

HIPAA Consent Form
Consent to Use and Disclose Health Information

This consent form is required, according to Federal HIPAA regulations, for Beth Block, LMFT to provide services. I understand that as part of my healthcare, Beth Block, LMFT originates and maintains health records describing my health history, symptoms, evaluation, test results, diagnosis and treatment plans. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the health professionals who contribute to my care.
3. A source of information for applying my diagnosis and the services rendered to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand and have been provided with, or have been provided access to, a Texas Notice Form (TNF) that provides a more complete description of information uses and disclosures. I understand that I have the right to review the TNF prior to signing this consent form. I understand that Beth Block reserves the right to change her TNF and prior to implementation will provide access to the new TNF. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Beth Block is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Beth Block has already taken action in reliance thereon.

Client Signature

Date

Signature of personal representative of client (if applicable)

Date

I request the following restrictions to the use or disclosure of my health information:

Client Signature

Date

Patient Privacy Policy

I consider you a partner in your mental health treatment. When you are well informed, participate in your treatment decisions, and communicate openly with me and any other health professionals involved in your care you help make your care is effective as possible. I encourage respect for the personal preferences and values of each patient with whom I work.

Your Rights As a Patient

You have the right to impartial access to treatment or accommodations that are available or indicated regardless of race, ethnicity, creed, sex, sexual preference, national origin, age, or disability.

You have the right to be informed about your treatment plan and possible outcomes and to discuss them with me.

You have the right to know the names, professional credentials, and the role of the people treating you.

You have the right to privacy, and I will protect your privacy as much as possible. I will obtain authorization before using or disclosing any of your PHI.

You have the right to expect that your psychotherapy records are confidential unless you have given permission to release information or reporting is required and/or permitted by law. When I release records to others, such as insurers, I emphasize that those records are confidential. Our practices are in compliance with all HIPAA requirements.

You have the right to review your psychotherapy records and to have the information explained, except when restricted by law.

You have the right to expect that I will give you the necessary psychotherapy services to the best of my ability. Treatment, referral, or transfer may be requested or recommended, and you will be informed of the risks, benefits, and alternatives should this become relevant.

You have to right to know if I have relationships with outside parties that may influence your treatment and care. These relationships may be educational institutions, other healthcare providers, or insurers.

You have the right to know about our rules of practice and ethical guidelines that affect you and your treatment.

You have the right to be told of realistic care alternatives.

You have the right to know about resources that may help you resolve problems, complaints, and questions about your care.

You have the right to considerate and respectful care.

You have the right to request and receive an itemized statement of your charges regardless of the source of payment.

You have the right to make statements regarding any aspect of your care - in written form or verbally. I encourage and respect your feedback.

You have the right to be placed in a protective environment when it is deemed necessary for your personal safety.

You have the right to participate in all aspects of your psychotherapeutic treatment.

You have the right to receive instructions and/or psycho-education to allow you to achieve an optimal level of wellness and an understanding of your basic needs.

You have the right to access your psychotherapy records. You have the right to challenge the accuracy of these records and to have your records corrected. You also have the right to transfer all such records to another mental health professional in the case of continuing care.

You have the right to receive information regarding your financial responsibilities, charges, payments and payment plans, and insurance requirements.

You have the right to protection of your identity to guard against identity theft. You have a right to be notified if there is a breach in the use or disclosure of your PHI in violation of the HIPAA Privacy Rule, that has not been encrypted to government standards and our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Your Responsibilities As a Patient

You are responsible for completing all necessary forms related to your mental health care and financial responsibilities. If you are unable to comply, please request our assistance.

You are responsible for working with me to arrange payment for services, and for asking questions when you do not understand information regarding your financial responsibilities for payment of services

You are responsible for providing correct and up-to-date information for any insurance claims that I agree to file on your behalf.

You are responsible for providing a photo ID at your intake session.

You are responsible for asking questions when you do not understand information or instructions related to your mental health treatment. If you believe you cannot follow through with your treatment or treatment recommendations, you are responsible for informing me.

Your mental health depends not just on your psychotherapeutic treatment but also, in the long-term, on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal mental health.

Understanding Your Bill

Insurance companies generally require that psychotherapeutic treatment be medically necessary, i.e., that your bill includes documentation of a DSM mental health diagnosis that is descriptive of the concerns you bring to your therapy. Without this diagnosis, insurance will generally not pay for your care. You have the right to appeal decisions made by her insurance company, and I will assist you in this as I am able.

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

Complaints/Grievances

If you have a complaint regarding your treatment while working with me that has not been resolved to your satisfaction, you may contact the Texas State Board of Marriage and Family Therapists Complaint Hotline at 1-800-942-5540 or write them at :

Texas State Board of Marriage and Family Therapists
Complaints Management and Investigative Section
P.O. Box 141369 Austin, TX 78701