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Clients Rights and Responsibilities

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 patients about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

• The laws of the state of New York and professional ethics govern the protection of information discussed within therapy. Typically no information will be released to any party without my authorization. There are exceptions under the law that mandate the release of information. They include: if suicidal threats are made, or homicidal threats, and the threat is judged to be serious; if a minor child threatens to run away and risks self-endangerment; if a minor may have been involved in human trafficking, or discloses physical, sexual abuse or neglect, or if an adult reports being responsible for the physical, sexual, and neglect of a minor child. NYS law mandates that these incidents of abuse and neglect be reported to the appropriate agencies.

• Regarding fees and payments, I understand that depending on insurance coverage, I am responsible to make direct payments to the provider at the time the service is provided, or prior to. If I am using Insurance to cover any portion of my treatment, this will require prior authorization, and the release of diagnosis, treatment, and other health information that will be kept on record with my Insurance Provider. No refunds of session fees, or package rates will be granted. **Client Initials:** _____

• If bills become delinquent, and no diligent effort has been made to make payment arrangements, I understand that the practitioner has the right to terminate services, and also to contact an attorney or collection agency to secure payment. All session fees are collected prior to, or at the beginning of each session to be paid in the full amount. Sessions last 50-60 minutes, and if the session goes beyond that allotted time, I will be billed for a pro-rated amount of the full session fee. I understand that texting an email are for scheduling purposes only, as they are not HIPPA Compliant. **Client Initials:** _____

• In addition, phone calls in between sessions that last longer than 10 minutes will also be pro-rated based on the full session fee. Cash, and all major credit cards are acceptable. Any fees incurred due to insufficient funds on credit or debit cards, will be billed in the amount of $50 to the client. If an emergency should arise, I need to contact 911, or Crisis Services at 834-3131. If I anticipate becoming involved in a court case, it is recommended that I discuss this fully before I waive my right to confidentiality. If my case requires my therapist's participation, I will be expected to pay for the professional time required. **Client Initials:** _____

• *If I fail to cancel a scheduled appointment, this time cannot be used for another client, and I will be billed for the entire cost of my missed appointment.* A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice, unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Although there is no guarantee of effectiveness of treatment, the possibility increases with regular attendance and active participation. If I cancel two sessions, my therapist may choose to terminate our relationship, and will discuss this. If I choose to terminate counseling, I will communicate my intentions with my therapist. **Client Initials:** _____

Client Financial Responsibility (circle one): Self- Pay HSA/FSA Card Out of Network Insurance

Acceptance of Terms: I have read the conditions set forth above, agree to abide by these terms, and voluntarily consent to treatment for myself, and/or my child.

_____

Client (Print Name) **Date**

_____

Client /Legal Guardian (Signature) **Date**

_____

Name of Child who will receive treatment (Indicate if non-applicable) **Date of Birth**

Policy updated on 10/29/15