INFORMED CONSENT REGARDING LIMITATIONS ON CONFIDENTIAL COMMUNICATIONS

I understand that information about my treatment and communications with my therapist of Counseling Associates of MA & NH, LLC, may not be released without my written authorization, whether for in person sessions or telehealth sessions. However, these communications or this information may have to be revealed without my permission, as explained below:

1. **If necessary to protect my safety or the safety of others.**
   (A) If I am clearly dangerous to myself, my therapist may take steps to seek involuntary hospitalization and may contact members of my family or others.
   (B) If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may:
      - Tell any reasonably identified victim;
      - Notify the police; or
      - Arrange for me to be hospitalized.
2. **If necessary for me to be hospitalized for psychiatric care.**
3. **If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.**
4. **In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.**
5. **If the therapist believes a child, a disabled person, or an elderly person in my care is suffering from abuse or neglect.**
6. **To provide information regarding my diagnosis, prognosis and course of treatment, or for the purposes of utilization review or quality assurance, to a third party payer.**
7. **In legal proceedings where I introduce my mental or emotional condition.**
8. **If I bring an action against the therapist and disclosure is necessary or relevant to the defense.**
9. **If necessary to use a collection agency or other process to collect amounts I owe for services.**
10. **If a court orders access to my records in a sexual assault or other criminal case.**

I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical service I receive.

OTHER IMPORTANT INFORMATION FOR YOU TO UNDERSTAND: Office Policies

Telephone: Clients can call and leave a confidential message on the voice mail system, on their therapist's extension.

Emergencies: In the event of an urgent matter when the office is closed, call the voice mail and follow directions about how to contact a therapist on call. The person on call can be reached by calling x0. If I am experiencing an emergency situation, I shall call 911 or proceed to the nearest Emergency room. If I am having thoughts of harming myself, I can call the National Suicide Prevention Hotline at 1-800-273-TALK (8255) for free 24-hour support.

Length of Sessions: The standard length of each session is forty-five minutes. In some cases, it is beneficial to have a sixty-minute session.

Fees: Sessions are $180.00 for the initial 50-minute intake session. Subsequent sessions are $140 per 45-minute session and $160 for a 60-minute session. Services are reimbursable to some extent by most insurance companies. Clients are held accountable for all costs not covered by insurance. Balances, co-payments, and deductibles are required to be paid each session. In child-related cases, the person who brings the child to treatment is responsible for paying required costs. In some cases, discount rates are negotiable.

CANCELLATIONS AND "NO-SHOWS": Clients are responsible for payment of each session unless cancellations are made at least 24 hours in advance. INSURANCES CANNOT BE BILLED UNLESS THE CLIENT ATTENDS. You can be billed $50- $65 if you do not give 48-hour notice. Each clinician will go over their individual cancellation policy. PLEASE NOTE.

SPECIAL CONSIDERATIONS FOR TELETHEALTH: In addition to the forgoing, the following shall apply: Telehealth sessions via the clinician's chosen telehealth platform are considered to be secure because these platforms are reported by their manufacturers to be encrypted and meeting HIPPA-acceptable privacy guidelines. Despite the manufacturers' representations, the therapist and Counseling Associates of MA & NH does not independently certify that these products meet the encryption criteria for HIPPA compliance, and therefore release this therapist and Counseling of MA & NH from any liability in the event the teletherapy platform is not secure and confidential as reported by the manufacturer.

I acknowledge that I have been given an opportunity to read a copy of the practice's Informed Consent Regarding Limitations of Confidential Communications and Office Policies. I have also been given an opportunity to read and have a copy if I wish of the practice's HIPPA Notice. I understand that if I have any questions regarding these notices, I may contact Leigh Bryant.

I have had the opportunity to discuss this informed consent statement (both pages) with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Name: _____ _____

CLIENT (Print) signature

DOB:_____ Date:_____

Signature of Parent, Guardian or Personal Representative* _____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, health surrogate, etc).

_____ Client refuses to Acknowledge Receipt

_____ _____

Signature of Staff Date