**HIPAA Client Consent Form**

**Privacy Rights**

I consent to the use of disclosure of my protected health information (PHI) by the clinic and the therapist for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct therapeutic treatment. I understand that diagnosis of treatment of me by my service provider may be conditioned upon my consent as evidence by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. We, as your service providers are not required to agree to these restrictions. However, if we do agree, than that restriction is binding.

I have the right to revoke this consent in writing at any time except to the extent that the service provider has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and re-created or received by my service provider, a health insurance plan, my employer or a health care clearinghouse. This PHI related to my past, present or future physical or mental health or condition can identify me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices Policy prior to signing this document and that one has been provided to me. The Notice of Privacy Practices Policy describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills and in the performance of health care treatments. This Notice also described my rights and the service provider’s duties and obligations with respect to my protected health information. We reserved the right to change the privacy practices that are described in the Notice of Privacy Practices Policy. I may obtain another copy of the Notice of Privacy Practices Policy by requesting it.

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Signature of client or guardian Date Guardian if necessary Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of client or guardian Date

LIMITS OF CONFIDENTIALITY

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Am/are the parents/guardians of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And I/we have been advised by the service provider of the nature, approach and limitations of the treatment of testing that is to be provided to our under-age minor or other vulnerable person. I/We have also been informed that all information disclosed during treatment and/or testing with the under-age minor or other vulnerable person discussed during treatment and/or testing received from those individuals will remain confidential unless a potential danger to someone is revealed. If such a danger is revealed, the service provider is required by law to take protective action and must inform proper authorities of the danger. I/we understand that no other information will be released to a third party concerning my/our under-age minor or other such vulnerable person unless I/we provide a written consent for such a release. I/we have also read, understand and agree to the record keeping and information releases policies as they are outlined on the bottom of this form. I/We have also been made aware that we can choose to allow these individuals confidential sessions with the service providers except where sessions are required to have a caregiver present in the room, to facilitate treatment/assessment. If we elect to allow confidential sessions, we would only be informed of details that would indicate potential dangerous situations that the individual of whom we are responsible may be involved in. I/we have understood these limitations to confidentiality and the record keeping policies.

I/We elect \_\_\_\_\_\_\_\_\_\_(initial) or do NOT\_\_\_\_\_\_ (initial) elect to allow the minor age children or other vulnerable person to have confidential sessions unless prohibited by regulation or law.

Your records will be retained in a locked file in the office for a period of seven (7) years or as per statue. It is possible that these files may be converted to digital files at some time in the future. Your records will only be released with your written consent and/or when ordered by a Court of Law. You may submit record requests in writing to the office. A copying fee will be charged depending on the size of your file. With proper authorization you may request information released in paper form to a third party as long as this information was not the property of the Court. Copyright laws will not be violated. When your written authorization is received to provide test scores to another licensed service provider, information as to the results of testing etc., will be released. Records received from another party that may be contained in your file will not be released. You will be notified through advertisement in the paper of record of any changes to the practice and retrieval of your records.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MCS Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**609 W Cottonwood Lane Suite 1 Casa Grande, AZ 85122 ph. 520.251.5166 fax 520.413.5787**

**New Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Work)

Best Place to leave a message: Home Cell Work Don’t leave a message

Relationship Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What brings you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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