CONSENT FOR TREATMENT AND ADVISEMENT ABOUT THE USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES THE CONDITIONS OF YOUR TREATMENT HERE, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PATIENT CONSENT FOR TREATMENT

I/We _____ consent to receive psychotherapy and counseling services at Pacific Bay Integrative Health Center (PBHIC). I/We understand that all dialogue between my therapist and me is held strictly confidential with some specific exceptions. I/We also understand that my case may be discussed at staff conferences with the proper safeguards to ensure confidentiality for the purposes of planning and evaluating the services being provided to me, and that this information shall not be released to any other person, organization, or company without my written permission unless ordered by the court system.

Mental health professionals are required by law to report suspicion of incidents of child abuse, elder abuse, dependent adult abuse, intent to do physical harm to oneself or another, or threats to another's property. While it is our legal responsibility to report any of the above, it is also our ethical responsibility to help you through this trying time.

I/We have been informed that there is a fee for the intake session and agree to be responsible for this payment.

ADVISEMENT ABOUT YOUR PERSONAL HEALTH INFORMATION

Your Private and Protected Healthcare Information
When we provide counseling and therapy services to you, we create, receive, and store health information that identifies you; this information is your Protected Health Information, or PHI, and we have a legal and ethical responsibility to protect your privacy. It is sometimes necessary to use and/or disclose this health information in order to provide the very best care for you.

We will obtain your consent for almost all uses and disclosures of your PHI; but under certain specific circumstances we may need to use or disclose your information without your consent.

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to assist other professionals to provide mental health treatment if necessary. You can revoke this consent at any time with a simple written note that we can provide for you. However, revoking your consent for PBHIC to release information does not cover any information already released.

Treatment
We need to use and disclose PHI about you to provide and coordinate your treatment here at PBHIC. This may include your therapist communicating with other PBHIC practitioners about your work here; however, please keep in mind that all PBHIC staff are held to the same high standards of confidentiality and respect for your privacy as your personal therapist. We take our work and your well-being very seriously, and any communication between PBHIC staff will be respectful of all aspects of your privacy and your treatment here.

Payment
Clients are personally responsible for payment for services rendered. However, some clients may wish to ask for reimbursement from their insurance carrier. In that case, we may need to release specific private information to your

insurance carrier so that you may be reimbursed. Typically, the information released would be your name, dates and types of service, and a diagnostic code to describe the reasons you are being seen. All of this information should be discussed between you and your therapist before any information is released. Our usual practice is to provide you with an itemized statement that you can submit to your insurance carrier. In the case of a client's refusal to pay their bill, we are permitted to release information to a collection agency to collect any outstanding balance due. Treatment information would not be released, but dates and types of service and fees would.

Emergencies and Other Disclosures
We may use and/or disclose your PHI under certain circumstances in which you do not have to consent or otherwise have an opportunity to agree or to object.

- *When the use and/or disclosure is required by law.* For example, we are required by law to report any suspicion of child or elder abuse or neglect. This would also include incidents of domestic violence when children are present or in the immediate vicinity.

- *When the use and/or disclosure is to protect against a serious threat to the health or safety of you or others.* For example, in case of a medical or psychiatric emergency we may release information necessary to keep you or others safe or to provide you with emergency treatment.

Requests from Courts and Other Outside Agencies
PBHIC policy is to protect your privacy to the best of our ability. In the case of a legitimate request from a court or other agency, PBHIC policy is to decline to provide the entire record; rather we would offer to prepare a summary of your treatment that is respectful of your privacy but meets the needs of the duly authorized agency. In most cases other agencies are agreeable to this; however, if the entire record is requested, we will only release the complete record if we receive an order from the court. When we provide any agency or individual with your PHI we will take all reasonable steps to insure the security of the information; however we cannot be held responsible for anything that happens to your PHI once it leaves our hands.

Your Access to Your Own PHI
PBHIC policy is to protect your privacy to the best of our ability. You have the right to know what information we keep in your record. If you wish to know what is written in your record, the first step is to discuss the matter with your therapist. We may choose to provide you with a verbal or a written summary rather than a copy of the complete record. If you wish to have a copy of your complete record, PBHIC policy requires that you obtain an order from a court. Regardless of the nature or extent of any disclosure of your PHI, you have the right to a listing of all disclosures we have made.

I/WE HAVE READ THIS CONSENT AND UNDERSTAND IT. I/WE CONSENT TO TREATMENT AND TO THE APPROPRIATE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT AND/OR PAYMENT.

Client signature	Date
Client signature	Date
Parent or Guardian (Relationship to Client)	Print Name