Choices Counseling and Advocacy Center Demographic Form

Patient First Name: _____ Middle Initial: _____ Last Name: _____

If minor, name of parent or guardian: _____

Date of birth: _____/_____/_____ Last 4 of SSN: _____

Gender: _____ Race: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Employment status: _____ Work Phone Number: (_____) _____

Emergency Contact Information:

Name: _____ Relationship to client: _____

Phone Number: _____

May we contact this person regarding appointment details and scheduling? ☐ YES ☐ NO

If you would like them to receive appointment information, please list their email address: _____

Verification of Insurance: Please fill out the information as listed on your insurance card if applicable.

Primary Insurance: _____ Name of Insured: _____

Relationship: _____ Date of birth: _____ Social Security Number: _____

Member/ Insurance Number: _____ Group Number: _____

Insurance Address: _____ Insurance Phone Number: _____

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/ RECORDS

I, client or parent/guardian of client _____ **Client's DOB:** _____

hereby give my permission to **Choices Counseling and Advocacy Center, LLC** to release or request information within in my medical records from a third-party. This information may be released requested to _____ (name of person/ organization) for the purposes of _____.

____(initial) 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.
____(initial) 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 federal law.
____(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 **Choices Counseling and Advocacy Center, LLC**.
____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Choices Counseling and Advocacy Center, LLC** 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 **Choices Counseling and Advocacy Center, LLC.** Choices Counseling and Advocacy Center, LLC will not be held liable for information disclosed to another party per the client's request.
____(initial) I understand that **Choices Counseling and Advocacy Center, LLC** 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.

The type of information to be disclosed/requested is as follows (Please check the appropriate options):

To Be Released * *from* ***Choices Counseling***

____Treatment Plans
____Process Notes
____Health/Medical Records (if applicable)
____Letter(s) of Progress
____Bio Psychosocial Evaluation/Assessment (if applicable)
____ Verbal Communication
____Other (Specify): _____

To Be Requested * *from third parties*

____Treatment Plans
____Process Notes
____Health/Medical/Academic Records
____Psychological/Psychiatric Evaluations/Assessments
____Court Documents
____Verbal Communication
____Other (Specify): _____

Release:

_____

Client/ Guardian Signature and Date

Request:

_____

Client/ Guardian Signature and Date

111A Library Hill Lane Lexington, SC, 29072

Ph- (803)851-4049 Fax- (803)785-4948

PART I: THERAPEUTIC PROCESS
THERAPY CONSENT, POLICIES, & AGREEMENT

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all people involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than you expected. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies, and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited to your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaboratively identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly, biweekly, or monthly for 45-60 minutes depending upon the nature of presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

By signing below, you agree and understand the therapeutic process.

_____ _____

Signature **Date**

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PART II: Fees and Cancellations

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment in advance of 24hr of the scheduled appointment time. A fee of $50 will be applied for late cancel/No show.*** ***If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. Each insurance panel has a different policy on whether clinicians can charge for missed appointment/s. Check your insurance provider's policies regarding cancellations and/or no shows.***

The clinician reserves the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES: The fee for each 60 minute (MAX) therapy session out of pocket is $202 for initial appointments and $185 for each reoccurring session. If your insurance is accepted, a $20 copay is required, with the exception of Medicaid insured. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 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. Payment due at request of documents.

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. If I get called into court by you or your attorney, you will be charged a fee of $250 per hour to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $15 for up to 50 pages and $30 for up to 100 pages. Payment for your medical records will be due at the time of the request and can be picked up at the office or securely sent electronically. Please allow at least 2 weeks to prepare medical records. A request form must be completed prior to fulfillment.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 9am-5pm, Mon-Thurs. If you need to contact the clinician for any reason please call 803-851-4049, leave a voicemail, and a return call will be returned in the order it was received, or within 2 business days. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 988. If either you or someone else is in danger of being harmed, dial 911. South Carolina Mobile Crisis 833-364-2274.

Initial Intake Assessment	$202
Individual Counseling 60 minutes	$185
Family Psychotherapy	$163
Psychological Testing	$455
Reunification Services	$2,040
Group Counseling: Psycho-Educational	$30/ per class
Group Counseling: 6-week course	$1,245
Court Testimony: Clinician	$250/ hr
Request for Medical Record <50 pages	$15
Request for Medical Records >50 pages	$30
Adult Medicaid Co-Payment	$3.40
Minor Medicaid Co-Payment	N/A

Minimum Co-Payment with the exception of Medicaid	$20
Cancellation Fee (Late Cancellation/No Show)	$50.

Please initial the following that applies to you:

_____*I do not have Insurance*. I understand payment is due at time services are rendered. I also understand that I am responsible for all payments to be made in full.

OR

_____*I have Insurance*. Based on information provided by my insurance company and my portion of the fee at the time of service, **my deductible is estimated to be:**

- ☐ Met
- ☐ Not met
- ☐ Unknown

OR

_____ The agency I was referred from is supposed to cover the cost of my services.***

****** Please note that if services are left unfinished, the agency may not cover it, and the client will assume responsibility for payments. Late cancellations/ no show fees and any other additional fees are NOT covered by State Agencies and will require out-of-pocket payment.******

By signing below, you agree and understand the fees and cancellation policies.

_____ _____

Signature **Date**

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PART III: 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 about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Prenatal Exposure to Controlled Substances**: Therapist must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Minors/ Guardianship**: Parents or legal guardians of non-emancipated minor clients have access the clients' records.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected of being a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists

as our work and your goals then become counterproductive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone. Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone. **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

By signing below you agree and understand the limitations on confidentiality and understand the ways to protect your private health information.

_____ _____

Signature **Date**

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PART IV: HEALTH INSURANCE

YOUR INSURANCE COMPANY: By using insurance, I am required to give a mental health disorder diagnosis that goes on your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

IMPORTANT: Some psychiatric diagnoses are not eligible for reimbursement (ie: marriage/couples therapy). **Choices Counseling and Advocacy Center, LLC** reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY: When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. If insurance is requesting information for continued services, confidentiality cannot be guaranteed. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS: Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance.
2. Company (mis)control of information when claims are processed.
3. Loss of confidentiality due to the increased number of people handling claims.
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is important that you're an informed consumer. This allows you to take charge regarding your health and medical record. At times, having a diagnosis can be helpful (ie: a child needing extra services in the school system or a person being able to receive disability). It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples' therapy.

- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify the continuation of services. Confidentiality cannot be guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates whether treatment will or will not be covered.

Note: Personal information might be added to national medical information data banks regarding treatment.

By signing below, you agree to and understand the risks associated with submitting to insurance, as well as additional fees that may arise. Please refer to the provider's policies and information for additional fee and diagnosis coverage.

_____ _____

Signature **Date**

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PART V: CONSENT

1. I have read and understand the information contained in the **Therapy Agreement, Policies and Consent**. I have discussed any questions that I have regarding this information with Choices Counseling and Advocacy Center, LLC. 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 Choices Counseling and Advocacy Center, LLC to provide counseling services that are considered necessary and advisable.

2. I authorize the release of **treatment and diagnosis information (as described in Part IV, above)** necessary to process bills for services to my insurance company, and request payment of benefits to Choices Counseling and Advocacy Center, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Choices Counseling and Advocacy Center, LLC may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

By signing below, you agree to the therapeutic agreement and insurance policies. You agree that you have read and received a copy of these records (PER REQUEST).

_____ _____

Signature **Date**

3. **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 Choices Counseling and Advocacy Center, LLC 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 Choices Counseling and Advocacy Center, LLC 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. ***Please only fill out the information below if the minor child is the client.***

_____ _____

Printed Name of Minor Child **DOB**

_____ _____

Signature **Date**

PART VI: 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 protection and patient 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 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 I can have 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 patient and a therapist. In most situations, I 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 I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. ***Please see Part III: Confidentiality for additional limitations on confidentiality.***

Use and Disclosure of Protected Health Information:

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

Patients' Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***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 insurance. I 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, I am 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 $15 for the first 50 pages, and $30 for 50 or more pages. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I 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 I will decide if it is and if I refuse to do so, I 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 complete 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. At your request, I 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; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with the names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me 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. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

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

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of South Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Your signature below indicates that you have read and agreed to these terms. This serves as an acknowledgement that you have received a HIPAA notice form described above.

_____

Client/ Legal Guardian Signature *Date*

_____

*Witness – **Choices Staff*** *Date*

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