR IN ADVANCE. I UNDERSTAND AND AGREE THAT ANY APPOINTMENTS I CANCEL WITH LESS THAN 48 HOURS NOTICE ARE SUBJECT TO FULL CHARGE.

Patient Signature	Date
Parent/Guardian	Date
Witness	Date

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ADDENDUM TREATMENT CONSENT FORM
REGARDING FORENSIC TESTIMONY (INCLUDING REPORTS)

1) Client may waive confidentiality to request or allow Anna Lively, LMHC (counselor) to provide copies of their personal PHI, medical records, assessments, notes, treatment plans and summaries.

2) Confidentiality can NOT be ensured where there are legal requirements to report (ie: suspected abuse of a vulnerable adult or child, reasonable belief client may harm him or herself or another), receipt of a court order.

3) In the event counselor's records are subpoenaed or court ordered, client may be responsible to pay counselor's fee of $175.00 per hour for:
   (a) Testimony at a sworn statement (including depositions)
   (b) Testimony at court
   (c) Treatment summaries
   (d) Phone calls
   (e) Travel time

4) Due to the adversarial nature of court proceedings, it may be necessary for this counselor to terminate the counseling relationship with client in the event she is called as a witness or to provide testimony in a legal proceeding where client is a party. Counselor will provide a referral to another counselor for continued services if needed.

I UNDERSTAND THAT FEES FOR SERVICES ARE TO BE PAID PRIOR TO APPEARANCE AT COURT PROCEEDING OR FOR PROVIDING SWORN TESTIMONY. I UNDERSTAND AND AGREE THAT ANY COURT APPEARANCE OR DEPOSITION SCHEDULED AND CANCELED WITH LESS THAN 48 HOURS NOTICE ARE SUBJECT TO A CHARGE OF $400.00.

Patient Signature	Date
Parent/Guardian	Date
Witness	Date