

THE FAMILY GUIDANCE AND COUNSELING CENTER
OF CENTRAL FLORIDA

AUTHORIZATION TO TREAT

The Family Guidance and Counseling Center of Central Florida is a center committed to providing service to you (the client) without regard to race, sex, color, religion, handicapped condition, sexual orientation, or national origin.

Rights and Risks:

Please feel free to ask questions about any aspect of the counseling process. You may remember unpleasant events that arouse intense emotions, and/or alter close relationships. Let us know your feelings on this as we want to proceed at a pace comfortable to you.

As a client, you have the right to individual dignity, to be treated in a respectful and confidential manner. Nondiscriminatory services are provided without regard to race, gender, ethnicity, age, or sexual preference. We seek to provide quality services suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements. You may withdraw your consent for any specific activity.

Confidentiality:

- ❖ Information shared will be held in confidence.
- ❖ Information will not be released without your written consent, except for professional consultation if needed and/or supervision and unless required by law.
- ❖ If you present a danger to yourself or others, we are legally, ethically, and morally required to protect the safety of the threatened person(s). If abuse or neglect of a child, elder, or disabled person is known or suspected, we are required to report it to the Florida Abuse Hotline .
- ❖ If we receive a court order for client records, staff deposition or court testimony, we are required to comply. We are also required to report attendance compliance by court ordered clients.
- ❖ In the course of review of records on center premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation may not disclose client names or other identifying information and must be in accord with federal confidentiality regulations.

In the event that group services are provided, it is acknowledged that Family Guidance and Counseling Center or its staff cannot be held responsible for a breach of confidentiality on the part of a peer group member. It is understood that information regarding treatment and diagnosis may

be provided to an insurance company. You may want to discuss further limits or exceptions of confidentiality.

Termination: Services may be discontinued for repeatedly missed appointments or if you come to appointments intoxicated and/or under the influence of substances or if you show evidence of inappropriate behavior.

Appointments:

All office visits are by appointment and may be scheduled through the counselor directly. The usual length of an appointment is 50 minutes. Please us know as soon as possible if you need to cancel or re-schedule an appointment.

Fees:

The client portion (co-pay) of fees is expected at time of service. Please verify with your insurance company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, this is your responsibility and needs to be handled prior to your first visit.

Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged. I have read, understand, and agree to the above policies. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desired.

I hereby authorize The Family Guidance and Counseling Center to release to my insurance company any information acquired in the course of my therapy (if client is a minor, parent or guardian sign).

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred or on account of this client and hereby assign The Family Guidance and Counseling Center, and all insurance benefits due to me to the full extent of my financial obligation. I have read and/or received a copy of The Family Guidance and Counseling Center's privacy policy. *If conjoint (couple or family) all adults need to sign this contract because of confidentiality and your rights, even though one person is the identified patient and paying.*

Session Fee (50 minutes) \$75.00

Client(s) signature: _____ **Date:** _____

Therapist's signature: _____ **Date:** _____

Emergencies:

The best phone number to reach Chris is (386) 490-5745 and Betsy (407) 416-5611. If you hear our voice mail, please leave a message and we will get back with you as soon as possible. **In a crisis situation, if we cannot be reached, please dial 911 or go immediately to your local emergency room.**

Family Guidance & Counseling Center of Central Florida Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this notice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and 15 the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Chris Hertenstein

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI. We may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,

- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Chris or Betsy Hertenstein.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our 10 practice, contact Chris Hertenstein. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. ¹⁵ After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact **either Chris or Betsy Hertenstein**.

I have read the HIPPA form supplied by Family Guidance & Counseling Center.

_____ I do want a copy of this form for my records.

_____ I do not want a copy of this form for my records

Signature and
date: _____