Oak Lake Wellness

Patient Consent For The Use And Or Disclosure Of Protected Health Information

I, _____ herby state that by signing this consent, I acknowledge and agree as follows:

1.) The Practice's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and /or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The practice has further explained my right to obtain a copy if the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

2.) The practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.

3.) I understand that, and consent to the following appointment reminders that will be used by the practice: a) telephoning my home or mobile phone number indicated on the Client Information sheet; and leaving a message on my answering machine or voicemail. b) Texting my mobile phone; c) emailing me at the address provided on the Client Information sheet. Although the practice will make all reasonable efforts to secure my privacy during these times, I *further* understand that these methods of contacting me may or may not be confidential and or subject to outsider viewing or listening.

4.) The practice may use and /or disclose my Protected Health Information (which may include information about my health or condition, my address, my phone number, the date of my birth; or that information pertaining to the subscriber of my insurance plan that may include a parent or spouse) in order for the practice to treat me, and obtain payment for that treatment and as necessary for the practice to conduct its specific health care operations.

5.) I understand that I have the right to request that the practice restrict how my Protected Health Information is used and /or disclosed to carry out treatment, payment, and /or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the practice.

6.) I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.

7.) I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

8.) I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I understand.

_____ _____

Name of Individual (PRINTED) Signature of Individual

_____ _____

Signature of Legal Representative (if guardian, or parent of minor) Relationship

_____ _____

Date Signed Witness

Oak Lake Wellness

PATIENT PRIVACY AND CONFIDENTIALITY STATEMENT

DISCLOSURE OF INFORMATION

Oak Lake Wellness (owned by Triniti N. Anderson, LPC) may disclose information to other healthcare professionals (such as your primary care physician or pediatrician), and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with *Worker's Compensation* and *Public Health Laws* as well as *Judicial proceedings*. Triniti N. Anderson may contact your family member or other authorized person in the event of an emergency. Be assured that Triniti N. Anderson will not disclose any information without your expressed written consent, unless otherwise compelled to do so by legal authority, and or where indicated to protect your safety, or those of others. Further, you will be contacted by phone or mail in the event a request for information has been made by the above entities. At times, Triniti N. Anderson may consult with other professionals about your case, but every effort will be made to avoid revealing identifying information in accordance with the ethical standards outlined in the American Counseling Association Code of Ethics. Please read the statement below regarding patient confidentiality.

FACILITY SET UP

Please be informed that this practice is set up through a tele-medicine/tele-therapy platform and is owned by Triniti N. Anderson. All sessions will occur through a video platform called Doxy.Me. Doxy.Me is a HIPPA compliant video and messaging platform used by physicians, counselors, and other healthcare professionals. Triniti will take all reasonable measures to secure your privacy while in a video session (this may include but are not limited to, conducting sessions from a private room so that conversations are not overheard and using a personal devise that is not accessible by others). Clients should ALSO secure a private room/setting in which to meet for therapy and should consider who may have access to their device(s) used for therapy. At times, due to disruptions in connectivity and other interruptions, sessions may be conducted via mobile phone. This is NOT a secure means by which to conduct therapy sessions. If in such instances, the client and therapist will work together to achieve reasonable privacy and security of the phone session. Please ask Triniti if you have any questions or concerns related to Doxy.Me or other privacy matters.

YOUR RIGHTS

1.) Send Triniti N. Anderson a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If Triniti N. Anderson did not create the information, we will refer you to the source, such as another doctor or hospital.

2.) You have the right to request additional restrictions on uses and disclosures of your health information. Triniti N. Anderson is not required to agree to these requests. Further, in some instances law may prohibit those restrictions.

3.) You have the right to request that Triniti N. Anderson communicate with you about medical matters using reasonable alternative means or at an alternative address.

4.) You have the right to receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

5.) You have the right to inspect and have a copy of your health information. There is no cost for the first copy; any copy thereafter will be $25.00.

6.) You have the right to amend your information. Please note that Triniti N. Anderson has the right to disagree with your amendments. If there is a disagreement you will be provided with information about the denial of your amendment and how you may appeal the denial of amendment.

7.) You have the right to a copy of the notice upon request.

COMPLAINTS

Complaints about your privacy rights, or how your privacy is handled at this office can be directed to D.A. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave. S.W., Room 509F HHH Building. Washington, DC 20201.

CONFIDENTIALITY STATEMENT

In general, the privacy of all communications between a patient and a counselor, or therapist are protected by law and that information can only be released with your written permission, but there are exceptions. Those exceptions include release of information during a legal proceeding, in an emergency, and when the health and safety of you, a child, or those in the community are deemed at risk. Be advised that Triniti N. Anderson is legally obligated to report any and all incidents whereby a child, or elderly person's safety, or wellbeing may be at risk of harm. In such incidents, Triniti N. Anderson will report such risks of harm to state agencies whereby an investigation by the state may occur. In addition, if such risks to yourself or anyone in the community is deemed as harmful, or potentially harmful, Triniti N. Anderson is obligated to report these risks to appropriate parties (that may include law-enforcement personnel, emergency services, hospitals, or in the case of anyone under 14, your parents may also be informed) at which time further treatment may be mandated by those parties. If such incidents (although rare) occur in the office, Triniti N. Anderson will make every effort to discuss it with you before taking action.

I have read and understand this Privacy Notice and Confidentiality Statement regarding my rights and confidentiality contained in this notice. By signing this form, I provide authorization and consent to use and disclose my protected health information, and further understand the risks to my confidentiality as noted above.

_____ _____

Name of Client (please PRINT) Signature of Client Date

_____

Witness