MINDFULNESS COUNSELING

CONSENT FOR TREATMENT and HIPAA COMPLIANCE ACKNOWLEDGMENT

FEES

Payment shall be made at the time of service unless other arrangements are made in advance. By signing below, you acknowledge that you are fully responsible for payment of any charges incurred and for all services provided to you/your child.

CANCELLATION POLICY

Appointment times have been reserved for only you/your child. If you need to cancel your appointment, you must provide a 24-hour advance notice. You will be charged your regular session rate for any missed appointment without a 24-hour notice.

CONFIDENTIALITY AND PRIVACY

Sessions are confidential. Information regarding treatment may be shared with a third party only with written consent from you, with few exceptions. Exceptions to confidentiality include when a client is in imminent danger of harming self or others, or when child or elder abuse is suspected. When the client is a minor, legal guardians will know about treatment, though privacy will be respected as much as possible. More complete information regarding your privacy rights can be found in the document, "HIPAA Notice of Privacy Practices," which has been provided to you. You may request an additional copy at any time. You may discuss any questions or concerns regarding confidentiality and privacy with us.

SOCIAL MEDIA POLICY

It is not my practice to search for clients on Google, Facebook, or any other search engines. I do not accept friend or contact requests from current or former clients. Please do not message me on any social media site. Please do not send me text messages, unless otherwise agreed upon. My primary concern is for your privacy.

SCHEDULING APPOINTMENTS

It is preferred that we schedule our next session at the conclusion of your current session. If you need to schedule an appointment or modify an existing appointment, please phone or email me. Do not include any personal or session-content related information in your email or phone message as these are not completely secure or confidential.

By signing below I acknowledge that I have read and understand the above policies. I also acknowledge receipt and understanding of the HIPAA Notice of Privacy Practices.

_____ _____ __/__/____

Client name (printed) Signature of Client, Parent or Guardian (circle) Date