Informed Consent for Therapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

If you are unhappy with what is happening in therapy, I hope you will speak with me so that I can respond to your concerns. Such concerns will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, culture, color, gender, gender identity, sexual orientation, age, religion, or national origin. You have the right to ask questions about any aspects of therapy and my specific training and experience.

Confidentiality and Professional Records

Your therapy records are maintained in a secure electronic format. I adhere to strict confidentiality of professional mental health records and do not recommend that chart notes be

released to anyone (including the client) due to the sensitive nature of the material. I will often recommend a letter or summary of treatment or our work together if any records are needed for referral or reporting purposes. If you are requesting a review of your own records, I recommend that we review them together as psychotherapy records can be misinterpreted by untrained readers. **Please note, that in some cases insurance companies may require access to your specific records for audit and review purposes.** This request is beyond my control and as long as you agree for me to bill your insurance company, there is a potential for insurance companies to request a review of your records.

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. **Limitations of such client held privilege of confidentiality exist and are itemized below:**

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Please Note:

I will provide you with a google voice number and professional email to coordinate appointments. **This is not to be used as a crisis service or hotline.** If you are in a crisis, please call 911, go to your local emergency room, or contact the suicide hotline (988). I do my best to answer general inquiries; however, please allow 24-48 hours before receiving a response.

Signature:

Date:

Consent for Telehealth Services

CONSENT FOR TELEHEALTH SERVICES

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY DOXY.ME

Telehealth by Doxy.me is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature:

Date:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
2. a. For my use in treating you.
3. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
4. c. For my use in defending myself in legal proceedings instituted by you.
5. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
6. e. Required by law and the use or disclosure is limited to the requirements of such law.
7. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
8. g. Required by a coroner who is performing duties authorized by law.
9. h. Required to help avert a serious threat to the health and safety of others.
10. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
11. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. 10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Signature:

Date:

Appointment and Financial Agreement

This document contains important information about professional services and business policies.

I. APPOINTMENTS

Appointments will ordinarily be 45-60 minutes in duration, and frequency is dependent on therapeutic recommendations and scheduling availability. If you need to cancel or reschedule a session, I ask that you provide at least 24 hours' notice. You will need to contact me directly via text or phone. If you miss a session without canceling or cancel with less than 24 hours' notice, my policy is to collect a $50 fee for the missed or late canceled session unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee described above. If it is possible, I will try to find another time to reschedule the appointment. If you are running late for your appointment, please call or text me immediately and I will do my best to hold your appointment for you. Appointments are considered missed at the 15-minute late mark. I understand many things happen that are unavoidable, and I will do my best to work with you, but depending on my schedule and how late your expected arrival is, we may have to reschedule entirely. Chronic no-shows, late arrivals, missed appointments, or dropping from therapy without contact could result in the termination of therapy services without the guarantee that I could reinstate you to my caseload.

II. PROFESSIONAL FEES

If you're using an insurance plan, the standard fee for 53-60 minutes of therapy is $175. An initial intake session is $200. **If you're a self-pay client, we can negotiate a reasonable fee that works best for your financial situation.**

You are responsible for paying at the time of your session unless prior arrangements have been made.

If I am in-network with your insurance company, you are responsible for the portion of your copay, coinsurance, or deductible that the insurance company requires. If you are uninsured, underinsured, or I am out of network with your insurance company and the standard fees are beyond your ability to pay, we may work out arrangements for a reduced/negotiated rate based on your financial circumstances.

Additional fees are charged for lengthy telephone communications, court attendance, letter/report writing, and medical records requests. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

If I receive a subpoena for your records or engage in any court-related activities regarding your case, I retain the right to seek legal advice regarding your case.

At any time during treatment should you become ineligible for insurance coverage, the client and/or responsible party agrees to notify me and will be responsible for 100% of the bill. I reserve the right to retain a professional collection agency for the pursuit of accounts that become delinquent.

III. INSURANCE

If I am a participating provider with your insurance company, you are expected to take care of your remaining fees: deductibles, copays, coinsurance, etc. as services are rendered. These fees are non-negotiable. Insurance companies have variable coverage of outpatient/office setting psychotherapy and verification of coverage will be required before our initial appointment, and I will conduct verification as a courtesy to you. If I am a participating provider with your insurance company, and your treatment has been preauthorized, I will bill your insurance company directly for the services provided. If you are using out-of-network benefits, I may or may not be able to bill your insurance company directly. Please understand that insurance companies only reimburse for services that meet "medical necessity" which means a thorough assessment must be conducted and a diagnosis assigned before insurance companies will pay or authorize visits. This is why it is important to also complete any intake forms or questionnaires that I may assign as obtaining this information is part of the assessment and diagnosis process. Unfortunately, there are times that I may be listed as a participating network provider with your insurance company, but your particular plan either has exclusions to the type of provider that is seen, the type of setting where treatment occurs, or has contracted out mental health benefits to an entirely different company that I may not be in-network with. I always try to determine this before we meet, but sometimes this information is not clear until the initial claim is filed. I will notify you immediately if there is a concern with your insurance company.

By signing this consent, you are agreeing for me to bill 3rd party companies on your behalf (your insurance, EAP, or other designated persons) to pay for your treatment. If you are paying by credit/debit card for your portion of the cost, you agree for me to charge your card; and/or send an electronic invoice/payment request so that your card can be charged; and/or save a card electronically for your card to be charged.

Signature:

Date:

LAROSA COUNSELING
PLLC

Medical Release Form

HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Date of Birth:

Date:

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

II. AUTHORIZATION. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

- ☐ - All of my medical-related information.
- ☐ - My medical information ONLY related to:
- ☐ - My medical-related information from
- ☐ - Other:

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to: (check one)

- ☐ - Any party that is approved by the Authorized Party.
- ☐ - ONLY the following party:

Name:

Address:

Phone:

Fax:

Email:

IV. PURPOSE. The reason for this authorization is: (check one)

- ☐ - General Purpose. At my request (general).
- ☐ - To Receive Payment. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.
- ☐ - Other:

V. TERMINATION. This authorization will terminate: (check one)

- ☐ - Upon sending a written revocation to the Authorization Party.
- ☐ - On the following date:
- ☐ - Other:

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures made based on my original permission cannot be returned.

I understand that Medical Records and information used or disclosed with my permission may be redisclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to participate in a research study), and I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

- ☐ - I consent to have the above information released.
- ☐ - I do not consent to have the above information released.

Signature of Patient/Guardian:

Date:

Print Name: