Client Rights and HIPPA Notice of Confidentiality

The undersigned client (“client”) understands that Diane G Clark, LLC d/b/a/ Ethos Therapy and LIfe Coaching (“Ethos”) complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and applicable law. Ethos is required by law to maintain the privacy and security of your protected health information, to comply with the duties and practices described in this notice, and to give you a copy of it. No information may be shared without your written consent. However, there are exceptions as follows:

- Reporting suspected abuse, neglect, or domestic violence.
- If I feel you are a danger to yourself or others
- To comply with the law, for example, if records are subpoenaed.
- To respond to lawsuits and legal actions.
- To submit claims to insurance if utilizing insurance for payment.

You may Ethos in writing if you change your mind. More information can be found at Www.hhs.gov/ocr/privacy/HIPAA/understanding/consumers/index.htmlnotify
The client understands that email and text communication are not completely assured of secure confidentiality. The client will be asked to set up a Spruce Care Messenger Application (“Spruce”) which provides a more secure form of communication with each Ethos Therapy and Life Coaching practitioner than other conventional online messenger applications. This is the best way to contact your Ethos provider for scheduling, rescheduling and crisis or contact outside regular sessions.

The client understands that Ethos Therapy and Life Coaching cannot provide services in the event of life threatening situations. The client agrees to seek emergency care through their local emergency room or by calling 911.

Consultation

The client understands that Ethos providers work collaboratively and consult regarding clients in order to provide the very best treatment to each client. Additionally, therapists may seek professional consultation outside Ethos without disclosing client names or identifying information. Ethos providers also consult to provide learning for graduate students and clinical supervisees. Clinician at the Master's level have their notes read and signed by a clinical worker within the agency. By signing below, client consents to such disclosure and actions by Ethos. If client has questions or concerns or does not wish specific consultation to take place, he or she is encouraged and has the right to discuss this with the applicable Ethos provider and has the right to revoke this permission in writing at any time.

The client understands that it is recommended that he or she has a thorough physical examination by client's primary care physician either prior to or concurrent with treatment in order to rule out potential physical issues. Ethos providers are required to coordinate treatment with client primary care physicians with the appropriate signed releases unless the client waives this right.

__Yes, coordinate care with my primary care physician
__No, I waive the right for the clinician to coordinate with my physician

Therapy

Therapy is the process of coming alongside a person to help gain deeper insight into issues creating pain or holding clients back using a variety of evidence based methods such as trauma based therapy, cognitive behavioral therapy, mindfulness, emotion focussed therapy and more. These issues may be from the past, physical symptoms, anxiety, depression, relationships, or current ways of thinking, behaving, beliefs or emotions. Therapy helps clients differentiate between choices made out of pain and out of a true heart and learning to live out of a higher level of freedom and maturity and bringing dissociated personality parts into line; heart, mind, body and spirit, and to live in the present versus the past or future. Clients relieve pain and barriers to restore hope and help a person move forward in freedom to live the best life.

Individual sessions generally run from 50-60 minutes weekly. Success is directly related to commitment, frequency and personal investment.

The therapeutic relationship is mainly one sided, although trust and connection with the therapist are key to success. The therapist will not friend or follow clients on social media. Contact with the therapist outside of sessions is by emergency only.

Client Responsibilities

The client agrees not to attend sessions while under the influence of alcohol or drugs not prescribed to them.

The client understands that Therapy has both benefits and risks and agrees to work together with the Therapist to identify treatment goals, resolve issues, work on problems, and follow through with recommendations. Lack of participation will impair the effectiveness of treatment.

Fee for Services

The client understands that the fee for service is due at each session according to the fee schedule presented at the start of services. If a hardship occurs, please discuss these concerns with your provider.

Therapy clients understand that a diagnosis must be reported to the insurance company for a claim to be processed. The Therapist will discuss the diagnosis with the client.

Therapy clients understand that if insurance is utilized, the copay and/or amount to meet deductible is due at the time of service. While we file claims on your behalf for the insurance companies we are in network with, we may ask for your participation in processing claims if problems occur. If the therapist is out of network with your insurance company, the client is required to pay the full amount for services and a super bill will be provided for the client to submit for insurance reimbursement.

By signing below, the client, if utilizing insurance, releases information regarding diagnosis and treatment needed to the insurance company for the purpose of filing claims and receiving benefits.

Payment for private payTherapy, Life Coaching, Massage Therapy, Yoga and Pastoral care is due at the time of service.

The client agrees to pay $35 on returned checks.

Cancellations and Scheduling

The client understands that a fee of $50 will be charged to their account for any session cancelled less than 24 hours prior to an appointment. No shows or missed appointments will result in a $50 charge. This cannot be charged to insurance. If the client is more than 15 minutes late, the appointment will be rescheduled and the client charged for a missed appointment.

Juvenile Clients

The client understands that in divorce situations, our office will only collect payment from the parent who initiated services. We do not offer divided billing services. These type of arrangements are to be worked out between the parents. We also expect that the individual representing a minor has privileges to consent to medical care. We will not be held liable for any misrepresentations. We may ask for a copy of the divorce decree.

Court Involvement

The client agrees that if a clinician is subpoenaed to appear in court on the client's behalf, or if the provider is requested to provide a court update or other written document regarding treatment progress, there will be a $165 per hour fee payable at the time the subpoena is received for the clinicians' time preparing for the court appearance or preparation of the documents. If the client is a minor child, the fee will be assessed to the parent whose attorney sent the subpoena.

The client agrees that if the clinician is subpoenaed to court, the client or guardian will pay for the clinician's time spent traveling to and from court and for the time the clinician is scheduled to be at court. The client agrees to pay the clinician's hourly rate of $165 per hour

RIGHTS OF THE CLIENT: READ AND SIGN BELOW:

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OR PRIVACY AND CLIENT RESPONSIBILITIES, THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED AS DESCRIBED IN THIS DOCUMENT BY SENDING A WRITTEN NOTIFICATION TO ETHOS. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AN A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO RE DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL REVOKED BY THE CLIENT OR REPRESENTATIVE SIGNING THE AUGHTOAIZATION.

Client Signature_____Date_____

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Witnessed by_____ Date_____