

# Inspired Healing

5350 E. Broadway-Suite 108, Tucson AZ 85711

Inspiredhealing.org

520.584.0343

## **Informed Consent for Treatment and Notice of Privacy Practices**

This notice and consent form describes how your health information may be used and disclosed and how you can access this information. Please review this information; the privacy of your health information is important to us.

### ***Services Provided***

Inspired Healing provides services that enhance wellness and address physical, emotional or chemical trauma, utilizing Network Spinal Analysis (services delivered by Arizona State licensed D.C) and/or Behavioral Health Counseling (services delivered by clinicians licensed in Arizona to provide professional counseling (LPC) or addictions counseling (LSAC). Care is provided in accordance with the practice member and/or the parent/guardians wishes, and the recommendations of the clinician. Behavioral Health services, if any provided, are outlined in a treatment Plan, which is reviewed and signed by the client and/or the parent/guardian and the clinician. Practice members and/or their guardians may refuse any and all services recommended. Inspired Healing reserves the right to refuse provision of requested services if the services requested are deemed inappropriate or inadequate to safely address the needs of the practice member or are outside the scope and training of Inspired Healing staff. At the practice member's request, referrals to other agencies may be provided.

### ***Payment for services***

Chiropractic Services provided to practice members according to fee schedule reviewed with and agreed to by the practice member, and/or the parent/guardian or guarantor of payment, prior to starting care at Inspired Healing. While Inspired Healing does not accept insurance, we will provide any reasonably requested documentation to the practice member, to facilitate reimbursement to the practice member.

### ***Counseling Fees***

The cost of your first session is \$175. Thereafter the fee for a 55 minute session is \$145. If Inspired Healing is contracted with your insurance carrier, you are obligated to pay any copayments or deductible amounts at the time of your session. If I am not a provider with your insurance company and you think your insurance will cover your counseling, I will provide you with a specialized receipt which you can submit to your insurance carrier. You can then get reimbursement by sending it in to your insurance with any of their required forms. When insurance does not cover your counseling, a sliding fee is available, based on income and number of family members is available. Sliding scale fee determination: With your income being \_\_\_\_\_ and the number of individuals in your family being \_\_\_\_\_, your fee for the initial session /subsequent sessions will be \_\_\_\_/\_\_\_\_

### ***Confidentiality of Practice Member Records***

Federal and state laws as well ethical standards dictate that Inspired Healing protect the confidentiality of information and records maintained by us. Inspired Healing will neither confirm nor deny to a person outside our office, that any person is a practice member or to disclose any information identifying an individual as a practice member unless:

1. The practice member and or the parent/guardian consent specifically to the disclosure in writing.
2. The disclosure is allowed by court order.

### ***Exceptions to Confidentiality***

Federal and state laws and regulations DO NOT protect information as follows:

1. A crime or a threat to commit a crime, either at the office or against any person who works for Inspired Healing may be reported to local police.
2. Any stated intent by a practice member to physically harm another person must be reported to the intended victim and to local police as required by law.
3. Suspected child abuse and/or neglect must be reported to local authorities as required by law.
4. Suicidal intent will result in an immediate assessment and communication of practice member information to other parties, as needed to maintain the safety of the practice member.

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## Uses and disclosures or your health information

1. Inspired Healing is required by law to protect the privacy of your health information and to provide you with the notice of our legal duties and privacy practices described in this notice. We have enacted safeguards and policies to ensure that your health information is a priority for us. You will be informed before any changes to policies are implemented. A new Notice of Privacy Policies will be posted at that time. You can also request a copy of our Notice of Privacy Policies at any time.
2. Federal law authorizes Inspired Healing to use or disclose your health information for treatment, payment, or operational purposes. If more than one law applies to the use or disclosure of your health information, then the law that most protects your health information will be followed. In the case of a medical emergency, we may disclose needed information without written authorization.
3. If any use or disclosure of your health information requires your written authorization, the authorization will be included in your medical record. For example, disclosure about behavioral health services requires specific written authorization from you. You may revoke your written authorization at any time.
4. Your health information may be used to to facilitate reimbursement to you from medicare, other insurance or state funding bodies. Written disclosure will be required to release this information to any party other than you. Any information released will be the minimum amount needed that is necessary.
5. Inspired Healing staff may use or disclose your health information to provide you with appointment reminders such as telephone calls, voice messages, letters/cards acknowledging birthdays or anniversaries or other events. These disclosures will not divulge the nature of the care you receive at Inspired Healing.
6. Inspired Healing must disclose your health information to you. At your request, we may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care. You must notify us however, so we can identify the designated individuals on your medical record.
7. In the event that you are incapacitated or otherwise incapable of communicating your wishes, then your provider will exercise his or her professional judgement to determine whether use or disclosure of health information to a family member, personal representative, or someone else will aid in your care.

## ***Your Rights***

1. You have the right to request that your health information be communicated to you in a confidential manner. For example, you may request that you be contacted somewhere other than your home address or telephone number.
2. In most cases you have the right to review or receive a copy of of your medical record or other relevant health information.
3. You will be notified of any disclosures made for reasons other than for treatment, payment, or related operational purposes.
4. Your health information will not be released except when specifically authorized by you, when required by law, or in emergency circumstances.
5. You have the right to request a paper copy of this Notice of Privacy Practices. You have the right to receive assistance reading and understanding this document if needed.

My signature below, acknowledges acceptances of this document and I hereby request and consent to treatment at Inspired Healing. This consent is for any and all services provided at Inspired Healing.

Guardian's Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Clients Name \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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(Please initial all boxes)

1. I have been fully informed of my rights as a client of Inspired Healing, the extent and limits of confidentiality in therapy, and the goals associated with this therapy. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency. Initials: \_\_\_\_\_

2. I understand that the staff of this agency may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. Initials: \_\_\_\_\_

3. I understand that my therapist may work with me at this agency, in my home, or in other settings based on his/her professional judgment. I further understand that my therapy may involve my participation in individual, couple, family, and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy. Initials: \_\_\_\_\_

4. I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group. Initials: \_\_\_\_\_

5. I understand that my therapy may include my attendance at meetings of independent self-help support groups including Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants. Initials: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Client's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Witness: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_/\_\_/\_\_