AGREEMENT & CONSENT FOR TREATMENT

I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will, although revocation is not retroactive**.**

I have been informed of and read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees for services rendered by my therapist.

If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:

CLIENT
SIGNATURE _____DATE _____

SIGNATURE OF SPOUSE IF
FAMILY/MARITAL
COUNSELING _____DATE _____

SIGNATURE OF PARENT OR
GUARDIAN IF CLIENT IS A
MINOR _____DATE _____

THERAPIST: _____DATE_____

Notice of Privacy Practices---HIPAA Compliance

---This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. You have a right to a copy of this notice.
---Your health information is secure and confidential. A new law requires me to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.
--The law permits me to use or disclose your health information to those involved in your treatment.
--I may use or disclose your health information for payment of your services. For example, I may send a report of your progress to the insurance company.
---I may use or disclose your health information for normal healthcare operations.
---I may share your medical information with business associates, such as a billing service and/or a website/software developer (Paul Mojica). Any business associate/billing service must also protect your privacy under HIPAA.
---I may use your information to contact you. For example, I may call to remind you of your appointments. If you do not answer the phone, I may leave this information on your answering machine or with the person who answers the telephone.
---In an emergency, I may disclose your health information to a family member or another person responsible for your care.
---I may release some or all of your health information when required by law.
---Except as described above, this practice will not use or disclose your health information without your prior written authorization.
---You may request in writing that I not use or disclose your health information as described above. I will let you know if we can fulfill your request.
---You have the right to know of any uses or disclosures made with your health information beyond the above normal uses. As I will need to contact you from time to time, I will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. With your written consent I will mail or fax copies of your records to another practice.
---You have the right to see and receive a copy of your health information, with a few exceptions. A written request regarding the information you want to see is required. If you also want a copy of your records, you may be charged you a reasonable fee for the copies.
---You have the right to request an amendment or change to your health information. Please provide your request to make changes in writing. If you wish to include a statement in your file, please provide it in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.
---lf any of the details of this notice are changed, you will be notified in writing.

Acknowledgement
I have received a copy of Kirstin R. Abraham, LCSW's notice of privacy practices.

_____ _____
SIGNED DATE

PRINT NAME _____

If signing as parent or guardian, please note the name of the patient _____