Welcome to Creative Healing

OFFICE INFORMATION

Creative Healing
1811 Bethlehem Pike
A102
Flourtown, PA 19031

Office Phone: 610-813-2575

Office Manager *(for receipt and billing requests)*: hello@creativehealingphilly.com

Clinical Director: Katie@creativehealingphilly.com

Therapist Contact Information:

- ❏ Bri Stairiker: bri.stairiker@creativehealingphilly.com
- ❏ Brie Ziegler: brie@creativehealingphilly.com
- ❏ Danielle Durante: ddurante@creativehealingphilly.com
- ❏ Hannah Heffner: hannah@creativehealingphilly.com
- ❏ Katie Durr: kdurr@creativehealingphilly.com
- ❏ Katie O'Dwyer: kodwyer@creativehealingphilly.com

Online Parent Portal: www.creativehealingphilly.com/parent-portal

Client Demographic Form

Client Name: _____ Age: _____

Date of Birth: _____School: _____ Grade: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Teen Cell Phone Number: _____

Parent Name: _____

Parent Phone Number: _____

Parent Email: _____

Legal Guardian Name: _____

Legal Guardian Phone Number: _____

Legal Guardian Email: _____

PART 1: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

- Child Abuse: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc.. If you reveal information relative to child abuse or child neglect, your therapist is required by law to report this to the appropriate authority.
- Vulnerable Adult Abuse: Vulnerable adult abuse or neglect. If you reveal information relative to vulnerable adult or elder abuse, your therapist is required by law to report this to the appropriate authority.
- Self-Harm: Threats, plans or attempts to harm oneself – your therapist may be permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information.
- Harm to Others: Threats regarding harm to another person. If you threaten bodily harm or death to another person, your therapist may be permitted by law to report this to the appropriate authority.
- Court Orders & Legal Issued Subpoenas: If your therapist receives a subpoena for your records, they will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. Your therapist will contact you twice by phone and send you an email or letter (if they cannot get in touch with you by phone). If a court of law issues a legitimate court order, your therapist is required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, your therapist is required to comply with a court order.
- Court Ordered Therapy: If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, the information/documentation that will be discussed/sent on your behalf will be discussed with you prior to information being sent to the court.
- Written Request: Your specific request, in writing, to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session (“psychotherapy notes”), your therapist may withhold such records from third party requests in compliance with Federal Privacy Rules, and depending on State law, you may not be entitled to a copy of the same. If therapy sessions involve more than 1 party, ALL parties over the age of 14 MUST consent to release of requested information prior to information being released.

- Fee Disputes: In the case of a credit card dispute, Creative Healing reserves the right to provide the needed and adequate documentation i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise your therapist otherwise.
- Parent Contact & "No Secret" Policy: When working with adolescents over age 14, all laws of confidentiality exist. We request that no parent attempt to persuade the therapist into keeping a "secret" that is detrimental to the goal of therapy for the adolescent identified client. An adolescent client will be informed when parent contact has been made (either as initiated by the parent or therapist.) If an adolescent and a parent call at the same time regarding the same situation, the adolescent's call will take precedence as the identified client. No details of the adolescent's treatment will be disclosed during a phone call with the parent.
- Dual Relationships & Public: Your relationship with your therapist is strictly professional. In order to preserve this relationship, it is imperative that you do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If you have contact with your therapist in a public setting, they will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, they may not be able to protect your confidentiality.
- Social Media: If you choose to connect with your therapist on any of our practice professional (not personal) social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. We will do our best to protect your identity. However, if you choose to comment on practice pages or posts, you do so at your own risk and Creative Healing cannot be held liable if someone identifies you as a client.
- Electronic Communication: Email offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist–client relationship. The following are some guidelines for contacting your therapist using e-mail. Do not use email for emergencies. If it's an emergency, consult with an emergency room. Email is not a substitute for seeing your therapist. If you think that you might need to be seen, you may email me to schedule and book an appointment or you may call the office. Emails should not be used to communicate sensitive medical or mental health information. Email is not confidential. Be aware that if you send emails from your work, your employer has the legal right to read your email. Email is a part of your record. Further,

texting also introduces some of the same challenges. Like email, it is not a substitute for seeing your therapist or making an appointment. Texting is not confidential. Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text. Further, your therapist cannot know the person who is texting is actually you, rather than another person who has possession of your phone.

- Phone and Video Sessions: For your convenience, or in times of inclement weather, Creative Healing is happy to offer you a phone or HIPAA compliant video sessions. Should you be unable to obtain transportation or should inclement weather make travel to the office difficult, your session may be kept by phone or secure video session to avoid disruption in services.

PART II: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. Your therapist will do their best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to help provide you with the most effective therapeutic services. We can make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. Your therapist may assign tasks between sessions related to your goals. Our commitment is to work as efficiently as possible, but at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals and will periodically review your progress toward them.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse

intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 45 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine from session to session how much longer therapy is recommended.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: *If you are prevented from keeping a scheduled appointment, you MUST notify your therapist (directly to their email address or by phone) 24 hours in advance. If we do not receive a 24-hour advance notice, you will be responsible for paying the full fee for the session you missed, and that such fee cannot be billed to your insurance company.* Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. Your therapist will, from time to time, take time off for vacation, to attend seminars, and/or become ill. We will attempt to give you adequate notice in advance and will arrange coverage for any emergencies by a colleague. If your therapist is unable to contact you directly due to circumstances out of their control, a colleague contact you to cancel or reschedule an appointment.

FEES: Your therapist's fee per session is $150. Payment is due at the time of the session in the form of exact-amount cash, check (made out to Creative Healing), or credit/debit card kept securely on file. In the event that you miss your scheduled appointment time or cancel less than 24 hours, your credit card or debit card on file will be automatically charged. By signing this document, you agree to such cancellation fees. All checks returned for insufficient funds will result in a $20 administrative fee in addition to the session fee due, to be paid in full by your next scheduled session.

Your therapist reserves the right to remove you from the schedule if more than 2 sessions are missed without proper notification. You will lose your preferred time slot and may need to schedule another intake session prior to returning for ongoing services.

Your therapist will charge the hourly rate in quarter hours for phone calls over 15 minutes in length, email correspondence, reading assessments or evaluations, writing

assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed to your credit/debit card on file.

Telephone and video therapy services offer people comfort and flexibility and are offered at our regular hourly rate.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if your therapist gets called into court by you or your attorney, which we strongly suggest not being involved in court in order to protect your confidentiality, you will be charged your therapist's full fee per hour, which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc. .

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records they will be dispensed at $1 per page. Payment for your medical records will be due prior or upon receipt of them and can be picked up at our office please allow at least 2 weeks to prepare your records.

PHONE CONTACTS AND EMERGENCIES: Our office manager is available Monday through Thursday from 12 to 6 PM and Fridays from 9 AM to 12 PM. Please call the office for questions or assistance during these times. If you need to contact your therapist directly, please email them, and they will get back to you within 48 hours. In emergency situations, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or or simply dial 911 if either you or someone else is in danger of being harmed.

EMERGENCY CONTACT:

It is necessary that Creative Healing has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number

☐ I agree to allow Creative Healing to contact my emergency contact on my behalf in the case of emergency

PART III: CONSENT

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with my therapist at Creative Healing. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Creative Healing to provide counseling services that are considered necessary and advisable.

2. Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Creative Healing to provide treatment to my minor child(ren). If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Creative Healing prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Parent	*Signature of Parent*	*Date*
Printed Name of Parent	*Signature of Legal Guardian*	*Date*

** Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. Since you initially received this paperwork through email it will be considered that you have an electronic copy.*

Credit Card Authorization

By completing the information below, you authorize Creative Healing to charge your credit card at the completion of each session if you do not submit cash or check at the time of service. You agree that no prior-notification will be provided unless the amount changes, in which case you will receive notice from Creative Healing at least 30 days prior to the new payment amount being collected.

Please complete the information below:

I _____ authorize Creative Healing to charge my credit card indicated below for the agreed upon session fee at the completion of services being provided. I also understand that cancellations charges as outlined in the cancellation policy will be automatically charged to my card on the date of a missed appointment if I do not provide 24 hours prior notice for cancellations.

Credit Card Number: _____

Expiration Date: _____ CVV # (Security Code) _____

SIGNATURE_____ DATE_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Creative Healing in writing of any changes in my account information or termination of this authorization at least 24 hours prior to my next scheduled session. I certify that I am an authorized user of this credit card/bank account and will not dispute these authorized transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in my signed agreement with Creative Healing.

Insurance Information (Optional)

Insurance:_____

Policy/ID #: _____Group #:_____

Effective Date: _____

Address on Insurance Card: _____

City: _____ State: _____ Zip Code: _____

Mental Health Phone Number: _____

Insured's Name: _____

Insured's Date of Birth: _____ Relationship to Client: _____

Insured's Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer:_____

Insured's Phone Number: _____

Creative Healing will initiate billing procedures with your insurance company. All professional fees are billed to the appropriate insurance provider shortly after services are provided. Fees generally cover individual, group and family sessions. Your insurance provider may send you a statement, an Explanation of Medical Benefits, for all of services. All client information is kept confidential in accordance with privacy policies. Legal and ethical requirements specify certain conditions when it is necessary to share information about the patient with other professionals. The client's insurance provider sometime requests clinical information to support payment. Insurance companies are responsible for keeping this information confidential as well.

I authorize Creative Healing to furnish information to my insurance carrier concerning my professional services rendered, and I understand that I am responsible for paying the amount not covered.

This assignment covers any and all benefits under private insurance and other health plans for services rendered. If services are out-of-network with my insurance company, I understand that I am responsible for the full fee of services provided up-front and that my insurance company will reimburse me directly for these services. I acknowledge that it is my responsibility to contact my insurance company and determine how much, if any, of these services will be reimbursed.

I authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed.

I have read, understood, agree, and consent to Creative Healing submitting claims to my insurance company on my behalf as stated in this agreement. I also understand that this agreement will remain in effect unless revoked by me in writing or will expire when treatment is discontinued.

Legal Guardian: _____Date: _____

Please complete so that we may coordinate care with your PSYCHIATRIST.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,_____ **DOB:**_____

hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

This information will be released/requested upon request to the following:

_____

First and last name and phone of person or organization

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Creative Healing

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): _____

To Be Requested * *from third parties*

_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): _____

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Creative Healing

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Creative Healing will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Creative Healing will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that Creative Healing will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Please complete so that we may coordinate care with your PRIMARY CARE DOCTOR.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,_____ **DOB:**_____
hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

This information will be released/requested upon request to the following:

_____

First and last name and phone of person or organization

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Creative Healing
_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): _____

To Be Requested * *from third parties*
_____Treatment Plans
_____Process Notes
_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): _____

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Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Please complete so that we may coordinate care with your SCHOOL COUNSELOR.

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Creative Healing * 1811 Bethlehem Pike, A102 * Flourtown, PA 19031

I,_____ **DOB:**_____

hereby give my permission to Creative Healing, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Pennsylvania or federal law.

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_____Letter(s) of Progress
_____Verbal Communication
_____Other (Specify): _____

To Be Requested * *from third parties*

_____Treatment Plans
_____Process Notes
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This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*
Printed Name of Therapist	*Signature of Therapist*	*Date*

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where your therapist is permitted or required to disclose information without either your consent or authorization. If such a situation arises, your therapist will limit their disclosure to what is necessary. Reasons they may have to release your information without authorization:

1. 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 psychologist-client privilege law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if they receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order your therapist to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, your therapist may be required to provide it for them.
3. If a client files a complaint or lawsuit against your therapist, they may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and your therapist is providing necessary treatment related to that claim, they must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. Creative Healing may disclose the minimum necessary health information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which your therapist is legally obligated to take actions, which they believe are necessary to attempt to protect others from harm, and they may have to reveal some information about a client's treatment:

1. If they know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires

that I file a report with the Pennsylvania Abuse Hotline. Once such a report is filed, your therapist may be required to provide additional information.

2. If they know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that your therapist file a report with the Pennsylvania Abuse Hotline. Once such a report is filed, they may be required to provide additional information.
3. If they believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, your therapist may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** – We may use and disclose your health information within Creative Healing as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Client's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, your therapist will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with your therapist. If you wish, Creative Healing will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with your therapist at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with your therapist in session before terminating or at least contact them by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI. They reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we am required to abide by the terms currently in effect. If we revise practice policies and procedures, we will provide you with a revised notice in office during session.

COMPLAINTS

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision they made about access to your records, you may contact Creative Healing, the State of Pennsylvania Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*

Phone/Online Session Informed Consent

I hereby consent to engaging in phone or secure online video sessions as part of my psychotherapy, should I be unable to obtain transportation or should inclement weather make travel to the office difficult, or should my therapist and I agree that this mode of treatment may best meet my individual needs.

I understand that phone and online sessions include the practice of counseling, consultation, treatment and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to phone and online sessions:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to phone and online sessions.. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the phone or online interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from phone and online sessions, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that phone and online psychotherapy services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will work with my therapist to find a time to come into the office for the recommended treatment to meet my goals. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from phone and online sessions, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Pennsylvania law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Printed Name of Client	*Signature of Client*	*Date*
Printed Name of Legal Guardian	*Signature of Legal Guardian*	*Date*