



kp counseling

Client Consent for Treatment

kp counseling is committed to helping individuals and organizations find their gifts and maximize their potential. We believe that all individuals have a light which represents their gifts and talents. We believe their light was designed by God (to their own understanding) to be used to fulfill their lives and serve others. Our mission is to help others improve the quality of their lives by focusing on building relationships with us, themselves, their families, and their community. We believe the key to a quality of life is awareness, education, and action. The human body is amazing in its ability to heal itself. Our focus is first on the health of the individual. The individual's physical and spiritual health is key to being healthy mentally and emotionally. Many times, trauma or deep-rooted wounds may interfere with the health of the individual and the focus is on the healing of those wounds for optimal living to occur. The goal is for individuals to develop skills of self-mastery, to not only have a fulfilled, quality life, but to also be a light and inspiration to others.

For the best results and for our own welfare, it is very important that you take the time to read and understand what it means to be receiving psychotherapeutic services from kp counseling. Please read the brief description below. If you understand it and choose to receive therapeutic services from kp counseling as described here, sign and date this form. If you have any questions or concerns, please speak to your therapist or one of our office staff.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you solve problems that may be limiting your satisfaction in life, and help you cope better with the feelings and challenges that you encounter in daily life.
2. The most common method of psychotherapy involves talking about your feelings, your problems or concerns, and your experiences and your situation. Other common methods involved using your imagination, keeping personal records of your experiences, and trying new and/or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions, or you may be asked to do them at home.
3. The length of psychotherapy often depends on your individual needs and the rate of your progress toward the agreed upon goals in your treatment plan. Many therapists use periodic reviews as a means of evaluating your needs, progress and satisfaction, and treatment plans are reviewed every three months at kp counseling.
4. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. If you feel that you are making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your psychotherapist. If you feel that your therapist has attempted to violate you in any way – financially, physically, sexually, or otherwise – you should inform the state agency responsible for professional licensing. You are also encouraged to contact the clinical director at the agency at any time with any concerns or feedback you may have about your therapist.
5. You always have the right to choose whether to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist or the Clinical Director at the agency should be able to offer information on possible referrals. Local mental health agencies can be found using your search engine of choice on the internet. Sometimes it is helpful to participate in different kinds of counseling in addition to or instead of psychotherapy. Some different kinds of counseling are self-help or support groups, therapeutic reading, and different forms of religious or pastoral counseling. The agency strongly supports you making the decision to participate in therapy that feels right for you. We will help you to the best of our ability to acquire appropriate care.

6. Communication is essential to successful psychotherapy. You are urged to ask questions, express concerns, and share information about your personal life with your therapist. This information must be kept private (confidential) by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by laws and are explained in the Limits of Confidentiality form that will be reviewed with you. If you do not understand the limits of confidentiality you are urged to discuss them with the intake counselor or your therapist.
7. kp counseling's mental health providers are diverse group from various disciplines. They include licensed professional counselors (LPC), licensed clinical professional counselors (LCPC), licensed social workers (LSW), licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT), Certified Alcohol Drug Counselor (CADC), as well as graduate school interns from several graduate programs in the state who may be observing as part of their training. All other providers are licensed (fully licensed and/or in-training licensed) professionals or are actively working towards their licensure through continuing education and supervision. All providers receive supervision, meaning they consult and collaborate with other mental health professionals within our agency about their clients without divulging the client's names or identifying information. If you have any questions about your therapist or about consultation/collaboration between providers, please do not hesitate to ask him or her, or the Clinical Director.

Audio or Video Recording of Any Session is Forbidden

I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). If I or any participant in my session do record any audio or video information during my treatment session(s) without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I may be permanently discharged from my provider and all providers in the kp counseling company.

Client Information and Informed Consent for Telehealth Treatment

Telehealth services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for services such as individual, couples, or family therapy. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with the technology (cell phone, computer, etc.) which is being utilized. It is important that both the client and the counselor be in a place where there is the most privacy, as possible, during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

Additional Points for Client Understanding:

- I understand that telehealth services are completely voluntary, and I can choose not to do it or not to answer questions at any time.
- I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
- I understand that telehealth will be performed with encrypted platforms only. My therapist and I will work together to choose the telehealth communication system/program that will work best for my needs.

kp counseling has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth session will not be the same as an in-person session since I will not be in the same room as my therapist.

- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing, text, or telephone connections are not adequate for the situation.
- I understand that I may experience benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

- I understand if there is an emergency during a telehealth session, as with an in-person session, my therapist will call emergency services and my emergency contact if needed clinically necessary.
- I understand that in advance of the telehealth session, a plan will be in place about how to re-connect if the connection drops while I am in a session.
- I understand that my therapist and I will create and have in place a safety plan in case of an emergency (see below).
- I understand I have the right to withhold or withdraw this consent at any time.
- I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the information, authorization, and consent to Treatment document.

Consent:

I consent to engaging in telehealth as part of my treatment at kp counseling. I understand telehealth includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or date communications.

I understand the information provided above regarding telehealth. I have discussed the consent with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth I my care.

**A Mental Health and AODA Clinic
Confidentiality of Alcohol and Drug Abuse Client Records**

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by the clinic, Generally, the clinic may not say to a person outside of the clinic that a client attends the clinic, or disclose any information identifying a client as an alcohol or drug abuse client unless:

1. The client consents in writing.
2. The disclosure is allowed by court order.
3. The disclosure is made to medical personnel in a medical emergency.

Violation of the Federal law and regulations by the clinic is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal Law and regulations do not protect any information about a crime committed by a client either at the clinic or against any person who works for the clinic or about any threat to commit such crime.

Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for federal regulations.

Confidentiality of Medical Health Client Records

All information concerning your identity and all treatment information in your files at kp counseling shall remain confidential. Your records will not be released without your written informed consent unless as provided under sections 740 ILCS 110/ of Illinois State Statutes, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 of the federal state statutes, 42 C.F.R. Part 2 of the federal regulations, or as otherwise allowed or required by state or federal law They may also be released to other persons with your written informed consent, or the written informed consent of a person authorized by you. Feel free to request additional information or have your Therapist/Counselor explain the circumstances under which your records may be released if you wish further clarification.

You are not required to give kp counseling any specific information. However, all information that you give will help us gain funds for the services you may receive.

All information that you give will also help your Therapist/Counselor provide you (and your family) with the best care possible. Feel free to have your Therapist/Counselor explain further if you wish clarification.

You have the right to review your file with staff present and to contest the accuracy of any statement in your file with which you disagree.

Grievance Procedures Outline

kp counseling is devoted to providing competent mental health and AODA Treatment to our clientele. The agency would also like every client to know that he/she does have a voice in the kind of care received. Grievances involve complaints about services, breach of confidentiality or abuse. The following instructions are steps to be taken should a client feel the need for resolution of a situation. If level one does not provide satisfactory results, the client should proceed to the next level, and so on.

Level One

One of the most important tools in psychotherapy is the relationship between the therapist and the client. If a client has a discrepancy with the therapist, those issues should be discussed directly with the therapist. The two parties will discuss the matter and come to an agreeable resolution.

Level Two

Clients of kp counseling have the right to speak directly to the Clinical Director if speaking with the therapist has not helped the situation. The Clinical Director will attempt to mediate the difficulties between therapist and client.

Level Three

At this level, clients should place all grievances and steps that have been taken to remedy the situation in writing using the "Grievance and Complaint Summary Form" within one month of the meeting with the Clinical Director. This form may be obtained from the Client Rights Specialist/Director. The Director will review the situation and meet with the parties involved to discuss resolutions. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

Coordination of Care Between Health Care Providers

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. If you complete a Release of Information (ROI) this form will allow your behavioral health provider to share protected health information (PHI) with your other provider. The information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, Diagnostic Assessment, and case notes, if necessary.

Client Rights

- You may end this authorization (permission to disclose information) at any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see applicable Notice of Privacy Practices.
- You will be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Medical Information Notice of Privacy Practices

Effective March 1, 2023

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the behavioral health care providers and entities that are owned or controlled by OptumHealth Holdings, LLC and which are part of an affiliated covered entity (collectively referred to herein as the "Optum Behavioral Care ACE" or "OBC ACE," which includes Refresh Mental Health) for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). References in this notice to "we," "us," and "our" mean the OBC ACE. For a list of the entities participating in the OBC ACE, please contact the Refresh Mental Health Privacy Administrator at the address listed below.

We are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you, and when we can give out or "disclose" that information to others. You have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website www.refreshmentalhealth.com. If we maintain a physical delivery site, we will also post a copy in our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may collect, use and disclose your health information:

- **For Payment.** We may collect, use, and disclose health information to obtain payment for health care services. For example, we may collect information from, or disclose information to, your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect, information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice, and we may use it for any lawful purpose.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Reminders.** We may collect, use, and disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you, or reminders related to medicines prescribed for you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment, or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the

institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors Information
 9. Prescriptions
 10. Reproductive Health
 11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled "Exercising Your Rights."

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous

confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, www.refreshmentalhealth.com or by calling 1-855-205-0990.

Exercising Your Rights

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call 1-855-205-0990.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

**Refresh Mental Health Privacy Administrator
MN101-E013
11000 Optum Circle
Eden Prairie, MN 55344**

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not retaliate against you for filing a complaint.



kp counseling

Client Consent for Treatment

Client Name: _____

Client#: _____

Authorization to Release Information for Assignment of Insurance/EAP Benefits

Please Indicate your preference by checking either **A or B** below:

A. I hereby authorize kp counseling to release to my insurance company, EAP, and/or associate professionals any information from my medical records which may be necessary to determine benefits payable under my policy and/or expedite treatment. This information may be transmitted electronically with appropriate assurances for confidentiality. I further authorize payment directly to kp counseling for the benefits of otherwise payable to me for the amount which covers but does not exceed charges for services delivered. I hereby guarantee payment of all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. I am also aware that any co-pays, coinsurance, deductible amounts are expected at the time of service. I understand if a Release of Information is completed for person(s) and/or organizations that are not health care providers, health plans or a health care clearing house, who must follow the federal privacy standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed with my authorization.

Please Note: If consent has been given to release information to my insurance company, I understand that some communications may be transmitted by facsimile ("fax") or electronically. Although every attempt is made to ensure confidentiality of these transmissions, the nature of this method cannot absolutely guarantee confidentiality.

OR

B. I DO NOT authorize my insurance/EAP company to be billed and I DO NOT authorize any information from my medical records to be released to my insurance company. I understand that I am solely responsible for private/self-payment of all charges incurred with kp counseling. I am aware that payment for services is expected at the time of service.

Acknowledgement

I acknowledge that I have received the written "Grievance Procedure for Community Services" and "Notice of Privacy Practices". I understand the "Clients Rights and the Grievance Procedure for Community Services" and acknowledge the understanding of this process by signing this acknowledgement.

I have read and understand the above confidentiality policy of client records. I understand that my records may be released to other people without my informed consent only as provided by State and Federal law, or to persons with my informed consent or the informed consent of a person authorized by me.

I have read the policy regarding the prohibition of audio and video recording. I agree to abide by this policy.

I have read the authorization to release information for assignment of Insurance/EAP benefits, have indicated my preference, and am acknowledging my understanding of the information hereinabove.

Your signature indicates that you have understood the above description of psychotherapy and are consenting to psychotherapy & telehealth if applicable with the understanding that you retain the right to review and revise the decision at later points in time.

Print Client Name _____ DOB _____

Signature of Client _____ Date _____

Print Parent/Guardian Name(if applicable) _____

Signature of Parent/Guardian(if applicable) _____ Date _____