

# INFORMED CONSENT & CONFIDENTIALITY POLICY

## The Therapy Process

Your therapist will work with you to identify presenting issues and develop a plan of care. However, it is your commitment to identifying personal goals towards which you desire to move and obstacles which may prevent that movement which will, in large part, determine the success of the therapy. If you have a crisis situation develop after hours, you may call our on-call therapist at (316) 239-5042, call the suicide prevention hotline at (800) 784-2433 or go to the St. Joseph campus of Via Christi for evaluation.

As a counseling center we operate under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are ethically and legally committed to the confidentiality of your Personal Health Information.

## Our Legal Responsibility

We have a legal responsibility under the laws of the United States and the state of Kansas to keep your Personal Health Information (PHI) private. It is also required by law to give you this notice and to follow the terms of this notice while it is in effect.

We have the right to make changes in our privacy practices at any time as long as those changes are permitted or required by law. Any changes in our privacy practices will affect how we protect the privacy of your PHI. This includes any PHI we receive about you or that we create in the course of your therapy. These changes could also affect how we protect the privacy of any of your PHI we had before the changes. If we make changes, we will change this notice and make the new one available to you.

## Uses and Disclosure of Your Personal Health Information (PHI)

We will not use or disclose your PHI for any purpose not listed below, without your specific written authorization. You must give us written authorization to disclose your health information to anyone for any reason you want. Any specific written authorization you provide may be revoked at any time by your written request.

- *Health Care Provider* - We may use and disclose PHI to your physician or other healthcare provider who is also treating you.
- *Payment* - We may use and disclose your PHI to your health insurance plan or other third party for payment of services we provide for you. If your contract with your insurance company requires that we provide information relevant to the services we provide, we may be required to provide them with a clinical diagnosis, as well as clinical information such as treatment plans or summaries and/or copies of any records we maintain about your therapy sessions.
- *Health Care Operations* - We may use and disclose your PHI to our own staff for our Center's operations, such as evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
- *As Law Requires* - We may use and disclose your PHI to any person required by federal, state, or local laws to have lawful access to your treatment program.
- *Court Orders, Judicial and Administrative Proceedings, and Law Enforcement* - We may disclose your PHI as part of a court proceeding, in response to a subpoena, or in other situations as required by law.
- *Appointment Reminders* - We may contact you by phone or email for an appointment reminder. If contact is by phone, we may leave a recorded message on your answering machine.

- *Therapist Cancellation* – If for some reason your therapist must cancel an appointment, we will contact you by phone or email. If contact is by phone, we may leave a recorded message on your answering machine/voicemail.
- *Victims of Abuse, Neglect, or Domestic Violence* - We may use or disclose your PHI to authorized persons from state agencies in cases of disclosures required by applicable state laws governing abuse, neglect, criminal activities, threats to the health/safety of the client and others, domestic violence, etc. In the case of minor children, we are required by law to disclose such information.
- *Event of an Emergency* - We may disclose your PHI to a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object or are not present or are incapable of responding, we will go ahead and use or disclose your PHI in your best interest at that time. In so doing, we will only use or disclose the aspects of your PHI that are necessary to respond to the emergency.

## **Patient Rights**

- With limited exceptions, you can make a written request to inspect your PHI that is maintained by us for our use. Your PHI includes basic information about your diagnosis, treatment dates, treatment plans, intake and termination summaries. Psychotherapy notes are exempt from this ruling.
- Requested copies of any PHI information will be provided at the cost of \$.25 per page.
- You can make a written request to have us communicate with you about your PHI by alternative means at an alternative location. (An example would be if your primary language is not spoken at this Center and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.
- You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
- You can make a written request that we amend your PHI.
  - If approved, we will change our records accordingly. We will also notify anyone else who may have received this information and anyone else of your choosing.
  - If denied, you can place a written statement in our records disagreeing with our denial of your request.

## **For Questions, Concerns, and Complaints**

Our therapists are licensed by the State of Kansas through the Behavioral Sciences Regulatory Board (BSRB). As licensed mental health professionals, we are committed to practice according to the ethics of our profession. We ask that you contact the director of the Counseling Center if you have a concern or complaint. Our phone number is 316-264-8800 and our fax is 316-264-8809.

You may also contact the BSRB and/or the secretary of the United States Department of Health and Human Services with questions or to register complaints about any licensed mental health professional.

# ACKNOWLEDGMENT FORM

## For Informed Consent & Confidentiality Policy

- ✓ I have received the Informed Consent & Confidentiality Policy and have been given an opportunity to review it. Highlights are listed below:
- I understand that my therapist may discuss case information as needed with the Counseling Center staff, therapists, and clinical supervisor for oversight and consultation.
  - I understand that I may be contacted 12-24 hours in advance to confirm a scheduled appointment.
    - I have provided a day-time phone number at which I want to be called and where a message can be left if I am not available. \_\_\_\_\_
    - I prefer to receive an email reminder at \_\_\_\_\_.
  - I understand that my therapist may need to cancel a scheduled appointment.
    - I have provided a day-time phone number at which I want to be called and where a message can be left if I am not available. \_\_\_\_\_
    - I prefer to receive an email notification at \_\_\_\_\_.

### KANSAS DIRECTIVE

In Kansas, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of such consultation is to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms. **The client/parent/legal guardian may also choose to waive such consultation.** The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived.

\_\_\_\_\_ I accept the consultation and have completed a release of information to the physician or psychiatrist of my choice.

\_\_\_\_\_ I choose to waive the consultation, understanding that I may at any time complete a release of information to the physician or psychiatrist of my choice.

I choose to enter into a therapy relationship under the circumstances described in the Informed Consent & Confidentiality Policy.

Name Printed \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_