HIPAA INFORMED CONSENT

Consent for Treatment, Understanding Confidentiality, & Receipt of Notice of Privacy Practices

(Please read "Associates in Family Care's Notice of Privacy Practices." Available online at aifamilycare.com and posted in the offices of Associates in Family Care. You may request a hard copy if desired.)

This is to acknowledge that I have read and agree with the Associates in Family Care Notice of Privacy Practices. I hereby give my consent to receive treatment and related services from the designated professional(s) providing services to me at Associates in Family Care. I understand that this consent is for the duration of the services to be provided. Your clinician is committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including the following:

1. Any threat to harm yourself or others, including murder, suicide, and assault.
2. Any reports of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly or dependent adult.
4. Clinician is court ordered to testify.

Clinician(s) may discuss cases with professional colleagues, without use of names, as deemed necessary. If your clinician is under supervision, they will discuss your case in detail for purposes of proper supervision required by the State of Ohio Counselor, Social Worker, & Marriage and Therapist Board.

Name of Supervisor (if applicable):_____

Cancellation Policy

→ _____ *INITIAL* I hereby am in acknowledgment that I am responsible for contacting my counselor in the event I am unable to attend my counseling session. If I do not show up for my session and do not contact my counselor to inform them of this absence, I will be charged a $75 no-call no-show fee. I will do my utmost to ideally give a 24-hr notice with an understanding that emergencies happen.

_____	_____	____/____/____
Client's Printed Name	**Client's Signature**	**Date**
	_____	____/____/____
	Clinician's Signature & Credentials	Date

If the client is a minor, the parent/guardian must sign this statement:

I hereby give my consent as a parent or guardian for the specified client above to receive treatment and related services from the signing professional providing services at Associates in Family Care. I understand that this consent is for the duration of the services provided. I have read, understood, and agree with the limits of confidentiality.
I hereby give my consent as parent or guardian for the specified client above to receive treatment. I also acknowledge that I have read and agree with the Associates in Family Care Notice of Privacy Practices.

_____	_____	____/____/____
Parent/Guardian's Printed Name	**Parent/Guardian's Signature**	**Date**