2019 Creative Coping Consent Forms

Thank you for joining us for our 6-week (with option to extend) Creative Coping: Addressing Stress and Anxiety Through Altered Book Art Journaling group. We hope that this is a place where you are able to connect with yourself, your emotions, and other participants to explore creative ways of managing stress and anxiety. Please read through the following information regarding confidentiality, your rights as a client and group member, as well as information about contacting us. If you have any questions or concerns about these forms or beginning therapy, please let us know.

CONFIDENTIALITY

Our confidentiality policies are further outlined in the HIPPA Notice of Privacy Practices and the Client Rights handouts. If you have any questions about these documents or confidentiality, please feel free to bring it up throughout your course of treatment. There are certain exceptions to confidentiality within therapy, which you should be aware of before entering into a therapeutic relationship. Please read through these exceptions and be sure to ask your counselor if you have any questions:

- ➢ If you pose a threat of harm to yourself, another person, or the community, we will take whatever steps are required by law, or permitted by law to help prevent the potential harm from happening. This may include contacting your family or law enforcement;
- ➢ In the event of a psychiatric hospitalization
- ➢ If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect;
- ➢ A court order, issued by a judge, could require us to release information contained in your records, or could require a therapist to testify
- ➢ Because this is a therapeutic group we cannot guarantee that your confidentiality will be upheld by other group members.

CONTACTING US

We often are not immediately available by telephone. We will not answer the phone when with clients or unavailable. At these times, you may leave a message on our confidential voice mails and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear back from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the Iowa County 24-Hour Mental Health Crisis Line 800-362-5717, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call.

Mary Williams 608-305-4325
Kelly Toltzien 608-520-0846
Taryn Garland 608-709-9562

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRBIES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

We respect our clients and their privacy and are therefore very committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collections purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent. There are some instances where we may be required to use and disclose information without your consent**.** For example, but not limited to; information you and/or your child or children report about physical or sexual abuse: then by Wisconsin state law we are obligated to report this to the Department of Child Protective Services. If you provide information that notifies us that you are in danger of harming yourself or others. Information to remind you of/or to schedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Client Rights

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you provided us with when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our therapists communicate with you in a different way.

May we contact you at home? (circle one) **Yes or no?**
If yes, may we leave a message? **Yes or no?**
May we contact you at work? **Yes or no?**
If yes, may we leave a message? **Yes or no?**
May we contact you by cellphone? **Yes or no?**
If yes, may we leave a message? **Yes or no?**
May we contact you by email? **Yes or no?**
May we contact you by text message? **Yes or no?**

Right to release your medical record

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records

You have the right to inspect and obtain a copy of your information contained in our medical record. To request access to your billing or health information, contact your therapist. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the cost of copying, mailing, and supplies.

Right to add information or amend your medical records

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact your therapist. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with your family, or information that you gave us specific consent to release. It also excludes information that we are required to release. To receive information regarding disclosure made for a specific time period no longer than 6 years and after April 14th, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on the use and disclosure of your health information

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to your therapist. However, we are not required to agree to such requests.

Right to complain

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the US Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy

Consent for Treatment

FOR ADULT PARTICIPANTS:

By signing this form, you are:

- ➢ Consenting to your participation in the above mentioned therapeutic group.
- ➢ Releasing Madison Art Therapy (Kelly Toltzien LLC, Mary Williams LLC, and Madison Art Therapy Intern) from any and all liability.
- ➢ Showing you understand that you are participating in a group which contains activities that are therapeutic in nature, potentially eliciting uncomfortable or vulnerable feelings.
- ➢ Consenting to your therapy treatment.

_____ _____

Signature Date

_____

Print Name

I give consent for photos of my artwork to be taken and used by Madison Art Therapy. (Please circle your choice below…)

YES NO
