

“Practice Name” Professional Disclosure Statement and Consent for Treatment with “Licensee’s Name”

The majority of this document is mandated by both South Carolina State law and Public Law 104-191; it is provided for **your** protection. “Practice Name” has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with “Licensee’s Name”.

Contact Information: “Practice Name” is located at street/city/state. This is also our mailing address. Our usual office hours are _____ “day name” through “day name.” Our clients are seen by appointment only and special appointments for evenings, weekends, and other selected times will be considered. Our telephone number is _____ (the voicemail is confidential) and our fax number is _____. Our email address is _____ it is checked at least once every working day. Our webpage is _____ and contains more information regarding “Practice Name”.

Personal Qualifications: “Licensee name” is the Clinical Director of “Practice Name”. Please note some of his/her credentials listed below: *(Examples given below for illustration such as...)*

- South Carolina Licensed Marriage and Family Therapist
- South Carolina Licensed Supervisor for Marriage and Family Therapists
- South Carolina Licensed Professional Counselor
- South Carolina Licensed Supervisor for Professional Counselors
- Clinical Member/Approved Supervisor, American Association for Marriage and Family Therapists
- Certified Trauma Specialist
- Diplomate, American Board of Forensic Examiners
- Master Practitioner, Neurolinguistic Programming
- South Carolina Certified Victim Assistance Specialist

“Licensee’s Name” received his/her Bachelor’s Degree (Type) from “Name College” in _____, his/her Master’s Degree (Type) from “Name University” in _____, and if applicable, his/her PhD (Type) from “University Name” in _____.

Services: “Licensee’s Name” provides a number of psychotherapeutic services which include: *(Examples given below such as...)*

- Therapy involving adjustment to changes encountered by individual life cycle development
- Therapy involving adjustment to changes encountered by couple life cycle development
- Therapy involving adjustment to changes encountered by family life cycle development
- Therapy involving adjustment to changes encountered in the course of marital development
- Therapeutic assessment and treatment of Posttraumatic Stress Disorder (PTSD) in individuals, groups and families.

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Fees: It is customary to pay for professional services at the time they are rendered. The hourly fee for individual, couple, and family therapy is \$_____ per hour. Group therapy, if offered, with “Licensee’s Name” is \$_____ per hour per person. If “Licensee’s Name” accepts your insurance, you will only be required to pay a co-pay for your therapy. If you do not know whether your deductible has been met, *you will be charged full fee.* We will refund your fee minus the co-pay if we find your deductible has been met. **If you choose to not file insurance and pay cash, Licensee’s Name offers a 20% discount off his/her hourly fee.** *If you have insurance, you are responsible for any fees - due to “Licensee’s Names” - that your insurance company does not pay.*

Confidentiality: The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. “Licensee’s Name” is mandated by standards - through Duties to Warn - to breach confidentiality if he/she discovers: 1.) you are threatening self-harm or suicide, 2.) you are threatening to harm another or homicide, 3.) a child has been or is being abused or neglected, and/or 4.) a vulnerable adult has been or is being abused or neglected. Finally, if you wish your protected health information released to another party, you *must* sign a specific Release of Information.

Ethics: “Licensee’s Name” follows the Code of Ethics of the following organizations: *Examples follow such as...*

- ❖ The South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists
- ❖ The American Association for Marriage and Family Therapy
- ❖ The Association of Traumatic Stress Specialists
- ❖ The American College of Forensic Examiners.

Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.

Informed Consent: You will be asked to sign the last page of this document. Your signature verifies you have been given this document and the HIPAA document that follows; that you have read and understand these documents, and that you consent to treatment. Further you need to be aware:

- Treatment isn’t always successful and may open unexpected emotionally sensitive areas.
- “Licensee’s Name” is not a physician and cannot prescribe medications.
- “Licensee’s Name” may need to consult with your physician, attorney, or other counselor.
- “Licensee’s Name” is not available 24 hours a day.
- Appointments may be successfully canceled as late as 24 hours prior to the scheduled time. If this is not done, you *may* be charged \$50.00 for a missed appointment.
- “Licensee’s Name” is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingtree Building) in Columbia, South Carolina at 803-896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).
- The Executive Administrator for the “Practice’s Name” is_____. He/she is a confidential administrator under state and federal law. He/she will be your major contact for appointments, problems, complaints, and commendations.

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered “protected health information” by HIPAA. As such, your protected health information ***cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.*** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist’s/counselor’s Professional Disclosure Statement and Consent for Treatment.

**Use or disclosure of the following protected health information
does not require your consent or authorization:**

1. Uses and disclosures required by law - *like files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence - *like the Duties to Warn explained in your therapist’s/counselor’s Disclosure Statement*
3. Uses and disclosures for health and oversight activities - *like correcting records or correcting records already disclosed*
4. Uses and disclosures for judicial and administrative proceedings - *like a case where you are claiming malpractice or breach of ethics*
5. Uses and disclosures for law enforcement purposes - *like if you intend to harm someone else (see Duties to Warn in your therapist’s/counselor’s Disclosure Statement)*
7. Uses and disclosures for research purposes - *like using client information in research; always maintaining client confidentiality*
7. Uses and disclosures to avert a serious threat to health or safety - *like calling Probate Court for a commitment hearing*
8. Uses and disclosures for Workers’ Compensation - *like the basic information obtained in therapy/counseling as a result of your Worker’s Compensation claim*

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Your Rights as a Counseling/Therapy Client under HIPAA

- ⇒ As a client, you have the right to see your counseling/therapy file. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*
- ⇒ As a client, you have the right to receive a copy of your counseling/therapy file. This file copy will consist of only documents generated by us. You will be charged copying fees @ \$.20/page. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*
- ⇒ As a client, you have the right to request amendments to your counseling/therapy file.
- ⇒ As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ \$.20/page.
- ⇒ As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- ⇒ As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your counseling or therapy, you will receive 1.) an exact duplicate of these two pages and 2.) your therapist’s/counselor’s Professional Disclosure Statement and Consent for Treatment - both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understand both documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client’s Rights or the Professional Disclosure Statement and Consent for Treatment. Your counselor or therapist will be happy to explain these documents further.

Page 5 is the signature certificate and you will leave it with “Licensee’s Name”.

Thank you!

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I acknowledge that I have received and read the *“Practice Name” Professional Disclosure Statement and Consent for Treatment* and the *HIPAA Client’s Rights*. I further acknowledge that I seek and consent to treatment with “Licensee’s Name”. My signature below confirms that I understand and accept all the information contained in the *“Practice Name” Professional Disclosure Statement and Consent for Treatment* and the *HIPAA Client’s Rights*.

Signature of Client

Date



If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the others sign below. Signatures below confirms that each understands and accepts all the information contained in the *“Practice Name” Professional Disclosure Statement and Consent for Treatment* and the *HIPAA Client’s Rights*, and that each seeks and consents to treatment. We will provide additional copies of the *“Practice Name” Professional Disclosure Statement and Consent for Treatment* and the *HIPAA Client’s Rights* upon request.

Signature of Client #2

Signature of Client #7

Signature of Client #3

Signature of Client #8

Signature of Client #4

Signature of Client #9

Signature of Client #5

Signature of Client #6