



**LEEWARD THERAPY & COMMUNITY SUPPORTS**  
MAKING MEANINGFUL CHANGES

## **Health Insurance Portability Accountability Act (HIPAA)**

### **Clients Rights & Therapist Duties**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), 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 healthcare operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and other healthcare operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this Notice. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at anytime. This revocation will be binding unless I have taken action in reliance on it.

#### **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a workers compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contact.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the FLORIDA Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the FLORIDA Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police, or to seek hospitalization of the patient.

## **CLIENT RIGHTS AND THERAPIST DUTIES**

### **Use and Disclosure of Protected Health Information:**

- ***For Treatment*** - I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another healthcare provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** - I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** - I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

### **Patient's Rights:**

- ***Right to Treatment*** - You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** - You have the right to have your healthcare information protected. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of \$1.00 per page. Please make your request well in advance and allow two weeks to receive the copies. If I refuse your request for access to your records, you have the right of review, which I will discuss with you upon request.
- ***Right to Amend*** - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it and if I refuse to do so, I will tell you why within a 60 day period.
- ***Right to a Copy of This Notice*** - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at the first session a copy will be provided to you per your request, or at anytime.
- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has authority and can act for you before I take any action.
- ***Right to Choose*** - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** - You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone, letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** - With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.
- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

## COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of FLORIDA Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

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Client/ Legal Guardian Printed Name

Client/ Legal Guardian Signature

Date

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Therapist Signature

Date



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**Therapy terms and conditions**

**Office Hours: \*office hours may vary\***

Monday 5:00pm-8:00pm Tuesday 6:00pm-8:00 pm Wednesday: 5:00 pm-8:00pm  
Thursday: 6:00pm-8:00pm Friday: 4:00pm-7:00 pm

**Privacy/Confidentiality:**

Client's personal and therapeutic information is protected and complied with HIPPA compliances. This therapist will not disclose any information to any third parties without a release of information consent signed by the client. Privacy and confidentiality may be breached and reported to the appropriate agencies if the client has REPORTED/DISCLOSED the following: Client Initial:\_\_\_\_\_

1. Self-Harm or Suicide
2. Harm to others or Homicide
3. Harming a minor (abuse, neglect)

**Appointment Cancellations/No Show/ Reschedule/Termination:**

Clients are asked to schedule an appointment with me. I will remind clients of the appointment date and time, if you have a case manager I may reach out to follow up if you have not been continuing services. Please reschedule or cancel 24 hours in advance of your appointment date and time . If you are in need of crisis services please contact Hawaii Cares Line @ 808-832-3100 or 911. \* 2 CONSECUTIVE NO SHOW APPOINTMENTS WILL RESULT IN WAIT LISTING OR TERMINATION OF SERVICES\* Client Initial:\_\_\_\_\_

Clinician or Client may end this therapeutic relationship at any time with a verbal or written notice. Services may stop or end if insurance parties have not been paying for client services. Payments will be billed through Care Hawaii. Termination may end if client self-determines services are no longer needed, If clinician has clinical data and information that client has reached/managed their goals and has seen substantial change. Clinician may end services if client becomes inappropriate with clinician such as being verbally, mentally, emotionally, sexually, and physically abusive/harmful towards the therapist or others. Client Initial:\_\_\_\_\_

**Services:**

I provide individual therapy sessions to adult individuals who are seeking mental health wellness due to a clinical mental health diagnosis. I perform therapy using variations of therapy models such as CBT (cognitive behavioral therapy), MI (motivational Interviewing), Solution-Focused therapy, and psychoanalytic therapy. Client Initial:\_\_\_\_\_

The way therapy is conducted (telehealth or phone) and duration of therapy will vary from person to person. Telehealth includes telephone calls, texting, emails, facetime, and zoom. Client Initial:\_\_\_\_\_

**Therapeutic relationship:**

This is a professional 1 to 1 relationship that involves two parties( Therapist and Client) who have agreed to treatment in the scope of this clinician's professional practice. Client Initial:\_\_\_\_\_

\_\_\_\_\_  
Print Name (self/guardian)

\_\_\_\_\_  
sign name

\_\_\_\_\_  
Date

If you agree to these terms and conditions, please sign here  
(signature is valid & will expire for 1 year from the date listed below)



