Consent for Treatment

Welcome to my practice! The following guidelines should answer most of your questions about my policies and procedures for treatment.

Consent to Treatment

This consent is to verify that you, the client or Parent/Legal Guardian, give permission to Lisa Inoue, LMSW PLLC to provide psychotherapy to you, your child and/or your family. The practice of psychotherapy is not an exact science and no guarantees can be made as to the results of therapy.

Please know I commit to keeping our appointments as scheduled, however, in the event of an emergency or other unforeseen circumstance, I reserve the right to cancel an appointment and will do my best to provide you with at least 24 hours notice of the cancellation.

Limits to Confidentiality

Confidentiality is an increasingly complex issue. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on April 14, 2003. However, some situations, described in the bullets below, require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following situations:

- I often find it helpful to consult other health and mental health professionals about a case and regularly participate in peer consultation groups with fellow clinicians. During such consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical Record.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.
- If I am being compensated for providing treatment to you as a result of your having filed a worker's compensation claim, I must, upon appropriate request, provide information necessary for utilization review purposes.
- In the event of an emergency or otherwise unforeseen circumstance where you might need therapeutic intervention, it might be necessary for me to disclose relevant information about your care for another practitioner to provide consultation to you in my

absence. You would ultimately have consent in this instance regarding the consulting practitioner and information being disclosed.

In addition, your insurance company, if you use one, requires a diagnosis be given in order to reimburse you for services rendered. They may also request additional information to authorize mental health services, to process insurance claims and facilitate payments for mental health services, and to conduct retrospective reviews for quality assurance purposes. This information will be provided as needed (see the section on Client Records below). I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-patient privilege law. I cannot provide any information without either your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If you ask me to disclose parts of the Client Record to a third party to support a disability claim, a civil lawsuit, divorce, or similar legal or quasi-legal pursuit, I will strongly advise you against doing so because of the potential harm to our therapeutic relationship. If, as you read this, you have in mind using any part of the Clinical Record for an upcoming legal or quasi-legal pursuit, please inform me immediately and I will be happy to provide referrals for a clinician who can perform such an evaluation.

There are additional situations in which I am legally obligated to take actions. These rare situations only occur when I believe harm may come to yourself or others as a result of your actions. If this happens, I may have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Such situations include the following:

- If I have reasonable cause to suspect current abuse or neglect of a child or a dependent adult or elder-abuse.
- If you communicate a threat of physical violence against a reasonably identifiable third person and I judge that there is apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, his/her parents) contacting the police, and/or seeking hospitalization for you.
- If I receive a subpoena, summons, court order, or court-ordered warrant, or an administrative request from a government agency including civil or authorized investigative demand or similar process authorized by law, I may be compelled to yield information. Even in these cases, however, only the minimum amount of information needed to satisfy the demand.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Record Keeping

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records:

One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You have a right to examine and/or receive a copy of your clinical record if you request it in writing, except in unusual circumstances, as follows:

- where disclosure would physically endanger you and/or others,
- when your record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person,
- where others have supplied information to me confidentially.

Because these are professional records, they can be misinterpreted and thus upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your Clinical Records, you have a formal right of review, which I will discuss with you upon request.

The second set of records is Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my assessment of those conversations, and how these conversations affect your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Emergency Accessibility

A 24-hour voicemail is available for your non-urgent messages. It is checked multiple times daily, Monday through Sunday, and calls are typically returned within 24 hours. ***In the event of a life-threatening emergency, please call 911 or take yourself and/or your child to your nearest emergency room.***

Termination

Either one of us may decide at some point that our continued working together is not adequately meeting your needs or the needs of your child. I am ethically bound not to continue work that is harmful to you or your child or treatment that is less effective than what you might receive from another provider. If this situation arises (or any other unforeseen impediment to our working together, e.g., my becoming ill), I will try to provide as much advance notice as I can and will provide you with appropriate referrals.

Likewise, you have the right to end this therapeutic relationship at any time and I will support you during this transition. Should this be the case, I ask that you provide advance notice of your intention to terminate therapy for either yourself or your child. Doing so allows us to address the inevitable issues that come up when ending an important relationship and helps to provide a sense of accomplishment and closure for yourself and/or your child.

If you cancel an appointment or fail to show up for an appointment and do not reschedule, I may not be able to hold that regular meeting time open for you. One month from the time of our last face-to-face contact, I will mail you a letter asking if you would like to schedule another appointment. If I receive no reply to this letter within two weeks of having sent it, I will take this as an indication that you want to end treatment. You are welcome to ask me for help in finding another therapist, and if you decide subsequently that you want to begin treatment again, I will be happy to see you if there is an available regular appointment time.

Agreement

By signing below, you agree that you have read this agreement and consent to its terms. It also serves as an acknowledgment that you have been offered the HIPAA Notice described above.

Client Name

Client Signature
(or signature of parent/guardian)

Date

Witness Signature

Date

I have received, read and understood the following documents

Please write your initials next to each document below:

____ Notice of Privacy Practices

____ Client Email/Texting Informed Consent

____ Fee and Payment Agreement