Cutler Counseling; Leslie P. Cutler, M.A., LMHC, Psychotherapist

E-Mail: Leslie@CutlerCounseling.net
Web: www.CutlerCounseling.net

235 Washington Street
Route 53
Pembroke, MA 02359
Phone: 781.826.9700

Client Rights, Responsibilities and Consent

Client Rights

- We provide counseling by Master level; licensed clinicians and you as a client have the right to services, which are provided in a professional manner.
- If you feel psychotherapy is not being provided as agreed upon, please discuss it with your therapist.

Client Responsibilities

- Payment for clinical fee is the responsibility of the client and is due at the time the service is rendered. Clinical policy prohibits scheduling further appointment when there is an overdue balance.
- If payment is not made at time of service, a $5.00 fee will be added to balance owed.
- Repeated cancellations or no-shows may result in termination of service.

Client Consent and Authorization

- I hereby give consent for outpatient treatment and understand that I may rescind this authorization and terminate care at any time, with or without prior notice.
- I understand that information about me will be kept confidential and will not be released without my consent except in special circumstances, which have been explained to me.

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Cancellation Policy

It is our goal to provide appointments that are flexible and responsive to your needs. As part of the therapeutic process, we encourage clients to take responsibility for their decisions. This includes the setting up and cancellation of appointments.

It is the policy of our office to charge our clients directly for appointments missed without 24 hours notice. This fee does not include legitimate absences such as accidents or emergencies.

We are requesting each client or guardian be responsible for payment of broken appointments. Payment must be made prior to or at the time of the next appointment. **The no-show or late cancellation fee is $50.00 and may be made by check, cash or credit card**. A payment schedule can be made in the case of hardship. If a credit card is on file with the clinician, the $45.00 no-show or late cancellation fee will be automatically applied to the credit card on file.

Agreement

I agree to abide by the clinic policy requiring a 24-hour notice for cancellation of appointments, excluding emergencies.

Client/Guardian Signature Date

Witness Signature Date

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Emergency Contact Form

Please know we are committed to meeting your needs. If you need to contact us after hours, you may leave a message on our answering machine. We will do out best to check it regularly and return your call as soon as possible. If we are not available and you are in immediate danger, please contact "911" or go to your nearest emergency room.

In the event of an emergency, I am requesting the following individual be contacted:

Client Name: _____ **DOB:** _____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

_____

Client/Guardian Signature Date

_____

Witness Signature Date

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Medical Release Form

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information. The privacy law requires me to sign an authorization in order for researchers to be able to use or disclose my protected health information for psychotherapy purposes only.

1. I authorize the following person(s) and/or organizations(s) to disclose my protected health information (as specified below):
   Name:_____
   Organization(s):_____
   Address:_____

2. I authorize the following person(s) and/or organizations(s) to receive my protected health information (as specified above):
   Name:_____
   Organization(s):_____
   Address:_____

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____

Client/Guardian Signature Date

_____

Witness Signature Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your protected health information as part of providing professional case. We also are required by law to keep your information private.

For Treatment

We use your medication information to provide you with psychological treatments or services. These might include individual, family or group therapy, psychological, educational or vocational testing, treatment planning g or measuring the benefits of our services.

We may share or disclose your protected health information to others who provide treatment to you. We are likely to share your information with your personal physician. If a team is treating you, they can share your protected health information with us so that the services you receive will be able to work together. If you receive treatment in the future from other professionals, we can also share your protected health information with them. There are some examples so that you can see how we use and disclose your protected health information for treatment.

For Payment

We may use your information to bill you or others so we can be paid for the treatments we provide you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnosis, what treatment you have received and the changes we expect in your conditions.

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We will need to tell them about when we have met, your progress, and other similar things.

Your Health Case Operations

There are a few ways we may use or disclose your health case information for what are called health care operations. For example, we may use your information to see where we can make improvements in the case and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and protected information will be removed from what we send.

Other Uses in Healthcare

Appointment Reminders: We may use and disclose medical information to reschedule or remind you of appointments for treatment or other case. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just let us know.

Treatment Alternatives: We may use and disclose your health information to tell you about or recommend possible treatment or alternatives that may be of help to you.

Other Benefits and Services: We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you.

Business Associates: There are some jobs we may hire other businesses to do for us. In the law, they are called Business Associates. Examples include telephone answering services, software vendors and a bill collection agency. These business associates need to receive some of your health care information to do their jobs

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properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

Uses and Disclosures That Require Your Authorization

If we want to use your information for any purpose those described above, we need your permission on an Authorization Form. We don't expect to need this very often.

If you do authorize us to use or disclose your protected health information, you can revoke that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes that we agreed upon. Of course, we cannot take back any information we have disclosed with your permission or that we had used in our office.

Of course, we will keep your health information private, but there are some times when the laws require us to share it. For example:

1. When there is a serious threat to your health and safety or another individual or the public. We will only share information with a person or organization, which is able to help prevent or reduce the threat.
2. Some lawsuits or legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.
5. When we receive information about abuse or neglect of a child, disabled adult or person over age 65.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you.

For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members, and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical or billing records. You can even get a copy of these records, but we may charge you.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this require in writing and send it to us. You must tell us the reason you want to make these changes.
5. Upon written request, you may obtain an account of certain disclosures of your protected health information made to us during any period of time prior to the date of your request provided such period does not exceed six year. If you request an accounting more than once during a twelve (12) month period, we will charge you a $0.25 per page of the accounting statement.
6. You have the right to a copy of this notice. If we change this document, we will supply you with the updated document.
7. If you need more information or have questions about this Privacy Policy, please feel free to ask.

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Witness Signature Date

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Consent To Use And Disclose Your Heatlh Information

This form is an agreement between you, _____ and our agency. When we use the word "you" below, if can mean you, your child, a relative or person if you have written his or her name here _____.

When we diagnose, treat or refer you we will be collecting what the law calls Protected Health Information about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here. The Notice of Privacy Policy explains in more detail your rights and how we can use and share your information. Please read the Notice of Privacy Practices before you sign this consent form.

If you do not sign this consent form agreement to what is our Notice of Privacy Practices we cannot treat you.

If you are concerned about some of your information, you have the right to ask us to not use your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing us a letter and we will comply with your wishes about suing and sharing your information form that time on. However, we may already have used or shared some of your information and we cannot change that.

Signature of client or his or her personal representative Date

Signature of client to his or her personal representative Date

Description of person representative's authority: _____

_____