Road To Healing Counseling
1345 East 3900 South, Suite 104
Millcreek, UT 84124
Tel. 801-441-8943
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www.RoadToHealingCounseling.com

Consent for Care Agreement

This document provides information about clinical services that I provide and represents an Agreement of consent for care. Accompanying this document is a Notice explaining many details of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires you are provided with a Notice of Privacy Practices for use and disclosure of personal health information (PHI) for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. This Act requires that I obtain your signature acknowledging you have been provided with this information by the end of the first session.

Your signature on this consent form represents an agreement for care. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; for example, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or, if you have not satisfied any financial obligations you have incurred.

You have a right to refuse treatment at any point during our work together. It is your responsibility to choose the provider and the type of treatment that best suits your needs. You have the right to ask questions concerning the findings of an evaluation, the right to raise questions about the therapeutic approaches and the progress that is being made at any time. If you feel that progress is not being made, please bring it to my attention quickly. We will make every effort to respond to your concerns. I am always willing to facilitate a referral to other resources if you wish.

Consent and confidentiality for Minors

As psychologists, we must treat the legal guardian(s) of the child as the patient with respect to protected health information relevant to that representation (letting the guardian exercise the privacy rights that patient would normally exercise, e.g., receiving notice, consenting to disclosure, having access to their records and the right to amend).

Divorced or Separated parents

When parents are separated or divorced, it is required that both parents consent to evaluation or treatment for their child and to agree regarding payment for these services. Unless there is legal documentation to the contrary, either parent may request access to the child's information. Please understand that I do not perform custody evaluations and therefore do not make custody or visitation recommendations.

Consent and confidentiality with school/Agency Involvement

There are times when services provided to an individual are funded through a school district or outside agency. In this case, the agency and the parents/legal guardians are required to provide consent to care. In addition, it needs to be understood that there is an open exchange of information between the

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parents/legal guardians, agency and Road To Healing Counseling, such that any information given to us by the agency can be shared with the parents/legal guardians and any information provided to us by the parents/legal guardians can be shared with the agency.

Contacting us

I am often not immediately available by telephone. Therefore, I cannot provide consistent crisis care. If you think that you may need this level of support, please let me know so that we can determine whether I am an appropriate provider or if we need to develop a crisis plan for you. Leaving a message on my voicemail is usually the only way to reach me. If you are in crisis, you should call 988, or go to the nearest Emergency Room and ask for the psychologist or psychiatrist on call or call the Huntsman Mental Health Institute Crisis Center at (801) 587-3000.

Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgement that you have received the HIPAA Notice form described above.

I have read and understand the policies and have had the opportunity to ask questions. I give permission for evaluation and treatment for my child, and state that we are/I am the parent or legal guardian for this individual.

_____

Patient's Name:

_____ _____/_____

Date Signature of Responsible Party/Relationship to Patient

_____

Najmeh Hourmanesh, Ph.D.