Behavioral Health Affiliates, LLC
84 High Street, Suite 2A · Medford, MA 02155 · 781-393-0009 · 781-395-2909 fax

Patient's Informed Consent

- I have chosen to receive treatment services from Behavioral Health Affiliates, LLC. My choice has been voluntary and I understand that I may terminate therapy at any time.

- I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself, we will work together in a cooperative manner to resolve my difficulties.

- I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

- I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. Written patient release information is usually required for the transfer of records. However, there are some exceptions where a minimal amount of information may be shared without a patient release and are specified below.

- I understand that I have the right to inspect or copy Protected Health Information (P.H.I.) and/or psychotherapy notes unless it is determined this would adversely affect my well being.

- I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and/or others.

- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information including court ordered testimony and rendering of records.

- I understand that general feedback on treatment progress is reported to the parents/guardians of children under 18 years.

- I understand that I may be contacted by my insurer to ensure continuity and quality of my treatment and /or after the completion of treatment, to assess the outcome of treatment.

- I understand that occasionally, peer consultation is needed for successful treatment. In these cases, no names will be disclosed in order to protect confidentiality.

- I understand that the following disclosures do <u>not</u> require authorization:
  - To health oversight agency
  - For workman's compensation
  - To avert imminent harm to client or others, as per duty to protect statute
  - As required by law (e.g. child abuse reporting)
  - Under court order
  - To HHS, Office of Civil Rights (OCP) to determine compliance with the privacy rule
  - When defending legal action brought by a client

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- I have received a copy of the basic rights of individuals receiving therapy at Behavioral Health Affiliates, LLC. These rights include:

    - The right to be informed of the various steps and activities involved in receiving services.
    - The right to confidentiality under federal and state laws relating to the receipt of services.
    - The right to humane care and protection from harm, abuse or neglect.
    - The right to make an informed decision whether to accept or refuse treatment.
    - The right to contact and consult with counsel at my expense.
    - The right to select alternate practitioners of my choice at my expense.

- The right to request restrictions on uses and disclosures (e.g. request certain things not be included in a record) except where there is an exception by law, e.g. 51A.

- I understand that my therapist, my insurer and my primary care provider may exchange any and all information pertaining to my treatment, payment and/or healthcare operations. Non-clinical information may be released to billing or collection service for the purpose of collecting the payments owed for services rendered.

- I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in advance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid.

- Additionally and in accordance with the laws of the Commonwealth of Massachusetts:
    - My clinical records may be released upon written consent of the patient.
    - Records may be released upon a signed, appropriate order from a court of competent jurisdiction.
    - There will be a charge to you directly for administrative time spent assembling and copying clinical records.

I have read and understand the above:

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian, Conservator Date