CONSENT AND AGREEMENT FOR CLINICAL TREATMENT

Our Practice

Groff & Associates, LLC is an integrative family psychotherapy clinic providing professional emotional, mental, and behavioral health care for individuals, couples, and families. "*Integrative*" means we take a whole-person approach — addressing physical, emotional, spiritual, relational, social, and vocational/academic well-being in collaboration with other healthcare professionals when appropriate. As such, this integrative model, under an Organized Healthcare Arrangement (OHCA), affords our team the ability to hold case conferences, share interventions, treatment plans, and align therapeutic tools to ensure coordinated, consistent, and high-quality care for every client and family we serve. Our goal is to support you and your family through compassionate, evidence-based care in a confidential environment.

Groff & Associates, LLC is committed to provide quality, professional emotional and mental healthcare to all of our clients. The treatment information is handled with the utmost care to ensure privacy. This document is for consent and agreement for clinical treatment and to understand client rights and the Agency's rights. I understand that counseling is a cooperative effort between myself and my AND/OR my minor child's clinician. I understand that I may withdraw this Consent in writing and terminate counseling at any time.

Consent for Treatment

I, _____, hereby attest that I have voluntarily entered into treatment and give
(Client's First and Last Name)
my consent for myself AND/OR my minor child at Groff & Associates, LLC, hereby referred to as the "Agency". Further, I consent and agree to have treatment provided by any licensed clinician in the State of Indiana, Master's level Resident or Intern in collaboration with his/her approved licensed supervisor, associated with this Agency, under the terms of this agreement.

I understand:

- Counseling is a collaborative process between myself (and/or my minor child) and my clinician.
- I may withdraw consent and terminate counseling at any time by submitting a written request.
- The rights, risks, and benefits of treatment have been explained to me.
- Treatment may be discontinued at any time by either party.

I understand that I must sign this Consent before counseling begins. **IF I AM UNDER THE AGE OF 18 YEARS**, I must have a parent(s) or legal guardian(s) sign this Consent before counseling begins.

Non-Voluntary Discharge from Treatment: I acknowledge I AND/OR my minor child may be terminated from the Agency non-voluntarily if:

- I AND/OR my minor child exhibits any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the Agency and/or,

- I AND/OR my minor child refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, do not provide the appropriate forms upon initial treatment, or do not make payment or payment arrangements in a timely manner and/or,
- I don't maintain other people's privacy such as: refraining from taking pictures or making recordings of any kind and/or,
- I refuse to pay any non-negotiated, outstanding account balance for my AND/OR my minor child's care.

I acknowledge I will be notified of the non-voluntary discharge immediately. I understand I may request continuation of services with the Clinical Director, which shall be at his or her sole discretion, and/or I may request to re-apply for services at a later date.

Client Notice of Confidentiality: The client record ("designated record set") and all subsequent or additional protected health information maintained by the Agency is protected by Federal and/or State laws and regulations. Generally, the Agency may not disclose to a person outside the Agency that I AND/OR my minor child attended treatment or disclose any information identifying myself OR my minor child as an alcohol or drug abuser unless:

A) I consent in writing and/or,
B) The disclosure is allowed by a court order and/or,
C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation, and/or
D) The disclosure is otherwise permitted or required pursuant to HIPAA and our policies and procedures.

Federal and/or State laws and regulations concerning confidentiality do not generally protect or restrict information about a crime committed by a person, including a client, either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities. In addition, there are laws and standards, which can require such disclosures under certain circumstances.

Clinicians are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of my death AND/OR my minor child, my spouse or my child(ren)'s parent or legal guardian may have a right to access my records.

Professional misconduct by a clinician must be reported by other clinicians, in which case related client records may be released to substantiate disciplinary concerns.

Technology and Communication Disclosure: Groff & Associates uses secure, HIPAA-compliant systems to protect your information:

- **Email:** We use Gmail and Therapy Appointment for business communications under a Business Associate Agreement (BAA) with Google and Therapy Appointment to ensure HIPAA compliance.

- **Electronic Records:** We use Therapy Appointment, a HIPAA-compliant electronic health record and scheduling platform, also covered under a BAA.

For your privacy and to ensure compliance with HIPAA, **text messaging** is strictly prohibited for all clinical or administrative communication. Use of any **AI tools** is strictly for administrative, clinical support or educational tasks and will never include any Protected Health Information (PHI) to ensure protection under HIPAA.

Telemedicine Services: I understand telemedicine is the use of electronic information and communication technologies by a healthcare clinician to deliver services to an individual when he/she is located at a different location or site than I am. I understand the telemedicine session will be done through a two-way, HIPAA compliant, audio/video link-up. The clinician will be able to see my AND/OR my minor child's image on the screen and hear my voice. I will be able to hear and see my AND/OR my minor child's clinician. I understand the laws protecting privacy and the confidentiality of medical information, including HIPAA, also apply to telemedicine. I accept the responsibility to have a PC, laptop or mobile device that has a strong Internet connection in order to have an effective telemedicine session. I will be responsible to maintain privacy on my AND/OR my minor child's end of the communication. I understand that there is not guarantee of confidentiality if I choose a public setting to conduct a telemedicine session. I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time and realize it may affect my ability to continue treatment with my AND/OR my minor child's assigned clinician. My AND/OR my minor child's assigned clinician will discuss my options with me should I decide to no longer continue with telemedicine services.

Third-Party Payer Rights: In order for the Agency to contact the applicable insurance company on behalf of my OR my minor child's clinician, this consent must be signed by me to enable the Agency pre-authorization to request eligibility and benefit information, to file any insurance claim or process necessary paperwork. Client data of clinical outcomes may be used for program evaluation or with your insurance company, but Protected Health Information (PHI) as stipulated by the Department of Health and Human Services will not be disclosed to any outside sources without a **Authorization to Release Information** form, except as permitted or required. I hereby consent to the disclosure of client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes a health insurance company and Employee Assistance Program (EAP) providers. The Agency is not responsible for any client disclosure (i.e. diagnostic information, date of service, billing information, etc.) from a health insurance company to the primary insured.

Disclaimers and Limitations of Liability: It is expressly understood and agreed that the Agency's liability is limited to the fees paid for services and in no event will the Agency be liable for any special, incidental, consequential, or indirect damages. It is intended this limitation apply to any and all liability or cause of action however alleged or arising, unless otherwise prohibited by law, including but not limited to negligence, breach of contract, or any other claim whatsoever.

Missed Appointments and Cancellations: I understand I'm given one grace session per year if I'm unable to keep a scheduled appointment with my AND/OR my minor child's clinician due to a missed appointment or late cancellation. I understand it is my responsibility and requirement to give my clinician and/or office staff, a twenty-four (24) hour advance notification by either contacting my AND/OR my minor child's clinician directly

or the business office at (317) 474-6448 x102. If I have exceeded my one grace session per year and if twenty-four (24) hour notice is not given, One-Hundred Dollars (**$100.00)** will be charged for late cancellation(s) or missed appointment(s). I understand that if I'm more than 15 minutes late to my scheduled session, the clinician may not be able to see me AND/OR my minor child on the same session date, and I may need to reschedule. I understand my AND/OR my minor child's clinician will try to contact me if I'm more than 15 minutes late to my given session and will leave a message indicating that my credit card will be charged for the missed appointment or late cancellation.

Payment Due at Time of Service: I hereby acknowledge that all fees are due at the time of service and are to be made payable to: Groff & Associates, LLC. Payment can be made by either by: check, cash, authorized credit/debit card, or HSA insurance card. The Agency is not responsible for any HSA insurance card that doesn't approve my clinical treatment. As such, any declined HSA insurance card is my responsibility and I must provide another form of payment at the time of service. Any nonsufficient funds (NSF) received via a check or bank/debit card will result in a fee of Thirty-five Dollars **($35.00)**. When appointment fees are not paid in a timely manner, I understand a collection agency may be given appropriate billing and financial information about me, but will not receive any clinical information. If my insurance company doesn't provide financial reimbursement for my treatment or is cancelled at any time during treatment, I am responsible for any of the outstanding balance.

Consent and Affirmation of Understanding: My signature below indicates that I have read this Consent for Treatment, or have had it read to me if I am unable to do so. I understand the rights and responsibilities outlined by Groff & Associates, LLC. I acknowledge receipt of the Notice of Privacy Practices and understand that it describes how my protected health information may be used and disclosed and how I may access this information.

I have been given the opportunity to ask questions regarding both in-person counseling and telehealth services and understand the differences between them. I agree that my questions have been answered to my satisfaction. I hereby consent to treatment and agree to abide by the policies and agreements of Groff & Associates, LLC.

Client's Printed Name:	**Date:**	**Client's Signature:**

If signing on behalf of a minor child,		
Parent/Legal Guardian's Printed Name:	Date:	Parent/Legal Guardian's Signature:

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