**PATIENT CONSENT AND AUTHORIZATION**

**Consent to Treatment**

I hereby consent to receive mental health treatment from Eric Eichler, LCSW. I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option Mr. Eichler offers and that I may withdraw my consent at any time.

I accept that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. I understand that the changes I make may have an impact on others around me, including my important contacts, and if applicable, my partner. I accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. *This is especially true if I have dependent children*. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

**Treatment Sessions/Cancellation Policy**

I understand that standard individual treatment sessions average 50 minutes in length, and group sessions are 90 minutes. **If I am unable to keep an appointment, I agree to notify Mr. Eichler at least 24 hours in advance. I understand that I will be charged the full session rate for all sessions cancelled with less than 24-hour notice.** I also understand that Mr. Eichler may waive this fee in cases involving emergencies, but that such waiver is solely at the discretion of Mr. Eichler.

**Confidentiality**

I understand that our communications are private and protected by law. Because of laws protecting confidentiality, in most situations my therapist cannot share information about our work without my permission. However, there are certain specific limits to confidentiality. I fully understand these limits below.

1. There may be times during our work when, in order to support progress toward my goals, my therapist may consult with a colleague or supervisor. He will do this in a way that does not include identifying information. All mental health professionals with whom my therapist consults are bound by the rules of confidentiality.
2. Generally, if I am involved in legal proceedings, my therapist cannot provide any information about our work without my permission. There are exceptions and, if I anticipate being involved in litigation, I should consult my attorney to determine whether a court could order my therapist to disclose information.
3. If I file a complaint or lawsuit against my therapist, my therapist may disclose relevant information pertaining to me in order to defend himself.
4. If, in the course of our work, my therapist has reasonable cause to believe that any child under the age of 18 is being (or has been) physically or emotionally harmed in any way (either because of abuse, including sexual abuse, or neglect) the law REQUIRES my therapist to file a report with Colorado Child Protective Services. My therapist will inform me if he finds that he must file a report.
5. Similarly, if my therapist has reasonable cause to believe that an elderly person (age 59 or older) or a handicapped person of any age is (or has been) suffering from abuse, the law REQUIRES that my therapist file a report with the appropriate authorities.
6. Finally, if I let my therapist know that I intend to harm myself or intend to harm another person, and my therapist believes the risk is real, my therapist may be REQUIRED to break confidentiality by contacting the police, alerting the intended victim, contacting a family member, or seeking my hospitalization without my consent.

**Communication and Availability**

Due to my therapist’s work schedule, I acknowledge that he is often not immediately available by telephone. When my therapist is unavailable, an automated voice mail answers his/her telephone. My therapist will make every effort to return my call on the same day I make it, with the exception of weekends and holidays. If I will be difficult to reach, I will inform my therapist of times when I will be available. In a life-threatening emergency, I will call 911 or go to the nearest Emergency Room.

I understand that email is not a secure medium for communication and my therapist’s preference is that I contact him/her by phone. However, if I choose to contact my therapist using email, I am doing so with the full understanding that my therapist cannot guarantee the safety and security of that communication. I also acknowledge that e-mail communication may be delayed in comparison to telephone.

**Financial Obligation**

I understand that I am responsible for full payment of all fees for services provided by Eric Eichler, LCSW, at the time of service.

**ACKNOWLEDGEMENT**

My signature below affirms that I understand and accept the terms and conditions of this authorization and agreement.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_**

**TELETHERAPY SERVICES**

Prior to starting video or telephone conferencing services, we discussed and agreed to the following:

* There are potential benefits and risks of video or telephone conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
* Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
* For videoconferencing you need to use a webcam or smartphone during the session.
* It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
* It is important to use a secure internet connection rather than public/free Wi-Fi.
* It is important to be on time. If you need to cancel or change your tele-appointment, you must notify Mr. Eichler in advance by phone or email.
* We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
* You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
* As your therapist, I may determine that due to certain circumstances, teletherapy is no longer appropriate and that we should resume our sessions in-person.

**PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_**

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Uses and Disclosures for Treatment, Payment, and Health Care Operations**

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 consult with another health care provider, such as your family physician or another psychologist. Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. Health Care Operations are activities that relate 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, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “Disclosure” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

After you have read this notice you will be asked to sign a form indicating receipt of this notice as well as a separate Consent form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here in my office or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or health care **operations**.

**Uses and Disclosures Requiring Authorization**

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

* Releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session.
* Use or disclosure of your protected health information for marketing purposes.

You may revoke all such authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing.

**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, in the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority.
* *Adult and Domestic Abuse* - If I know or in good faith suspect that an elderly individual or an individual who is disabled or incompetent has been abused, I may disclose the appropriate information.
* *Health Oversight Activities* - If a government agency is investigating my practice, I have to disclose some information.
* *Judicial and Administrative Proceedings* - There are some federal, state, or local laws which require me to disclose PHI.
  1. If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so after trying to inform you of the request, consulting your lawyer, or trying to obtain a court order to protect the requested information.
  2. If you bring a lawsuit against me and disclosure is necessary or relevant to a defense, I may disclose the appropriate information.
* *Serious Threat to Health or Safety* - If I believe in good faith that there is risk of imminent personal injury to yourself or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information. I may also disclose PHI if it is necessary for you to be hospitalized for psychiatric care.
* *Worker’s Compensation* - I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**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 you request.
* *Right 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 and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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 for which you have neither provided consent nor authorization (as described above in this Notice). 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, even if you have agreed to receive the notice electronically.
* *Right to Restrict Disclosures When You Have Paid for Your Care Out*-*of-Pocket*. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
* *Right to Be Notified if There is a Breach of Your Unsecured PHI*. You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

**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.
* If I revise my policies and procedures, I will notify you in person, via mail, or via another method agree to in advance.

**Questions and Complaints.** If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (510) 367-8965 for additional information. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at **1155 Sherman St., Box 33, Denver, CO 80203**. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**NOTICE OF PRIVACY PRACTICES**

THE SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM Eric Eichler, LCSW.

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_**

**The effective date of this notice is September 15, 2020.**