Harmony Counseling Services

257 Mercer Street. Harmony, PA 16037

Client Rights and Responsibilities

(Therapist Name)_____Qualifications:_____

I have the following rights/responsibilities throughout the therapeutic process to include:

1. Non-discriminatory therapy regardless of my race, religion, socio economic background, sexual orientation, and physical restrictions.
2. Review my therapist's credentials and experience.
3. Be fully informed about costs, appointment times and confidentiality.
4. Be fully informed about the goals of therapy and the methods used to reach those goals.

In addition to the above mentioned rights I, as a client, am responsible to:

1. Arrive for all appointments on time. If a session needs to be cancelled, 24-hour notice must be given to the therapist. You will be billed $50.00 for any session that is not cancelled without a 24 hour notice.
2. Payment or Co-payment must be made at the time of the therapy session.

The therapist must maintain full confidentiality about therapy sessions. No information will be released to anyone without the client's written consent. The consent form is time limited and specific in terms of what can be released and to whom. Confidentiality can only be breached, according to state law, when child abuse is reported or a person's life or safety is threatened. Under this conditions, the therapist mandated to report the child abuse and/or intent with plans to commit suicide or homicide to the appropriate authorities.

I understand my responsibilities/rights of this contract and will abide to its contents.

In emergencies, contact 911 or your general doctor. If you are in crisis during nights and weekends, please contact your county's mental health hotline:

Butler: 1-800-292-3866 Beaver: 1-800-400-6180 Allegheny (Resolve): 1-888-796-8226

CLIENT:_____DATE:_____

THERAPIST:_____DATE:_____

INFORMED CONSENT

Your therapist works with a group of independent mental health professionals, under the name Harmony Counseling Services. This group is an association of independently practicing professionals that share certain expenses and administrative functions. While the members share a name and office space, your therapist is completely independent in providing you with clinical services, and they alone are fully responsible for those services. Each therapist's professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

NOTICE OF PRIVACY PRACTICES

This notice was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Effective date of this notice is March 1st, 2016. Harmony Counseling Services is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting business, our practice will create records based upon your treatment and services provided to you.

The Use and Disclosure of Protected Health Information (PHI):

1. Treatment. This may include communicating with other health care providers regarding your treatment.

For example, your therapist may use and disclose information when you need a referral for other health care services, or to receive authorization to begin services.

2. Payment. Generally, your therapist may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services, your therapist may share information about these services with your insurer to assure that services are covered.

3. Release of Information to Family/Friends. Your therapist may disclose information about you to a relative, or any other person you identify if that person is involved in your care and the information is relevant to your care. Where the client is a minor, for instance, I may disclose information about the minor to a parent, guardian, or other person responsible for the minor except in limited circumstances. Your therapist may also disclose information about you to a relative or other person involved in your care if there is an emergency situation, and I need to notify someone of your location or condition. You may request that your therapist not disclose information to persons involved in your care. Your therapist will generally comply with your request, unless there is an emergency, or if the client is a minor the non-custodial parent must give consent to treatment.

4. Disclosures required by Law. I may use and/or disclose information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an

opportunity to agree or object. Those circumstances include when you disclose that you will hurt yourself or others.

• Judicial or Administrative Proceedings when the use and/or disclosure is required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceedings, or when the disclosure relates to victims of abuse, neglect or domestic violence.

• Health Oversight Activities. For example, we may disclose information about you to a state or federal health oversight agency which is authorized by law to oversee our operations or to assure the public health.

• Law Enforcement Purposes. For example, we may disclose information about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries, or in reporting of missing persons.

• Serious Threat to Health or Safety. For example, we may disclose information about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

• Correctional Institutions and in other Law Enforcement Custodial Situations. For example, in certain circumstances, we may disclose information about you to a correctional institution having lawful custody of you.

• Notification. I may notify a family member or other person you have noted as emergency contact of your general condition. If you are unavailable, for example, because you incapacitated, I cannot reach you for several days, or because of some other emergency circumstance, your therapist will use professional judgment to determine what is in your best interest regarding any such disclosure.

• Minors. If you are an un-emancipated minor under Pennsylvania law, there may be a circumstance in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with legal and ethical responsibilities.

• Parents. If you are a parent of an un-emancipated minor and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances.

• Personal Representative. If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

5. Instances where we may use or disclose health information about you with your authorization. We will obtain authorization (written permission) from you for any release of information

beyond the general consent for the above listed specific disclosures. You may revoke all such authorizations at any time, provided each revocation is in writing.

You have Several Rights Regarding your Protected Health Information

1. You have the right to request restrictions on uses and disclosures of information about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Department of Health and Human Services, and uses and disclosures described in the previous section of this Notice.

2. You have the right to request different ways in which we communicate with you. You have the right to request how and where we contact you. For example, you may request that we contact you at your work address or phone number or by email.

3. You have the right to request to see and receive a copy of information in your clinical record. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You have the right to request amendments or changes to clinical, billing and other records used to make decisions about you. If you believe that we have information that is either inaccurate or incomplete, we may add information to indicate the problem and notify others who have copies of the inaccurate or incomplete information.

4. You have the right to receive a written list of disclosures about you. You may ask for disclosures made up to six (6) years before your request. We are not required to include disclosures:

• For your treatment;

• For billing and collection of payment for your treatment;

• For health care operations;

• Authorized by you, or which are made to individuals involved in your care;

• Allowed or required by law when the use and/or disclosure relates to certain specialized

government functions;

• As part of a limited set of information which does not contain certain information which would identify you. The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure.

5. You have the right to request a paper copy of this Notice at any time.

6. You have the right to request restrictions on uses and disclosures. You have the right to request that we limit the use and disclosure of information about you for treatment, payment and health care purposes.

Filing a Complaint: If you think your privacy rights have been violated or that you have been treated unethically you may send a written complaint to the Department of Health and Human Services at:

Office for Civil Rights

US Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

If you file a complaint, we will not take any action against you or change your treatment in any way. When you have had these rights explained and received a copy, please sign the attached form.

Printed Name:_____

Signature:_____ Date:_____