IF YOU ARE IN CRISIS PLEASE DO NOT COMPLETE THIS DOCUMENT
CALL 911 IMMEDIATELY/GO TO NEAREST EMERGENCY ROOM

CLIENT SERVICE CONTRACT AND NOTICE OF PRIVACY PRACTICES

THIS DOCUMENT APPLIES TO IN OFFICE COUNSELING/INTERNET COUNSELING/ TELEPHONE COUNSELING

CLIENT NAME_____ SOCIAL SECURITY NUMBER_____

This document describes some details about your professional relationship with Hyde Park Counseling Professionals. Please review the document **thoroughly** and initial on the designated line after each section to indicate you have reviewed the section and agree to it. Upon completion of your review of the entire document please sign your full name in the designated area on the last page.

AUTHORIZATION FOR OUT PATIENT TREATMENT OF AMINOR CHILD
INTERNET COUNSLEING IS NOT PERMITTED FOR ANY MINOR CHILDREN

Your signature indicates that you are, either the **PARENT or GUARDIAN** of "**NAMED MINOR CHILD"** _____ and hereby authorize a therapist affiliated with Hyde Park Counseling Professionals to administer counseling diagnostic and therapeutic treatments that may be considered advisable or necessary in his/her judgment. No guarantee or assurance is made as to the results that may be obtained

CLIENT INITIALS_____

REPORTING ABUSE

The child reporting laws of the STATE OF OHIO require that any suspected abuse or neglect of any minor child under the age of 18, to be reported to the appropriate authorities, i.e. local police, Department of Children & Family Services. Child neglect may include, but is not limited to, inappropriate forms of punishment, physical and/or emotion neglect, abandonment or sexual molestation.

CLIENT INITIALS_____

EMERGENCY MEDICAL SERVICES: CALL 911/GO TO NEAREST EMERGENCY FACILITY

I do NOT provide emergency medical and/or psychological care and therefore, should the need for such treatment and/or become necessary, you must call 9-1-1 prior to ever calling me. More specifically, if you, at some point during outpatient counseling start to feel as though you might hurt yourself or take your own life, you hereby agree/and understand that I will call 9-1-1 to report your status. You will remain in my care until emergency authorities arrive to determine if the need for emergency treatment and/or transfer to a hospital may be necessary and appropriate. Signature on this document indicates your consent to such emergency treatment and/or transfer to a hospital and indemnifies me from any loss resulting from such emergency treatment and/or transfer. Your signature also indicates that you agree to assume sole responsibility for any and all charges incurred for such treatment.

CLIENT INITIALS_____

CONFIDENTIALITY:
I make every reasonable effort to safeguard the personal information, which you may share with me. The Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. Signature on this document acknowledges compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)
In accordance with Ohio law, my communication between you and I is **"confidential"** if it is not intended to be disclosed to third persons other than those personas present to further you interest in the consultation, examination or interview, those persons necessary for the transmission of the communication, and those persons who are participating in your diagnosis and treatment under my direction.
Under Federal Law, Protected Health Information (PHI) is the information I create and obtain in providing my services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment and applying to your insurance plan for future care or treatment. It also includes billing documents for those services. There are, however, several important instances when the privilege may be waived by you and Hyde Park Counseling Professional's therapist.

When I am a party defendant to a civil, criminal or disciplinary action arising from a complaint filed by you, in which case the waiver shall be limited to that action;

When there is a clear and immediate probability of physical harm to you, to other individuals or to society and I communicate the information only to the potential victim, appropriate family member, law enforcement or other appropriate authorities;

When you agree to the waiver, in writing, or, when more than one person in your family is receiving therapy, when each family member agrees to the waiver, in writing. If you consent, we are permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Appropriate written authorization will be obtained from you before we release your PHI for purposes of treatment, payment and health care operations.

EXAMPLES OF USE OF YOUR HEALTH INFORMATION FOR PAYMENT PURPOSES ARE;

A. I submit for a request for payment to your health insurance company. The health insurance company requests information from me regarding services rendered. I will provide that information to your insurance company about your and the care you receive so the health insurance can process your claim.
B. I verify insurance coverage prior to your first appointment and obtain prior authorization and pre-certification when required to do so by your policy coverage.

EXAMPLE OF USE OF YOUR HEALTH INFORMATION FOR HEALTH CARE OPTIONS:

A. I may have Business Associates such as billing services, bookkeepers, etc. who may have access to your PHI when they are preparing our routine financial statements or entering payments from insurance companies.

Additionally, there are several important instances when there is <u>no privilege</u> (which means No confidentiality of communications) between you and Hyde Park Counseling Professionals. Those instances are as follows:

1. For communications relevant to an issue in proceeding to compel hospitalization of you for mental illness, if I, in the course of diagnosis or treatment, have reasonable cause to believe you are in need of hospitalization;
2. For communication made in the course of a court-ordered examination of your mental or emotional condition;
3. For communications relevant to an issue of your mental or emotional condition in any proceeding in which you rely upon the condition as an element of your claim or defense or, after your death, in any proceeding in which any party relies upon the condition as an element of the part's claim or defense.
4. For any communication involving the perpetrator in any situation involving Known or suspected child abuse, abandonment, or neglect, regardless of the Source of the information requiring the report.
5. For any situation involving known or suspected abuse, neglect, or exploitation of the vulnerable adult (i.e., elderly person);
6. For preventing or controlling disease, injury or disability, as required by law, I may disclose your PHI to the public health or legal authorities
7. For health oversight activities, Federal Law allows me to release your protected health information to appropriate health oversight agencies.
8. For specialized government functions, as authorized by law, such as to Armed Forces personnel, for national security purposes, or to the public assistance program personnel.
9. For assistance in disaster relief efforts, as authorized by low.
10. For allowing funeral directors or coroners to carry out their duties, as authorized by law.

CLIENT INITIALS_____

By signing this form, you indicate the following:

1. That you consent to my use and disclosure of protected health information about you for treatment, payment and healthcare operations.
2. That you have the right to revoke this consent, and may in fact do so by submitting a Written signed request from you to me.
3. That this is my "Notice of Privacy Practices" and that you have had the opportunity to "Review this Notice of Privacy Practice."
4. That I reserve the right to change the "Notice of Privacy Practice Policies" at any time.
5. That you have the right to restrict the uses of your information but that I not have to agree to those restrictions.
6. That you may revoke this consent in writing at any time and all future disclosures will then cease, however such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.
7. That you may condition treatment upon the execution of this consent.
8. That counseling will cover emotional, physical aspects of my life and may be distressing and difficult.

CLIENT INITIALS_____

SIGNATURE ON FILE
ASSIGNMENT OF BENEFITS
Your signature indicates that you hereby authorize payment directly to Hyde Park Counseling Professionals LLC of the insurance benefits otherwise payable to you for the professional services. You also understand that you are financially responsible to Hyde Park Counseling Professionals LLC, for all charges not covered by your insurance company, including but not limited to deductible, co-insurance or disallowance of payment

CLIENT INITIALS_____

OUR RESPONSIBILITIES
Maintain the privacy of your PHI as required by Law.

1. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
2. Abide by the terms of this contract.
3. Notify you, if we cannot accommodate a requested restriction or request.
4. Accommodate your reasonable requests regarding methods to communicate health information about you.

By signing below, you acknowledge that you have received a copy of the Client Services Contract and Notice of Privacy Practices and that you have read and fully understand all the terms and conditions contained herein. Further, by signing below you are indicating your agreement to all of the terms and conditions contained here.

SIGNATURE_____

PRINTED NAME_____

DATE_____

SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE OF CLIENT

ACTING ON BEHALF OF CLIENT_____

DATE_____