PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Signiture_____ Date:_____

PSYCHOTHERAPY ASSOCIATES OF THE PALM BEACHES, INC. /Important information

Thank you for choosing **Psychotherapy Associates of the Palm Beaches, Inc**., to give you the professional help and guidance needed to improve your life. It is important that we develop a working relationship that is based on trust and open communication.
The following information describes some of the details of our professional relationship and responsibilities. If there is anything that is unclear, please don't hesitate to ask for clarification. I look forward to working with you, **helping you live a happier and healthier life**.

Confidentiality:
Confidentiality is of utmost importance and will be maintained at the highest level regarding any services you receive. This includes any related records or information in accordance with professional and legal standards. Under present law and regulations, limits of confidentiality include the following: (1) If you sign a waiver requesting release of information, (2) If a court orders the release of information, (3) If you raise the issue of your mental status or competency in a legal proceeding, (4) If there is a reason to believe that there is a clear and immediate probability that you will harm yourself and or someone else, or (5) If there is evidence or strong suspicion of child abuse or elder abuse.

Communication with your doctor(s)/physician(s) and other health care professionals:
Signing this form serves as a consent for Bonnie Goldman to contact other medical and health care professionals that have treated you. However, you have the right to withdraw that consent by written notice.

Appointments and Fees:
Fees for services are payable at the time of each session, unless other payment arrangements are agreed to in advance. In-network claims will be submitted directly to your insurance company by Bonnie Goldman; however, you will be responsible for paying any portion of the claim that is denied.
Appointments: If you are unable to keep your scheduled appointment time please give 24 hour notice for cancellation. If the 24 hour cancellation has not been made you will be responsible for the fee associated with the missed appointment. In case of emergencies there will not be a charge for your session.
Additional Services/Fees: Letters, reports, testing fees will be discussed prior to fulfilling the request. There is a service fee of $25 unless bank charges more for any returned check.
Telephone calls are available and can be scheduled as therapy sessions. However, all calls that exceed 5 minutes in length, a charge for a therapy session will be billed.

Insurance Assignments:
By signing below, you hereby instruct and direct your insurance company to pay Bonnie Goldman, Psychotherapy Associates of the Palm Beaches, Inc for all benefits allowable and payable under your insurance policies as payment toward the total charges for services rendered. This is a direct assignment of the rights and benefits under the insurance policy. This assignment

will not exceed your total indebtedness to Bonnie Goldman. You have agreed to pay in a current manner any balance over and above the insurance payments. A copy of this assignment shall be considered as effective and valid as the original. By signing below, you also authorize the release of any and all information about your case to your insurance company for the purposes of claim administration or review of the charges. Bonnie Goldman at Psychotherapy Associates of the Palm Beaches, Inc cannot control and is not responsible for any use the insurance company may make of this information.

I have read and understand the above, and I agree to engage your professional services under these terms and conditions. I acknowledge receipt of a copy of this information sheet.

_____ _____

Signature of client, Parent, or Guardian Date