Consent Form for Services

PATIENTS RIGHTS AND RESPONSIBILITIES

As a client of Psychological Associates of Broward, we are obligated to inform you of your rights to confidentiality and other important issues concerning treatment in this office.

I understand that I am ensured the following rights:

- The right to refuse and /or terminate treatment at any time.
- The right to a complete description and explanation of my counseling.
- The right to confidentiality, whereby, information revealed by me during individual or group therapy , evaluation or testing will be kept STRICTLY CONFIDENTIAL and will not be revealed to anyone without my written authorization. The law provides exceptions to this provision:

    1. If the therapist has knowledge of the clients' intent to harm himself or others (homicide/suicide with a plan).
    2. If the therapist receives a court order to the contrary.
    3. If the therapist has knowledge of neglect/abuse to children or elderly.

Due to grey areas of duty to warn regarding HIV issues, our counselors have chosen to adopt the policy of working with the client regarding these grey area issues. This policy will reduce the risk of jeopardizing the therapeutic relationship and also protect the liability of the therapist to the greatest extent possible regarding invasion of privacy, defamation, or breach of confidentiality. These issues include but are not limited to:

1. If, in my opinion, therapy cannot profitably proceed unless something you tell me is shared with another party. I may need to give you the choice of telling the other party yourself, having me tell them, or terminating therapy.

2. I have an ethical obligation to balance the interests of all human beings. If you tell me, in my opinion, of a situation that may be unethical, harmful, or unfair, I may, at my discretion, give you the choice of correcting the situation if possible, informing relevant party(s) of the situation, having me tell them, or terminating therapy.

3. In general, I will follow, to the best of my ability, all state laws and regulations, as well as the policy and code of ethics of the Florida Department of Professional Regulation.

FINANCIAL POLICY

All charges for office services are due at the time of my visit to PAB. I authorize the

practice to bill my insurance company. It is my responsibility to pay my co-payment at the time of each visit. If I do not have insurance a private payment will be determined with my therapist.

Checks returned for insufficient funds will be subject to a fee of forty ($40.00) dollars to cover both the check and the bank's penalty fee charged to this office. If such an event occurs more than once, you will be asked to make payment in cash or money order.

Sessions are an average of 50 minutes in length.
Clients may require a longer appointment .If this occurs additional charges will be discussed.

If you are finding it difficult to wait until your next session to speak to your therapist, u will need to schedule appointments more than once per week. **Please remember, telephone calls are for appointment arrangements only, not to have sessions over the phone unless this was previously arranged with your therapist.**

We require a 48-hour notice of cancellation of appointments to avoid being charged for a missed appointment. Repeated cancellation of appointments is counterproductive and may result in termination of your treatment with the option of referral to another treatment source.

I understand that I will be financially responsible for all charges for services rendered on my behalf. This will include any services rendered by your insurance carrier. In the case of a change in insurance carriers, during my time in therapy in this office, I agree to be the responsible party for my payment**.**

I consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. I understand that if I do not agree with this policy I have the option to pay cash for services to protect my privacy.

Consent to use Social Media

Please be advised that most of the therapists in this office use social media to contact their clients. Social media is defined as the use of email or text/phone communication.

There will be times, when social media use will be inappropriate, and not in the best interest for certain client communication. If this should be the case, the therapist and client will discuss the appropriate form of client contact. Each therapist is responsible to discuss how the use of social media will be used with their client.

The use of Facebook, tweeter, Instagram, and other varieties of social media are not

recommended for client/therapist communication. However, some therapist's may use various forms of social media for therapeutic purposes.

Each therapist will ensure that their computer will be safeguarded and or encrypted. All client contact and information will remain confidential and will be held to the highest level of technology standards.

If insurance companies, doctors' offices, attorney offices, schools, or the client themselves request for email letters to a third party, the therapist will determine with the client the expense related to the request. In these cases, the therapist will inform the client of the expense or cost rendered.

In the case of the therapist death, client records will be held at Psychotherapy Associates of Broward for two years. Each therapist will assign a colleague/individual who will be responsible for the holding of records and for the purpose of client referrals.

In case of an emergency please call 911 or you may call First Call for help at 954-467-6333.

I understand the above are important service policy and procedures.

_____ _____

Signature of client date

_____ _____

Guardian for client date