Emily Scott, M.S./Ed.S.
Licensed Mental Health Counselor

INFORMED CONSENT

By my signature below, I, _____, attest that I have voluntarily sought psychotherapy services, or give my consent for the minor or person under my legal guardianship, with Emily Scott, M.S./Ed.S., Licensed Mental Health Counselor. By signing this form, I understand the following:

Please initial:

____ The rights, risks, and benefits associated with psychotherapy services have been explained to me. I understand that Emily may discontinue services at any time. This decision is encouraged to be openly discussed to help facilitate a discharge plan.

____Confidentiality of client records held with Emily Scott, LMHC is protected by Federal and/or State laws and regulations. Current laws hold Emily Scott, M.S./Ed.S., Licensed Mental Health Counselor or any of her agents may not disclose my attendance or involvement in services without my written consent, unless (1) She is informed of or has reasonable suspicion of child, elderly, or disabled person abuse/neglect, (2) There is a likelihood that I pose a serious and immediate danger to myself,(3) The issue of my mental health is raised by me in court proceedings or my records are ordered to be released by a judge or (4)) I am threatening serious bodily harm to another person(s) and Emily believes that protective actions may be required including, but not limited to, notifying the potential victim(s) and police. In any of these circumstances, normal assumptions of confidentiality will not apply and Emily Scott, LMHC and/or her personnel have the authority to take action as mandated by law.

____ A client may be discharged from services with Emily Scott, LMHC, non-voluntarily, for (1) exhibition or threat of physical violence, verbal abuse, possession of a weapon, or engagement in illegal acts on or around the premises, (2) non-payment in accordance with the finance policy, or (3) noncompliance with treatment. Discharge notice will be in writing.

____I understand that Emily Scott, LMHC, does not provide an on-call service, and is not a crisis center. In case of emergency, a client must call 911 or go to the nearest emergency room for immediate clinical attention.

____ I have read and understand that my confidentiality may be waived in the event Emily Scott, LMHC chooses to enlist a collection agency and/or claims court to recover any unpaid balance for which I am responsible. In this case, only information relevant to payment would be released such as dates and types of service; no clinical information would be conveyed.

____I have read and understand the above statements, agree to abide by the terms, and freely seek treatment and/or evaluation with Emily Scott, LMHC. Further, by my signature below I attest that I have received a copy of this informed consent page as well as a copy of the uniform HIPAA notice. These forms have been explained to my satisfaction.

I consent to services and agree to abide by the above stated policies and agreements with Emily Scott, M.S./Ed.S., Licensed Mental Health Counselor.

_____ _____

Client Signature/Parent or Legal Guardian Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Notice of Policies and Practices to Protect the Privacy of Your Information

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this notice carefully. If you have any questions about this notice, please contact: (954)320-0173. Written requests should be addressed to:

I. Uses and Disclosures for Treatment, Payment, and Health Care Operation

I may USE or DISCLOSE your PROTECTED HEALTH INFORMATION (PHI), for TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS purposes with your CONSENT. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS"
    - TREATMENT is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consent with another health care provider, such as your family physician or psychologist.
    - PAYMENT is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility for coverage.
    - HEALTH CARE OPERATIONS are activities that related to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "USE" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "DISCLOSURE" applies to activities outside of my [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An AUTHORIZATION is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department or Child and Family Services.
- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, The Department has the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.
- **Social Security Administration:** If you are referred to me for a disability determination evaluation, all personal information SSA collects is protected by the Privacy Act of 1974. Once medical information disclosed by SSA, it is no longer protected by the health information privacy provisions of 45 CFR, part 164, mandated by the Health Insurance Portability and Accountability Act (HIPAA).
- **Research:** Under certain circumstances, we may use and disclose your PHI for research purposes, but only under certain criteria. You have the right to request information about these criteria and may obtain a copy of the policy by contacting the Privacy Officer if writing.
- **Specialized Government Functions:** If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may use and disclose your PHI to authorized federal, foreign and other national security officials when the use and disclosure is for activities deemed necessary to assure the proper execution of the military mission or for other specialized government functions.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction to your request.
- **Rich to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, ever if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. Changes will be posted on my practice website and a paper copy will be available from my office upon request.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about your access to your records, or have other concerns about your privacy rights, you may contact Emily Scott, LMHC at (561) 867-2622.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send a written complaint to:

Emily Scott, LMHC
11000 Prosperity Farms Road, Suite 202
Palm Beach Gardens, FL 33410

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with the address upon request.

You have specific rights under the Privacy Rule, which are protected and will not affect the services that you receive, if you exercise your right to file a complaint.

VI. Effective Date

These privacy practices are effect March 1, 2023.