A Caring Counselor
a healing place…
9900 W. Sample Rd., Suite # 300
Coral Springs, Fl. 33065
954-793-6442
www.acaringcounselor.net

<u>HIPPA Statement and Standard Consent for Treatment</u>

Below is the standard consent to treatment. It is in compliance with the new (April 2003) Federal Government mandated guidelines regarding Protected Health Information (PHI), as outlined in the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rules. These rules are not appreciably different from existing State of Florida laws regulating outpatient mental health services that we have always followed. Procedures and scope of the new law may affect certain privacy issues somewhat differently however. For example, under the new rules, any release of "psychotherapy notes" are given a greater degree of protection than PHI (e.g.; information identifying you in the record) and will require a special authorization be obtained prior to release as well as a separate file. In addition, when information for any purpose outside the scope of the treatment, payment, and health care operation directly relating to the treatment has been requested, an additional authorization, beyond this one, will be obtained as well. Be assured that **<u>Cindy Ricardo, MS, LMHC, CIRT</u>** will always strive to protect your legal rights to appropriate confidentiality to the utmost. The new HIPPA law is a work in progress for all of us. Feel free to ask any questions you may have.

If you wish, you may read the basic elements of the new law, and by signing below, you are also stating that you have been informed of the new HIPPA law and given the opportunity to read the content.

This is to certify that I give permission to **<u>Cindy Ricardo, MS, LMHC, CIRT</u>** to provide psychotherapy and/or psychological assessment for myself, and/or my child.

I will be treated with respect and honesty throughout this process. I can reasonably expect to benefit from treatment but I realize there are no guarantees. Outpatient psychotherapy does not have significant risks. However, I understand I may feel temporarily worse at times during the process. I further understand that maximum benefits tend to occur by following the plan for treatment.

Under most instances, communication between the therapist and myself is confidential. Special, specific authorizations are required to breach the confidentiality of the treatment situation. (See above and below). However, Florida law mandates reporting of the following to the appropriate person, entity or agency: 1) actual or suspected child or elder abuse; 2) an expressed intent to take harmful or dangerous action against another; 3) expressed suicidal thoughts or desires. Additionally, I realize that should I raise the issue of my mental health in a legal proceeding, information about my treatment may necessarily be released according to law. These, notwithstanding, I further attest that I will never involve my therapist or this therapy in any legal proceedings, either pending or future, if it is within my legal control to prevent such involvement.

Every reasonable effort will be made to appropriately resolve these issues or to attempt to have me notified should this be possible, before such a compromise of my confidentiality is made. I have the right to terminate the therapeutic relationship at any time that I desire without fault. I give permission for my therapist to communicate with my primary care doctor to ensure coordination and continuity of my care.

I understand that I am financially responsible for treatment regardless of third party actions. I recognize that if I choose to utilize third party payments (insurance entities), I am also giving permission for the therapist to provide the required information about my treatment requested by the insurance company, its agents or managed care entities. Signing this document also authorizes submission of claims for insurance (if used) purposes as well. ***I realize I must cancel my appointment at least 24 hours in advance or I will be billed a cancellation fee of $100.00 for the missed session***.

I further realize that any insurance coverage for mental health services may be contractually limited in scope. It may also include a mandated short-term component. If this is the case and elective therapy is deemed desirable, every reasonable effort will be made to make appropriate financial arrangements or provide a referral, if necessary.

Also, relative to policy regarding between session telephone contact, please note the following; ordinarily, except for clarifying or modifying an appointment time, or in the rare instance of an extremely emergency situation, between session telephone contact will not be permitted or encouraged. In a life-threatening emergency, either 911 or the police should be called.

By prior agreement, telephone time may be formally scheduled. Such time will incur professional charges based on the time scheduled and will be billed accordingly.

By signing this consent, I am certifying that I understand and agree to its terms, either expressed or implied. I have been notified about the new federally mandated guidelines regarding privacy and offered the option to read a fuller description of the new HIPPA law regarding my PHI as it relates to outpatient mental health services.

______________________________ ______________________________

Client Signature Client Printed Name

____

Date