Paula Hofmann, MA, LPCC
Balancing Acceptance and Change

INFORMED CONSENT FOR MENTAL HEALTH ASSESSMENT/ COUNSELING

I am a competent adult voluntarily seeking mental health assessment and/or counseling for myself and/or my minor child.

~ I understand that, although mental health counseling is expected to be helpful in resolving my problems, no guarantee has been made about the usefulness or effectiveness of treatment.
~ I understand that, except in the event of extreme emergency, advance notice of 24 hours is required if I am not able to keep a scheduled appointment and I may be billed for missed appointments.
~ If I am utilizing insurance or EAP to assist in payment for my services, I agree by my signature below to allow my therapist to release information in my record, including but not limited to: my history, condition, diagnosis, prognosis, treatment plan and treatment recommendations to insurance/EAP personnel involved in reviewing my case.
~ I understand that every effort will be made to protect the confidentiality of my medical records according to Heath Insurance Portability and Accountability Act guidelines and regulations imposed by my insurance provider.
~ I understand that the laws of this state and the guidelines of the therapist's profession allow the following exceptions to confidentiality and are legally required and will be followed by this practice:

1. All information will be held confidential and privileged unless the psychotherapist has reason to believe that I may have neglected or abused a child, a senior citizen or a disabled person, in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies.
2. All information will be held confidential and privileged unless I report suicidal or homicidal ideation with intent and/or plan, in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies so that treatment to protect the safety of myself and others may be provided.
3. Other information may be released in accordance with the Heath Insurance Portability and Accountability Act as described in this office's Notice of Privacy Practices.
4. Many patients like the convenience of **communicating via text and e-mail**. I do all that I can to protect the privacy of all exchanges with my patients/clients. Given the fact that these messages may not be secure, or may be read by others, and that both are stored on the servers of internet service providers, they may violate the privacy requirements of HIPAA. In addition, they often do not become part of patients' medical records despite the fact that they often contain very useful content. Given these realities, please indicate below whether you would like to communicate via each of the means below:

	For appointments & changes	For clinical matters & appointments
Text messages	____Yes ____ No	____Yes ____ No
E-mail messages	_____Yes ____No	____Yes ____ No
Telephone messages	_____Yes ____ No	____Yes_____No

_____ _____
Signature of client Date

_____ _____
Signature of witness Date

21 West Central Avenue
Delaware, Ohio 43015
Phone: 727-534-6621