



## **MINOR INFORMED CONSENT**

### **General Information**

Welcome to Choices Counseling & Advocacy Center, LLC. This consent contains important information about our professional services, advocacy services and summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment and care. This form represents an agreement between you and your provider regarding HIPAA and its use and exceptions. Any question you have relating to this consent can be discussed with your provider and/or their representative now or any time in the future.

### **The Process of Engaging in Professional and/or Advocacy Services**

Engagement in services requires a relationship between you and your provider that works, in part, because of clearly defined rights and responsibilities held by each person. As a patient, you have certain rights and responsibilities, as well as legal limits to these rights. In addition, your provider has corresponding responsibilities to you. It is important to understand these rights and responsibilities and they are described in the following sections.

All services are confidential processes designed to help your child address their concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. Your provider has the desire and willingness to work in collaboration with you to help you accomplish your individual goals. These processes involve sharing sensitive, personal, and private information that may at time be distressing. During the course of your child's work with their provider, there may be periods of increased anxiety or confusion. The outcome of participation in professional and/or advocacy services is often positive, however,

the level of satisfaction for any individual is not predictable. Your provider is available to support you throughout your engagement in these processes.

## **Confidentiality**

The therapeutic relationship relies upon the trust that one's confidential health information will be respectfully treated and remain confidential in as much as the law allows. Although every effort is made to protect the rights of each individual in services, it is difficult to guarantee and the parent/guardian must consent on the minor's behalf. In most cases the parent/guardian must sign a consent to treatment and may have rights to view treatment records. However, there are always situations in which a parent/guardian may not have legal access to the minor child's treatment records.

Choices Counseling and Advocacy Center, LLC is a holistic program and our provider team (mental wellness and family advocacy professionals) may share access to your child's treatment records and may consult with each other in order to ensure effective coordination of care. Occasionally, providers may need to consult with other members of the Choices Team in their areas of expertise. Your child's information is shared strictly on a need to know basis. A provider or health plan may send copies of your child's records to another provider or health plan only as needed for treatment or payment, or with your permission. Your written authorization is necessary before your child's health records are shared for any other reason.

Psychotherapy notes are notes that a mental wellness professional takes during a conversation with a patient and are the property of the provider. They are kept separate from the patient's medical and billing records. HIPAA does not allow the provider to make most disclosures about psychotherapy notes about you without your authorization.

## **Exceptions to Confidentiality**

- Your provider may consult with other professionals to deliver the best possible care.
- If there is evidence of clear and imminent danger of harm to yourself and/or others, your provider is legally required to report this information to the authorities responsible for ensuring safety.
- State laws require that if your providers learn of, or strongly suspects, physical or sexual abuse, or neglect of any person under 18 years of age, or

elderly or dependent adult, the provider must report this information to child or adult protective services.

- A court order, issued by a judge, may require your provider to release information contained in records and/or require a provider to testify in a court hearing.
- State laws regulations the right of parent's (custodial and/or non-custodial) access to a child's health care records after a divorce.
- Among professionals and advocates who work with young minors the following issues are considered dangerous enough to warrant them to break confidentiality:
  - Suicidal ideation
  - Illegal serious drug use
  - Selling or distribution of drugs
  - Ideas/plans about school shooting/mass shootings

### **Other Rights**

If you or your child has any concerns about the quality of care you are receiving please speak with your provider to consider how your concerns can be addressed. Any discussion will be taken seriously and handled with care and respect. You may also request to speak to the Patient Care Coordinator. You may request a referral to another provider and are free to terminate services with Choices at any time. In the event your employment is terminated and/or your mental health counseling benefits end, your sessions with discontinue. If you request, your provider will offer referrals to other similar providers in your community. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion or national origin. You have the right to ask questions about any aspect of your service and about your providers specific training and experience.

### **Courtesy**

We appreciate prompt arrival for appointment. Please notify us if you will be late or need to reschedule or cancel your appointment. A 48-hour notice of cancellation allow us to use the time for others. Cancellations less than 24-hour's notice are subject to charge.

**Consent**

I have read and discussed the above information. I understand the risks and benefits of mental health and advocacy services, the nature and limits of confidentiality and what is expected of me as a patient.

I agree that the minor patient and the provider may have a confidential relationship. \_\_\_\_\_Patients Initial

\_\_\_\_\_  
Minor Patients Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parents Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name