Amber Sky Counseling Services, Suzanne Jafferian, PhD, LMHC

HIPAA and Confidentiality, Patient's Rights, Consent to Treat

NAME: _____
DOB: _____
DATE: _____

Client Notice of Confidentiality and HIPAA:

Your therapist is required by Massachusetts Law (Chapter 112: Section 135B and Federal Law 45 CFR; HIPAA, 1996) that you are made aware of how your personal information may be used and disclosed and how you can access this information. Your specific written permission is needed for the release of any information to another individual or agency. However, there are a number of exceptions to this rule according to Massachusetts and Federal Law:

- Confidentiality will be breached without a client's permission if the therapist believes that a child, an elderly person, or a disabled person is being abused (in which case a report must be filed with an appropriate state agency).
- If a client threatens to harm him/herself, the therapist may be required to contact family members or others or to seek hospitalization for him/her.
- If in the therapist's professional judgment a client is threatening serious harm to another person, the therapist is required to take protective actions, which may include notifying the potential victim(s), notifying the police, or seeking the client's hospitalization.
- If you are under 18 years of age or under legal guardianship, please be aware that while specific content of your communications will remain confidential, your parent(s) or guardian(s) have a legal right to receive general information about how your treatment is proceeding.
- Your therapist consults regularly with other professionals regarding her clients. The consultant is legally required to maintain confidentiality. In addition, during consultations, the therapist makes every effort to maintain standards of confidentiality by not revealing identifiable information, unless otherwise specified.
- Lastly, your therapist may be required to comply with a legitimate court order in a judicial court proceeding.

The confidentiality of patient records maintained by your therapist is protected by Federal and/or State law and regulations, specifically, The Health Insurance Portability and Accountability Act (HIPAA). This is a summary of HIPAA. Please go to www.hhs.gov for more information or ask for a copy. You have the right to request these records. Generally, your therapist may not share treatment notes or patient information unless:

1) written consent is given,
2) the disclosure is allowed by a court order,
3) the disclosure is made to medical personnel in a medical emergency,
4) the patient's insurance company requests proof of treatment,
5) a collection agency is contacted due to non-payment of services,
6) disciplinary actions are being taken by client against the provider
7) in the event of a death while in treatment, a spouse or parent requests these records,
8) the parents or legal guardians of non-emancipated minor clients request records
9) the patient is suicidal or homicidal. Violation of Federal and/or State law and regulations by a provider is a crime.

You have the right to file a complaint regarding the violation of privacy practices by Suzanne Jafferian, LMHC with the Health and Human Services Office of Civil Rights (866 627-7748 or www.hhs.gov/ocr/hipaa)

My signature below indicates that I have read and understand my rights regarding confidentiality. Client data of clinical outcomes may be used for treatment evaluation purposes, but individual results will not be disclosed to outside sources. I consent to treatment and agree to abide by the above stated policies and agreements.

X_____ _____ _____ _____
Signature of Client/Legal Guardian Date Witness Date

_____
Client Name (Please Print)

Consent to Treat:

I, _____, hereby give my consent to, Amber Sky Counseling for evaluation and treatment to be provided to myself/child. I have been provided a copy of the practice policies and the limitations of communication.

I am aware that the practice of psychotherapy is not an exact science and results cannot be guaranteed. No promises have been made to me about the results of treatment. In the even that I, or my child, experience any physical or mental harm during the course of treatment, I will not hold Amber Sky Counseling responsible. The risks, benefits and consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. I understand the need to provide accurate information about myself/my child to ensure that I receive effective treatment. I also agree to be an active participant in the treatment process. I understand that I can see Massachusetts Law See Chapter 111: Section 70E for more details on my rights as a patient or can request a copy of this statute. I am aware that I may stop treatment at any time and that my therapist has the right to do the same. My signature below indicates that I understand and agree with all the above statements and have had the opportunity to ask questions about the treatment process.

X_____ _____ _____ _____
Signature of Client/Legal Guardian Date Witness Date

_____
Client Name (Please Print)