Consent for Treatment

Client's Name:
Date of Birth:

I hereby give full consent for myself or my child to receive services from Audrey Burgess, Ph.D. until I notify her or she determines services are no longer necessary or appropriate. I certify that I have the legal authority to consent to this treatment. In the case of a minor, I certify that as parent, managing conservator, or guardian of the child I authorize and consent to this treatment.

YOUR RIGHTS TO PRIVACY

- You have the right to inspect and receive a copy of your PHI, subject to the limitations placed on your accessibility to your PHI as outlined by the Texas State Board of Examiners of Psychologists (eg. Raw test data may not be released to you).
- You have the right to know instances in which your PHI has been disclosed for purposes other than treatment, claims processing, and organizational operations (eg. If your records are requested by a court of law under subpoena).
- You have the right to request amendment of your PHI if you feel that the information in your PHI is in error. However, if the information was not created by me or if the information is not part of your PHI kept by this office, then I cannot amend your PHI. I cannot change your PHI if the change is believed by me to be an inaccurate representation of your PHI.
- You have the right to request a restriction or limitation on the PHI I use or disclose about you for treatment, payment, or health care operations.
- You have the right to request that I communicate with you in a manner that ensures your privacy.
- You have the right to file a complaint if you believe that your privacy rights have been violated and you are unable to come to satisfactory terms, by contacting the Texas State Board of Examiners of Psychologists.
- Please note that Dr. Burgess follows the rules and laws established by the Texas State Board of Examiners of Psychologists in maintaining your privacy and releasing your PHI to you or others. The TSBEP places certain limits on what information Dr. Burgess can release to you or others. The TSBEP outlines several circumstances under which Dr. King-Burgess must release your PHI without your consent:
    - If Dr. Burgess has determined that you are a risk to yourself or others, and disclosure of your PHI will assist in ensuring your and/or others' safety.
    - If Dr. Burgess receives a subpoena or other court order to release your PHI.
    - If Dr. Burgess suspects that the patient is a victim or perpetrator of physical, sexual, or emotional abuse.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes,
and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

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Client Signature (Client's Parent/Guardian if under 18)

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Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency**.** A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

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Client Signature (Client’s Parent/Guardian if under 18)

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Today’s Date