



INFORMED CONSENT

Therapist-Client Service Agreement

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. In order to be most successful, you will have to work on things outside of sessions.

Appointments

Appointments will ordinarily be 45-50 minutes in duration, once per week, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, you must provide a day notice. If you miss a session without canceling, or cancel on the same day as your scheduled appointment, the appointment will be considered a "missed appointment." It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still end on time. Your appointment will be considered missed at 15 minutes past your appointment time and will need to be rescheduled. After 2 no show appointments, any recurring appointment day/time will be forfeit and sessions will need to be scheduled on a week-to-week basis. After 3 no call no show appointments for your scheduled appointment time, you will be terminated from treatment at Hilltop Counseling and referred to another therapist.

Professional Fees

In addition to weekly appointments, there are other billable professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request. If your case requires your therapist's participation, you will be expected to pay for the professional time required even if another party compels me him or her to testify.

Insurance

Some plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. If this is the case, we will do our best to find another provider who will help you continue your therapy. You should also be aware that most insurance companies require that we provide them with a clinical diagnosis. Sometimes additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) is required. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Hilltop Counseling has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. Some policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit card or cash. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

Professional Records

Hilltop Counseling is required to keep appropriate records of the services provided. Your records are maintained in a secure location in the office. Records note when you are here, reasons for seeking therapy, goal and progress set for treatment, your diagnosis, topics discussed, medical, social, and treatment history, records received from other providers, copies of records sent to others, and billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. If you are refused your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which will be discussed with you upon your request. You also have the right to request a copy of your file be made available to any other health care provider at your written request.

Confidentiality

Some of the people who can know your Private Health Information (PHI) are: our staff, your group health plan, medical professionals, and agencies that have legal access. Sometimes you will be asked to sign a release so we can share your PHI with another person such as a Probation Officer. How we may share your PHI without a release: for treatment (a doctor, if an emergency), for payment for services (for example, we may give some of your PHI such

as your name, diagnosis code and treatment code to an insurance company who covers your fees) and health care operations (in order to run our health plans, EAP programs, and other programs).

Parents & Minors

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is agency policy not to provide treatment to a child under age 13 unless s/he agrees that the therapist can share information considered necessary with a parent. For children 14 and older, an agreement between the client and the parents allowing the therapist to share general information about treatment progress and attendance, as well as a treatment summary upon completion. All other communication will require the child's agreement, unless there is a safety concern (see Confidentiality exceptions above), in which case every effort will be made to notify the child of the intention to disclose information ahead of time and handle any objections that are raised.

Other Rights

Please speak with your therapist so they may respond to your concerns if you are unhappy with therapy. Such comments will be taken seriously and handled with care and respect. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your therapist's specific training and experience. You have the right to expect that your therapist will not have social or sexual relationships with clients or with former clients. If you feel you have not been treated well, you may contact the New Mexico State Counseling and Therapy Practice Board or the New Mexico Board at (505) 476-7100.

Consent to Therapy

Your signature below indicates that you have read this Agreement and agree to its terms.

Signature of Patient/Legal Guardian

Printed Name of Patient/Guardian

Date

Signature of Agency Representative

Date



RELEASE OF INFORMATION (ROI)

Client Name: _____

Client DOB: _____ Date: _____

I hereby authorize: **Hilltop Counseling** to release information from my file to:

Insurance Provider: _____

The information to be released includes:

- Admission to treatment
- Diagnosis
- Attendance
- Progress
- Completion or discharge from treatment

This authorization will expire one year from date of signing. I understand that my records are protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that I (or my guardian, if applicable) may revoke this release at any time except to the extent that action has been taken in reliance upon it. All records are sent on my behalf.

Client signature: _____

Witness/Therapist: _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Client Full Legal Name

Client DOB

1. Please check one of the following:

☐ No, I DO NOT give consent to release information to my Primary Care Physician
(Skip to section 3)

☐ Yes, I DO give consent to release information to the Primary Care Physician (PCP)
named below (If you checked yes, the therapist will communicate with the named
physician and/or send treatment plan and/or progress notes).

2. If you checked yes, please complete the following:

I hereby give my informed consent for Hilltop Counseling to communicate with Primary
Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Patient Authorization: I understand:

- This authorization may be revoked at any time by submitting a written request.
Disclosure(s) made prior to revocation are authorized under the prior authorization.
- My refusal to release records will not affect my ability to receive treatment.
- If a person or facility receiving the above stated information is not a healthcare or
insurance provider covered by HIPAA Privacy Regulations this information could
be re-disclosed.

Client signature

Date

Parent/Guardian signature

Date

Hilltop Counseling, LLC

Notice of Client's Rights

In the Notice of Privacy Practices counselors are required to inform clients as to their rights under state and federal law. Please review below for your rights as a client:

Right to request where we contact you (please circle *yes* or *no*)

- Home *yes or no*
- Work *yes or no*
- Cell phone *yes or no*
- Email *yes or no*
- If not, how may we contact you _____

Right to release your medical records

- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent of prior consent and prior release of information, but will remain valid from the date and time of revocation

Right to inspect and copy your medical billing records

- Right to inspect and copy records
- Counselor may deny this request
- Charges for copying, mailing, etc.

Right to add information or amend your medical records

- May request to amend record
- Number of days to decide
- May deny the request
- If denied, right to file disagreement statement
- Disagreement statement and your response will be filled in the record
- Amendment request must be in writing

Right to accounting of disclosures

- Exceptions:
 - Disclosure for treatment, payment or healthcare operations
 - Disclosures pursuant to a signed release
 - Disclosure made to client
 - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your healthcare information

- Must be in writing
- You are not obligated to agree

Right to complain

- Please first contact Hilltop Counseling about concerns or complaints
- Right to complain to the New Mexico Counseling and Therapy Practice Board
- No retaliation

Right to receive changes in policy

- May request any future changes
- Request to privacy officer

Hilltop Counseling, LLC

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. All information in this document is for Hilltop Counseling, LLC and is effective beginning September, 2019. Hilltop Counseling only releases client information in accordance with state and federal laws and the ethics of the counseling profession.

This notice describes the policies for Hilltop Counseling related to the use and disclosure of the client's healthcare information. The use and disclosure of protected health information is for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for the following purposes:

TREATMENT Use and disclose health information to:

- Provide, manage or coordinate care
- Consultants
- Referral sources

PAYMENT Use and disclose health information to:

- Process claims and collect fees

HEALTHCARE OPERATIONS Use and disclose health information for:

- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

I have read the **Notice of Client's Rights** and **Notice of Privacy Practices** and understand the above information. I understand that if I have any questions, I have a right to ask my therapist.

Printed Name

Date

Signature of Client (or parent if under 14)