CYPRESS CREEK THERAPY & RELATIONSHIP CENTER
Karen Berner Arcuri, LMHC **822 62nd St Circle E, Ste 101**
941-920-0189 **Bradenton, Fl 34208**
www.bernercounseling.com

STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

It is intended that every client's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed upon and the provider shall encourage and assist in the fullest possible exercise of these rights.

- I am entitled, upon request to be told of Provider's training, degrees and description of services
- I have the right to be treated with dignity, respect and privacy
- I have the right to participate in decisions regarding my (or my child's) treatment plan, and to develop mutually agreed upon treatment goals.
- I have the right to a candid discussion of treatment options, regardless of cost or benefit coverage.
- I have the right to stop to terminate therapy at any time.
- I have the responsibility to provide to the best of my knowledge, accurate and complete information.
- I am responsible for following my treatment plan, developed between me and my provider.
- I am responsible for keeping my appointments. In the event I am unable to keep a scheduled appointment, I will give a 24 hour notice to my provider.
- I understand that confidentiality of records of information collected about me will be held or released in accordance with the information noted in the ***Provider's Notice of Privacy Practices*** and/or state laws regarding confidentiality of such records of information.

CLIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my health care, the practice originates, and maintains paper and/or electronic records describing my health history, symptoms, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as.

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care (with written consent)
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided

I have been provided the opportunity to review the ***"Notice of Privacy Practices"*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care options.

ALLOWANCES:
I consent to the disclosure of protected health information regarding treatment, purposes of payment or healthcare operation with the following persons.

☐ **Spouse** ☐ **Children** ☐ **Relatives** ☐ **Parents** ☐ **Others**

Please list the names and relationship if indicated:

_____ _____

_____ _____

_____ _____

RESTRICTIONS:
I request that the following restrictions to the use of disclosure of my health information be followed:

I acknowledge that I have read the above Client Rights and Responsibilities and have been given a copy of the provider's Notice of Privacy Practices.

_____ _____
Client/Parent (Guardian) Signature Date

_____
Client/Parent (Guardian) Printed Name

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NOTICE OF PRIVACY PRACTICES

Our ***Notice of Health Information Practices*** provides information about how we may use and disclose your protected health information (PHI). We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. **We will provide you with a copy of the Notice of Privacy Practices by posting in our office and providing one to you at your request.**

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU WITH AUTHORIZATION:

FOR TREATMENT: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating or managing your health care treatment and related services.. The PHI you give us goes in a confidential and private written or electronic record. The permanent record is kept for at least 7 years after you stop treatment.

FOR PAYMENT: We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are making a determination of eligibility or coverage for insurance benefit, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. Should collection processes become necessary due to lack of payment for services we will only disclose the minimum amount of PHI necessary for collection purposes.

FOR HEALTH CARE PURPOSES: We may use or disclose, as needed, you PHI in order to support our business activities including but not limited to, quality assessment activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, and conducting or arranging for other business activities such as billing provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

CONFIDENTIALITY OF FAX/EMAIL/TEXT/CELL PHONE COMMUNICATION: E-mail, text, fax and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. **Please notify us if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devises. Please do not use e-mail or Faxes for emergencies.**

REQUIRED BY LAW: We must make disclosure of your PHI to you upon your request. We must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirement of the Privacy Rule.

USES AND DISCLOSURES PERMITTED BY HIPPA WITHOUT AN AUTHORIZATION:

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:**Abuse and Neglect,Judicial and Administrative Proceedings, Law Enforcement, Emergencies, Public Safety (Duty to Warn), National Security**

- Required by law, such as the mandatory reporting of child abuse or neglect, exploitation of the elderly or disabled, or mandatory government agency audits or investigations (such as the Florida Licensing Board for Mental Health Counselors or health department)
- Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

VERBAL PERMISSIONS: We may use or disclose your information to family member(s) that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights please submit your request In writing to your therapist.

- You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We charge $1.00 per page for all requested copies plus $30/15min.
- If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment
- You have the right to request an accounting of the disclosures that we make of our PHI. We charge 50% of your service fee if a request is made more than one time in a 12 month period.
- You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. If your services were paid for out of pocket we will honor your request to restrict information to a health care plan.
- You have the right to request we communicate with you about medical matters in a certain way or at a certain location.
- If there is a breach of PHI concerning you we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- You have a right to a copy of this notice

_____ _____

Signature of Client or Guardian/Parent Date