

Compass Counseling Services, LLC

3575 Forest Lake Drive, Suite 100

Uniontown OH 44685

**PLEASE READ THE CONSENT AND PRIVACY PRACTICES CAREFULLY!**

**Informed Consent**

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 framework for our work together. Do not sign unless you completely understand and agree to all aspects. If you have any questions, please discuss them with me. When you sign this document, it will represent an agreement between us. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

**The Therapeutic Process**

You have taken a very positive step by deciding to seek therapy. Potential risks of therapy may include, but are not limited to, an increased level of distress, heightened emotions, or changes that may be seen as negative, and changes in relationships. In some cases, client's symptoms become worse during therapy. Throughout the process of therapeutic change, it is not uncommon for clients to reach a point of change where they may feel they are different and no longer able to be the same person they were upon entering therapy. At times these feelings can be unsettling.

Benefits of therapy may include but are not limited to, a higher level of functional coping, solutions to specific problems, new insights into self and others, more effective means of communicating in relationships, symptomatic relief, and improved self-esteem. Individuals may gain insight into personal issues, positive behavior changes, and increased clear internal thoughts.

**Notice of Privacy Practices- Brief Version (extended version available upon request)**

Health information about you is personal. I am committed to protecting health information about you. No Audio or Video recordings are permitted without consent of all parties involved (staff and client). A medical record of the services you receive is kept recording your treatment and to comply with certain legal requirements. The session content and all relevant materials to the client's treatment will be held confidential, with certain limitations.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

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. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a way there is a substantial risk of incurring serious bodily harm.
3. If a client threatens grave bodily harm or death to another person.
4. 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 , sexual abuse or neglect of children under the age of 18 years, an elderly person, or cognitively disabled individual.
5. Learned information of suspected neglect or abuse of any animals.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena. For judicial and administrative proceedings, including responding to a court or administrative order.
7. If a client is 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.
8. The client's treatment team providers such as, but not limited to, additional therapist, case manager, psychiatrist, primary care provider (doctor), or prescribing provider for medication management.
9. For health oversight activities, including audits and investigations.
10. Crimes occurring on Agency premises.
11. For workers' compensation purposes.
12. In the event you are unable to provide consent in an emergency, the emergency contact provided by you will be notified of your condition. This will be at therapist/staff discretion.
13. Appointment reminders and health related benefits or services.
14. If there is a need to consult with other professionals for case consultation in order to provide the best treatment for you information about you may be shared without using your name or identifying information.

15. Federal privacy rules allow health care providers who have direct treatment relationship with the client to use or disclose the 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.

16. While operating this practice we contract with various external vendors. In these cases we have a HIPAA business associate contract in place with our vendors. Steps are taken to protect your PHI in compliance with Hipaa guidelines. If you have any concerns or further questions, please talk to your therapist or Compliance staff at Compass Counseling Services LLC.

17. Psychotherapy Notes. I do keep "psychotherapy notes" and any use or disclosure of such notes requires your Authorization EXCEPT the use or disclosure is:

- a. For my use in treating you.
- 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.
- c. For my use in defending myself in legal proceedings instituted by you.
- d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- e. Required by law and the use or disclosure is limited to the requirements of such law.
- f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- g. Required by a coroner who is performing duties authorized by law.
- h. Required to help avert a serious threat to the health and safety of others.

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

I may provide minimal PHI to a family member, friend, or other person that **YOU** indicate is involved in your care regarding the payments for your health care, unless you object in whole or in part. The minimum information will be given, for example, that you attend, and a copay is collected. The opportunity to consent may be obtained retroactively in emergency situations.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for in full.
3. The Right to Choose How I Send PHI to You.
4. The Right to See and Get Copies of Your PHI, other than "psychotherapy notes"
5. The Right to Get a List of the Disclosures I Have Made.

6. The Right to Correct or Update Your PHI.
7. The Right to Get a Paper or Electronic Copy of this Notice.

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.

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 brief version of HIPPA Notice of Privacy Practices and may request the extended version at any time.