NSU
NOVA SOUTHEASTERN UNIVERSITY
College of Psychology
Psychology Services Center

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS
Please read the following information carefully. After you have read this Consent and Agreement for Treatment ("Agreement") please sign your name below to accept the terms of this agreement.

Welcome to the Nova Southeastern University, Psychology Services Center. This document (the Agreement) contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that the Nova Southeastern University Psychology Services Center provide you with a Notice of Privacy Practices (the Notice). The Notice explains HIPAA and its application to your personal health information in greater detail.

A. THERAPIST-IN-TRAINING

I understand that the Nova Southeastern University Psychology Services Center is a training facility for graduate students enrolled in the College of Psychology. The therapists-in-training are supervised by Licensed Psychologists. Students discuss their cases with their supervisors. Both the therapist-in-training and the supervisor will maintain confidentiality in accordance with state and federal privacy regulations. The name of my supervisor is _____.

B. CONSENT TO TREAT

As a legally consenting individual, I agree to permit the students, faculty and staff of the Nova Southeastern University Psychology Services Center to provide treatment and therapy to myself, or my child as applicable. I understand that I have the right to terminate therapy at any time without incurring additional costs.

Client/Representative's Initials _____

C. EMERGENCIES

The Nova Southeastern University Psychology Services Center operates by appointment only. If you have an emergency you should call 911, contact your primary physician, contact the mobile crisis hotline (954-463-0911), or go to your local emergency room.

D. APPOINTMENTS

When an appointment cannot be kept, the Center/Therapist-in-Training should be notified at least 24 hours in advance.

E. RIGHT TO DISCONTINUE TREATMENT

The Nova Southeastern University Psychology Services Center has the right to discontinue treatment for any appropriate reason, including but not limited to, repeated lateness and excessive cancellations. In such cases, the client or client's personal representative agrees to accept full responsibility for pursuing alternate professional mental heath care. A letter will be sent informing the client or their personal representative that treatment is being discontinued.

F. FEES

I understand that I am expected to pay for each session at the time it is held. In connection with the Nova Southeastern University Psychology Services Center mission to serve the community and subject to available resources, the Center may provide care on a sliding fee schedule to individuals who are unable to pay the usual and customary fee for service. An income determination form and supporting documentation must be provided to the Center for consideration of a fee adjustment.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the Psychology Services Center has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our disclosure of otherwise confidential information.

G. LIMITS OF CONFIDENTIALITY

Both Federal and State law protect the privacy of all communications between a client and a psychotherapist/therapist. In many situations, the Psychology Services Center can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state and federal privacy regulations. Please see the Notice of Privacy

Client/Representative's Initials _____

Practices, which explains HIPAA and its application to your personal health information in greater detail. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- The Psychology Services Center is a training site, information about you may be discussed at supervisory sessions.

- The Psychology Services Center therapists-in-training and/or staff may find it helpful to consult with other mental health providers within the Center about a case. The Psychology Services Center mental health providers are also legally bound to keep the information confidential.

- You should be aware that we practice with other mental health providers and that we employ administrative staff. In most cases, we need to share protected health information with these individuals for both clinical and administrative purposes, such as scheduling, filing and billing. All of the mental health providers are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the Center without the permission of a professional staff member or as otherwise legally appropriate.

- Disclosures required to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or authorization, including but not limited to:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychotherapist-client privilege law. We cannot provide any information without either:

  1) Your or your personal representative's written authorization;

  2) Receipt of a subpoena with documentation of satisfactory assurances of notice to the client and a certification that no objection was made by the client, or that the time for filing an objection has elapsed, and no objection was filed, or all objections filed were resolved by the court, and the disclosures are consistent with the resolution; or

Client/Representative's Initials _____

3) A court order.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

There are some situations in which we may be legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment, including but not limited to:

- If we have reasonable cause to suspect that a child under 18 is abused, abandoned or neglected, or if we have reasonable cause to believe that a vulnerable adult is abused, neglected or exploited, the law requires that we file a report with the appropriate government agency.

- If we believe that a client presents a clear and immediate probability of physical harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization of the client.

- If we believe that a client presents a clear and immediate probability of physical harm to himself/herself, we may be required to seek hospitalization for him/her, or to contact family members or others who help provide protection.

* If such a situation arises, we will attempt to limit our disclosure to what is necessary. Confidentiality issues can be complicated, so if you have any questions about them, please feel free to ask them now or in the future as needed.

H. PROFESSIONAL RECORDS

We maintain a Clinical Record for each client. It could include information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, and reports of any professional consultations. As detailed in the Notice, you may receive a copy of your Clinical Record that we generate, if you request it in writing.

Client/Representative's Initials _____

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents.

In most circumstances there will be a charge for copying. If we deny your request for access to your Clinical Records, you have a right of review which will be explained in a letter sent to you and which we will discuss with you upon request.

In addition, we may also in some cases keep a set of notes called Psychotherapy Notes ("Notes"). Pursuant to HIPAA, these records are specifically defined and carry special protection. They have a very specific meaning under the law. These Notes are for the supervisor and therapist-in- training use and are designed to assist us in providing you with quality care. While the contents of the Notes vary from client to client, they can include the contents of conversations, the analysis of those conversations, and how they impact on your therapy. These Notes are kept separate from your Clinical Record. You may receive a copy of the Psychotherapy Notes that we generate, if you request it in writing. In most circumstances there will be a charge for copying. If we deny your request for access to your Psychotherapy Notes, you have a right of review which will be explained in a letter sent to you and, which we will discuss with you upon request.

I. PATIENT RIGHTS

In addition to the right to obtain copies of your record as discussed above, HIPAA provides you with a number of rights, which briefly include the right to amend the information in your record and to request restrictions as to how you are contacted. Please review the Nova Southeastern University Notice of Privacy Practices carefully.

J. MEDICAL EXAMINER'S OFFICE

In the event of my death, I hereby release and hold harmless Nova Southeastern \ University as the custodian of my Clinical Record from any and all liability resulting from or arising out of the release of my record to the Medical Examiner's Office pursuant to state law.

K. MINORS & PARENTS

Emancipated Minors do not need parental consent for mental health care. Their PHI is confidential and must not be released to anyone, even parents or guardians, without the client's consent.

Client/Representative's Initials _____

Unemancipated Minors generally must have the consent of their personal representative for non-emergency mental health care. Personal representatives include natural or adoptive parents, legal custodians or guardians, or a person acting as the minor's parent. The personal representative may have access to the minor children's records in these cases, unless they have agreed in advance to a confidential status between the child and the therapist. That is, if a therapist asks a personal representative to step out so that the provider may talk confidentially to the minor client, the representative is, in effect, agreeing to a confidential relationship between the child and the provider, and may only know what the conversation was about if the child authorizes it.

The therapist is expected to use professional judgment in these situations and consider the client's best interests when deciding whether to share confidential information with a personal representative.

There are other instances where minors do not need the personal representative's consent for mental health care, and in those cases, the PHI related to that mental health care could only be shared with the personal representative with the minor client's authorization. Those cases include but are not limited to the following:

- Outpatient mental health diagnostic/evaluation services (13 years or older). Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any one (1) week period.

- Outpatient crisis intervention therapy/ counseling services (13 years or older). Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any one (1) week period.

- Outpatient substance abuse therapy/counseling services (13 years or older). Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation.

Client/Representative's Initials _____

Release of Information for Treatment and Health Care Operations

By signing this form, I am consenting to the use and disclosure of my Protected Health Information ("PHI") for treatment and Nova Southeastern University's health care operations purposes for myself or for the patient/client for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Psychology Services Center ("NSU") will share patient/client PHI according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

NSU's Notice of Privacy Practices provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at the NSU Psychology Services Centers.

I acknowledge and agree that the PHI that may be disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient/client: (i) any psychiatric or psychological information related to treatment of physical and/or mental illness; (ii) any information regarding drug abuse, chemical dependency or alcohol abuse; or (iii) any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); Sexually Transmitted Disease("STD"); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to county, state or federal public health agencies, as required by law.

I understand that I have the right to request that NSU restrict how it uses or discloses the patient/client's PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the client.

Client/Representative's Initials _____

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

Patient/Client or Patient/Client Representative Signature _____ Date _____

Print Name of Patient/Client or Patient/Client Representative _____ Patient/Client Date of Birth _____

Description of Patient/Client Representative's Authority _____

Confirmation of interpretation to Patient/Client (if applicable)
If the Patient/Client does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient/Client does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the Patient/Client so that he/she clearly understood what it meant before signing it.

Print Name of Interpreter _____ Relationship to Patient/Client _____

Signature of Interpreter _____