DrCFultz, LLC

Authorizations **and Consents**

Client Name _____**Guardian Name (if under 18)** _____

Notice to Client(s)

Dr. Cheryl Fultz, Pastoral Counselor cannot release information of any kind including information about appointments or billing to anyone other than the client/parent or legal guardian of the client. Please let Dr. Fultz know in advance if you would like to complete an authorization of release of information form.

1. **Confidentiality**: Please initial _____ (client/legal guardian or representative). All communication between client and counselor is confidential and will not be revealed unless required by law. We are required by law to report child abuse/neglect, major suicidal tendencies, and possible homicides. Your family will not receive any information from us unless you request it. Our files and documents are kept double locked. If you want us to discuss your case with someone else, you will be asked to sign an "Authorization to Release Information Form". Dr. Fultz will be discreet if it is necessary to contact you or leave a message at home or work. We follow the United States HIPPA rulings for privacy.

2. **The use of Social Media or Electronic Communication**: Please initial _____ (client/legal guardian or representative). The use of texting, email, skype or other forms of electronic communication cannot be guaranteed by Dr. Fultz to be completely confidential. Every effort will be made to ensure as much security as possible.

3. **Permission for mode of contact and people to be contacted concerning your personal information:** Please use the following forms of communication in contacting me: emails____, cell phone____, home phone ____, texting____, or other ____related to my appointments/sessions. The contacts I wish to know about my personal healthcare information from this office are listed below and should it change, I will contact you. Contact:_____, Relationship:_____, Contact:_____, Relationship _____.

4. **Cancellation of Appointments:** Please initial_____ (client/legal guardian or representative). A charge of $35 will be billed for the missed session when cancelled within 24 hours prior to scheduled session or not showing up for session.

5. **Emergency Phone Calls**: Please initial_____ (client/legal guardian or representative). Client may use given cell phone numbers in emergency circumstances and for confirming appointments. Cell phone number is not to be used or given out to be used for sales or to further business or contacts.

6. **Clients Rights and Responsibilities**: Please initial_____(client/legal guardian or representative). Any person receiving services is entitled to:
    a. Human care, protection from harm, and to be treated with dignity and respect.
    b. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
    c. The right to receive treatment in the least restrictive settings.
    d. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorizations, except in cases of medical emergency, by court order, or when otherwise dictated by law.
    e. The right to register complaints and to have his/her complaints heard and action taken, if required promptly.
    f. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly and in a competent state of mind. The waiver may be withdrawn at any time.

7. **Consent for Treatment Authorization**: I authorize and request Dr. Fultz to carry out Pastoral Counseling during my treatment. I understand that while the course of my treatment is designed to be helpful, Dr. Fultz can make no guarantees about the outcome of my treatment. Further, the treatment process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that reactions will be worked on between my counselor and me. With these understandings, I hereby authorize treatment for myself. I give permission to develop treatment and/or provide treatment. In the event that I become ill, injured or a threat to myself or someone else, I authorize Dr. Fultz to provide/obtain emergency medical services (i.e call 911).
    Signature of Client/Legal Guardian or Representative) _____Date_____

8. **Client Consent for Use/Disclosure of Health Care Information**: I understand that the clients health information is private and confidential. I understand that Dr. Fultz works very hard to protect the clients privacy and preserve the confidentiality of the clients personal health information. I understand that Dr. Fultz may use and disclose the clients personal health information to help provide health care to the client, to handle billing and payment and to take care of other health care operation. In general, there will be no other uses and disclosures of this information less I permit it. I understand that sometimes the law may require the release of this information without my permission. Examples would be if a client threatened to hurt someone or if child abuse is reported.
    Signature of Client/Legal Guardian or Representative) _____Date_____

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