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Client name/DOB: \_\_\_\_\_  
Last Four of SSN: \_\_\_\_\_  
Parent or guardian name: \_\_\_\_\_

### Therapist-Client Agreement

This section contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you be provided with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The law requires that your signature is obtained acknowledging that you have been provided with this information.

#### Confidentiality

The law protects the privacy of all communications between a client and a licensed therapist. In most situations, information about your treatment can only be released if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent.

Your signature on this agreement provides consent for those activities, as follows:

- During the course of your treatment it may become necessary for other health and mental health professionals to be consulted regarding your care. During a consultation, every effort is made to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. You will not be notified regarding these consultations unless it is deemed as important to your care and progress in therapy.
- There may be administrative workers and interns employed or working in direct service for this office. In most cases, protected information regarding individual clients will need to be shared for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All administrative staff and mental health care workers are bound by the same rules of confidentiality and have been given training about protecting your privacy.
- If a client threatens to harm himself/herself, he/she may be obligated to seek hospitalization and confidentiality agreements can be breached by the therapist for the safety of the client.

There are some situations in which your information is able to be disclosed without either your consent or authorization:

- If you are involved in a court proceeding and a request is made regarding your care, such information is protected and cannot be provided without your written authorization or a court order.
- There are some situations in which it is the therapist's legal obligation is to take actions which are believed to be necessary to protect others from harm and may result in the revelation of some of a client's confidential information
- If there is suspected abuse and/or neglect of a minor or elderly person, a therapist is required by law that a report be made with the appropriate governmental agency.
- If it is determined that a client presents a serious danger of violence to himself or another, the therapist may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client, per Baker Act procedures.

#### Client Records

The laws and standards of this profession require that Protected Health Information (PHI) be kept about you in your clinical record. You may be supplied with a written summary of your clinical record upon your request for a fee as listed in the financial policy. Also, upon your request and release of information, your treatment can be discussed with others who are relevant to your care.

#### Minors and Parents

Patients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment. However, if the therapist states that doing so would jeopardize the child's treatment, it is best for the therapeutic process for parents to be in agreement regarding disclosure of certain information. Although, if the therapist feels that the child is in immediate danger or is a danger to someone else, the parents will be notified immediately.

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date

Signature denotes that Client or Parent/Guardian has been provided access to Therapist-Client Agreement at [www.shantalaboss.com](http://www.shantalaboss.com). Printed version available upon request.