# Consent to Treatment and Recipient's Rights

**Client:**_____ **Chart #**:_____

I, _____ ,the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above to enter into treatment, at MindPsi School Psychological Services, PLLC, hereby referred to as the Clinic. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Clinic encourages that this decision be discussed with the treating provider to facilitate a more appropriate plan for discharge.

**PRIVACY OF YOUR INFORMATION**

The MindPsi School Psychological Services Center, PLLC. Understands that information we collect about you and your health is personal. Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The law says:

1. The clinic will not say to a person outside the Clinic that a client is receiving treatment from the facility unless: the client gives consent in writing, the disclosure is allowed by a court order, or to the insurance agency responsible for compensation.
2. You may ask that we not share certain health care information. You must make your request in writing. In some instances we may not be able to agree with your request. If that happens, we will explain the reasons to you.

Because the confidentiality of our clients is so important, we request that you respect the confidentiality of others whom you might encounter while in our offices. Please do not discuss with others what/whom you have seen or heard in our offices.

**USE OF YOUR INFORMATION**

**Your private health information may be used by providers, and our providers' supervisors who take care of you.** They may need your private health information to plan your care. We share information about you on a need-to-know basis in order to help you get services you may need.

**We may also use information about you to judge how well we do our job and for other performance improvement efforts within the Clinic.** For example, we may use information to review our treatment and services and to evaluate the performance of the providers. We may also combine information about many clients to help us decide what additional services we may need to offer or what services are no longer needed.

**You have a right to a copy of your medical record.** Your first copy is free; after that we may charge a fee for additional copies. We will keep your records in a secure place for at least 12 years after we last meet or have any contact. We would prefer to review the medical record with you before releasing it to make certain that you do not have any questions regarding its content. We have the right to hold the release of your medical record if you have failed to pay for treatment services in a reasonable time frame, provided the medical record is not requested as a result of an emergency situation.

**DISCLOSURE OF YOUR INFORMATION**
**There are several important instances when confidential information may be released to others according to Kentucky state law.**

1). **If you threaten to harm either yourself or someone else** and we believe your threat to be serious, we are required under the law to take whatever actions seems necessary to protect people from harm. This may include revealing confidential information to others and would be done only under unusual circumstances where someone's life appeared to be in danger.

2). **If you tell us information which gives us reason to believe that any person is being abused or neglected**, we are obligated by law to report this to the appropriate state agency which handles such cases.

3). **If you are involved in litigation of any kind** and inform the court of the services that you received from us (making your mental health an issue before the court), you may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received treatment.

4). **If you fail to pay your fees in a timely manner**, we reserve the right to provide identifying information (such as name, address, social security number, dates of service, and amount owed) to a collection agency.

5)**. If you are under the age of 18, your parent or legal guardian has the right to review your medical record and be informed of the treatment goals and course of therapy.**
Finally, there may be several other instances in which issues regarding confidentiality may be quite important; typically, these will be discussed when the need arises. Examples of such situations are family or couples therapy.

**If you would like your information to be sent somewhere else, you will be asked to sign a separate form called an Authorization to Release Information, allowing your health care information to go to someone else such as another provider.** Your authorization tells us what information is to be sent where and to whom. This authorization is good for 60 days or until the date you put on the form. You can cancel the authorization or limit the information sent by letting us know in writing. After we receive your cancellation, we will not share any more information, but it cannot be helped if information was shared before your request was received.

**You also have the right to request restrictions on the information we use or disclose about you for treatment, payment or healthcare operations. We are not required to agree.** However, if we do agree we will comply with your request unless the information is needed to give you emergency treatment. To request restrictions, you must make your request in writing. In your request you must state:

1. What information you want to limit
2. Whether you want to limit or use, disclosure or both
3. To whom you want the limits to apply (i.e. disclosure to your spouse).

**You may ask for a list of any places where health information may have been sent.** Exclusions to the account would include disclosures for: treatment, payment purposes, to make sure you received quality care, or to make sure laws are being followed. We also will not list persons or facilities to whom we sent information if you signed an Authorization Form allowing us to send the information.

**CONTACT WITH CLIENTS OUTSIDE THE OFFICE**

Your therapist will not see you on a social basis or enter into any business or other relationship besides the professional one, no matter how rational or beneficial it may seem at the time. If you and your therapist meet on the street or socially, he/she will not speak unless you speak to him/her first and will limit the conversation, in order to preserve the confidentiality of your services with our facility. Therapists typically communicate via cellular phones with their clients. Given that this method of communication is not 100% secure, if you would prefer to speak from a land-line phone instead please let the therapist know.

**THERAPEUTIC ISSUES**

1). **Therapist qualifications**. You have the right to have full and complete knowledge of the therapist's and the supervisors' qualifications and training.

2). **Treatment Planning.** You have the right and are encouraged to take an active role in your treatment, including setting treatment goals. You may refuse services offered to you and be informed of any potential consequences of treatment.

2). **Complaints**. If at any time, you feel dissatisfaction with any aspect of our services, please discuss your concerns with your therapist or the Director of the facility, Dr. Florell, as soon as possible so we can resolve the problem. If you feel that you have been treated improperly or unethically, and cannot resolve this problem with your therapist, you can contact the State Board of Psychology at 502-564-3296. Our therapists and supervisors fully abide by the Ethical Principles of the American Psychological Association (a copy is available for review at your request).

3). **Privacy Complaint**. If you think we have not protected your privacy and wish to complain to the MindPsi School Psychological Services Center, send your complaint in writing to:

Dan Florell, Ph.D.
MindPsi School Psychological Services, PLLC
793 Eastern Bypass, Suite 208
Richmond, KY 40475

Nothing will happen to you if you file a complaint. It is against the law for us to take any retaliatory or any other negative action against you if you file a complaint.

4). **Non-discrimination policy**. In our professional practice as mental health providers, we do not discriminate in accepting or providing services based on age, gender, race, ethnicity, religion, national origin, language, disability, sexual orientation, socioeconomic status, or any basis prohibited by law. This is both a personal commitment and is made in accordance with Federal, State, and local laws and regulations. If you believe you have been discriminated against, please bring the matter to our attention immediately.
5). **Termination of treatment.** You have the right to terminate your treatment at any time. If it appears, for any reason, that you are not benefiting from treatment, it is our ethical responsibility to discontinue services and perhaps suggest that you see another therapist (either within or outside of our facility).

**PATEINTS RESPONSIBILITIES**
You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services. You are also responsible for following the policies of the clinic and treating staff and fellow clients in a respectful, cordial manner in which their rights are not violated. In order to help us help you meet your treatment goals, it is expected that you provide accurate information about yourself and your treatment and to discuss concerns, challenges, or other circumstances that influence your treatment outcomes. It is also expected that you actively participate in your treatment including attending sessions and completing homework assignments.

**We will be happy to discuss any questions you may have about the information described on this sheet.**

**I have read the above information and understand it satisfactorily. I have had an opportunity to discuss any questions about this information. I consent to treatment and agree to abide by the above-stated policies and agreements with MindPsi School Psychological Services, PLLC.**

_____ _____
Signature of Client/Legal guardian Date

_____ _____
Witness Date