

# Daring Minds Therapy Client Agreement, Consent, and HIPAA Compliance

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## Client Information

**Client Full Legal Name:** \_\_\_\_\_

**Date of Birth (MM/DD/YYYY):** \_\_\_\_\_

**Home Address (Street, City, State, ZIP):**

\_\_\_\_\_

**Primary Phone Number:** \_\_\_\_\_

**Secondary Phone Number (if applicable):** \_\_\_\_\_

**Email Address (for administrative use only):** \_\_\_\_\_

If this form is being completed by someone other than the client, please provide the following:

**Name of Person Completing Form:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

\_\_\_\_\_

### 1. Consent to Treatment

I authorize Daring Minds Therapy to provide mental health and/or substance use treatment services. I understand that psychotherapy has both benefits (e.g., reduced distress, improved relationships) and potential risks (e.g., increased uncomfortable emotions such as sadness or anxiety). Success in therapy requires active effort, including work outside of sessions. The first 2–4 sessions will evaluate my needs, establish goals, and develop a treatment plan. I am encouraged to discuss concerns and may request a second opinion.

**Initials:** \_\_\_\_\_

I understand that therapy documentation may involve the use of **HIPAA-compliant Artificial Intelligence (AI) tools** solely for **administrative and documentation support purposes**. These tools may assist with organizing content or transcribing information during or after sessions, but:

- **No diagnostic decisions or clinical judgments are made by AI systems.**
- **All notes are reviewed, edited, and finalized solely by a licensed clinician.**

Use of these tools complies with the **HITECH Act, HIPAA, and CMS documentation guidance**. I understand this process helps ensure secure, accurate, and complete records. Policies may change, and updated copies will be made available upon request.

**Updated: Feb 16, 2026**

**Initials (AI Documentation Consent):** \_\_\_\_\_

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## 2. Telehealth Ethical and Security Guidelines

Daring Minds Therapy offers services using secure, HIPAA-compliant telehealth platforms. These services comply with the Nebraska Telehealth Act, Nebraska Medicaid regulations (471 NAC 10), and ethical standards outlined by the American Counseling Association (ACA) Code of Ethics (Section H). I understand and consent to the following:

- **Informed Choice & Disclosure (H.2.a):** I have the right to choose whether or not to receive services via telehealth and may revoke consent at any time without penalty or loss of access to future in-person care or services.
- **Confidentiality Limits (H.2.b):** Telehealth sessions may carry privacy risks, such as unauthorized access to electronic information. Daring Minds Therapy takes all reasonable steps to minimize these risks using HIPAA-compliant systems.
- **Technology Limitations (H.2.c):** I understand that, while reasonable safeguards are in place, no system is 100% secure. Technical problems (e.g., poor connectivity or video/audio failure) may occasionally disrupt care.
- **Platform Security (H.2.d):** Daring Minds Therapy only uses encrypted, secure, HIPAA-compliant systems for telehealth delivery, including real-time, two-way interactive video and/or audio communication.
- **Presence & Participation:** I will be notified of anyone physically or electronically present during the session. I may exclude any person at either site at any time.
- **Emergency Planning:** I agree to participate in telehealth services from a secure, private location where emergency services are available if needed. In the event of an emergency during a session, my provider will follow crisis protocols and emergency contact information I have provided.
- **Alternatives to Telehealth:** If I decline or withdraw from telehealth services, I may request to receive care in person, or my provider may offer referrals to local providers for in-person treatment, as appropriate.
- **Confidentiality Protections:** All existing legal confidentiality protections apply to telehealth services under HIPAA, HITECH, and 42 CFR Part 2 (where applicable). My records will not be shared without written consent except as required by law.
- **Access to Records:** I have the right to request and obtain copies of records related to my telehealth services.

- **Duration of Consent:** This consent is valid for up to six (6) months from the date of signature and will apply to all follow-up sessions with the same provider unless revoked earlier in writing.
- **Clinical Documentation:** This signed consent will be included in my medical record as required by law.

**Initials (Telehealth Consent):** \_\_\_\_\_

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### 3. Client Rights

I have the right to receive treatment free from discrimination, abuse, neglect, or harassment. My rights under federal (HIPAA, HITECH, 42 CFR Part 2) and Nebraska law include:

- The right to respectful, qualified care with provider credentials available.
- The right to clear billing practices and to participate in treatment decisions.
- The right to revoke a consent for information release in writing (not retroactive).
- The right to confidentiality and to access my records within 5 business days of a written request to Daring Minds Therapy. Daring Minds Therapy owns clinical records; copies are available for a reasonable fee under Nebraska law.
- The right to file grievances without retaliation through: Nebraska DHHS, 1033 “O” St, Lincoln, NE 68508 | 402-471-0175

**Note:** Clients under age 19 (unless emancipated) require parental consent. Parents may access records unless restricted by law. Substance use records are protected under 42 CFR Part 2 and require written consent or a court order. Records are retained for at least 7 years after the final date of service.

**Initials:** \_\_\_\_\_

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### 4. Client Responsibilities

- I agree to pay all applicable fees, including copayments, deductibles, and any no-show or late cancellation fees permitted by law and my insurance plan.
- I agree to submit to a breathalyzer if clinically requested and applicable.
- I am responsible for the cost of emergency services or intentional property damage.

- I agree to follow all safety policies: no weapons, substances, harassment, or violence on the premises or during therapy-related activities. Non-compliance or non-payment may result in discharge, with referrals provided upon request.
- I understand that service animals are permitted under Nebraska state and federal laws. Emotional support animals are not recognized as service animals and are not permitted on premises unless otherwise protected by law and/or approved by the provider.

**Initials:** \_\_\_\_\_

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## 5. HIPAA Compliance and Privacy

I acknowledge that I have received, read, or been offered the **Notice of Privacy Practices**, which explains how my Protected Health Information (PHI) may be used or disclosed for treatment, payment, or health care operations, as permitted by HIPAA and the HITECH Act. **I understand that a full Notice of Privacy Practices is available at any time and that I have the right to request clarification or ask questions about its contents.**

I consent to these uses and disclosures, including limited de-identified data for internal quality improvement or training purposes.

I understand that:

- Electronic records are securely stored using encrypted platforms.
- Confidentiality may be broken if required by law (e.g., abuse, threats to self/others, court order).
- I may request restrictions on how my Protected Health Information (PHI) is used or disclosed. However, Daring Minds Therapy is not required to accept these restrictions unless legally obligated—for example, if I pay for services entirely out-of-pocket and formally request in writing that information not be shared with my insurance provider.
- If I use insurance or Medicaid to pay for services, I understand that my insurer or Medicaid Managed Care Organization may request access to all relevant clinical records, including psychotherapy notes, for purposes such as utilization review, quality assurance, medical necessity verification, or compliance audits. By consenting to treatment and using insurance, I agree to these disclosures as required under applicable law and my insurance plan.
- I may revoke this consent in writing at any time, except to the extent that actions have already been taken based on prior consent.
- Email and text communication may not be fully secure, and I accept this risk for administrative convenience.

**Updated: Feb 16, 2026**

## Additional Confidentiality Protections for Substance Use Disorder Records

- If my treatment includes assessment, diagnosis, or services related to Substance Use Disorder, those records are protected under federal law (42 C.F.R. Part 2) in addition to HIPAA.
- I understand that:
  - These records may not be disclosed without my written authorization except as permitted by law.
  - I may revoke such authorization at any time in writing, except to the extent that action has already been taken in reliance on it.
  - Federal law prohibits the use of Substance Use Disorder records to discriminate against me in employment, housing, health care access, court proceedings, or public benefits.
- Redislosure Notice:

This information may include records protected under 42 C.F.R. Part 2. Federal rules prohibit you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.
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**Initials:** \_\_\_\_\_

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## 6. Billing and Insurance

Copays, deductibles, and self-pay fees are due at the time of service unless otherwise agreed upon in writing between the clinician and client. I understand I am financially responsible for all services not covered by insurance. Balances are due within 30 days of the date of service. A \$10 monthly finance charge may apply to balances exceeding 120 days. Accounts with unpaid balances after 120 days may be referred to a third-party collections agency. Returned checks may be subject to applicable bank fees.

A \$75 no-show or late cancellation fee will apply for any missed appointments without at least 24 hours' advance notice. Clients whose services are covered by Nebraska Medicaid will not be charged no-show or late cancellation fees. To support continuity of care, clients are encouraged to attend scheduled appointments and provide at least 24 hours' notice if they need to cancel or reschedule.

Repeated missed appointments or cancellations may result in a review of treatment needs and, if appropriate, discharge from services in accordance with the practice's attendance policy.

I authorize Daring Minds Therapy to submit insurance claims on my behalf and to release necessary medical information for billing purposes. I assign insurance benefits to Daring Minds Therapy and understand that I remain financially responsible for any charges not paid by my insurance carrier, except where prohibited by law.

**Initials:** \_\_\_\_\_

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## 7. Good Faith Estimate & No Surprises Act Notice

Updated: Feb 16, 2026

Under the No Surprises Act, you have the right to receive a Good Faith Estimate (GFE) explaining the cost of your care if you are uninsured or not using insurance. You may request a GFE at any time. If actual billed charges exceed your GFE by \$400 or more, you may file a dispute.

**Note:** This notice does **not apply to clients actively enrolled in Medicaid**, as they are not billed directly for services.

To learn more or begin the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059.

This estimate is not a contract and does not obligate you to receive services. Actual costs may vary based on your treatment needs.

**Initials:** \_\_\_\_\_

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## 8. Office Policies

- **Hours:** Monday–Thursday, 8 AM–5 PM (some Fridays available)
  - **Phone Calls:** Calls over 10 minutes may be billed at \$10 per 10-minute increment
  - **Letters/Forms:** Require a minimum of 72 hours’ notice
  - **Emotional Support Animals:** ESA letters are reviewed on a case-by-case basis. However, our providers generally do not issue ESA letters as part of standard clinical practice.
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## 9. Custody and Consent for Treatment

Daring Minds Therapy does not conduct custody evaluations or provide recommendations related to legal custody matters. In cases involving shared custody, a current parenting plan must be provided, and written consent is required from all parties who hold legal decision-making authority before therapeutic services can begin.

**If legal custody changes during treatment, the client/guardian agrees to provide updated legal documentation within 14 days.**

**Initials (if applicable):** \_\_\_\_\_

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## 10. Emergency Contact

In case of emergency, I give permission for Daring Minds Therapy to contact:

**Name:** \_\_\_\_\_

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**Updated: Feb 16, 2026**

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

This information may be used only in emergencies or for safety purposes.

**Initials:** \_\_\_\_\_

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### 11. Communication Preferences

I understand that Daring Minds Therapy may use phone, voicemail, text, or email for administrative purposes such as scheduling. I may indicate my preferences below:

- May we contact you to confirm appointments?  YES  NO
- May we leave voicemail/text messages?  YES  NO

These preferences can be updated at any time by notifying your provider.

**Initials:** \_\_\_\_\_

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### 12. Agreement and Release

I have read and understood this agreement and have received a copy. I understand treatment may be conditioned on acceptance of these terms. I release Daring Minds Therapy from liability for injuries occurring on premises or during services, except in cases of gross negligence or willful misconduct.

**Printed Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### Record Request Contact

Submit requests to:

**Daring Minds Therapy**  
Attn: Records Coordinator  
5550 S. 59th St. Suite 11  
Lincoln, NE 68516

Requests are processed within five business days in accordance with Nebraska law.

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