STEVEN ROWE
THE THERAPY GUY
LOS ANGELES, CA 90018

Treatment Consent Information Form

The purpose of this information sheet is to acquaint you with the policies and procedures of my office. Please read and sign this form. To protect your best interests and personal rights, I would like you to be aware that professional ethics and law dictate whatever you say in a psychotherapy session (Protected Health Information or PHI) will remain confidential and will not be shared with anyone without your written permission and with some exceptions. The following policies outline the uses and disclosures of your PHI. Please refer to the **Notice of Privacy Concerns** located in my office.

1. **HOW MAY I USE AND DISCLOSE YOUR PHI WITHOUT WRITTEN CONSENT**
   - -Relating to treatment
   - -To obtain payment for treatment
   - -For health care operations
   - -Emergency treatment
   - -When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement
   - -For public health activities
   - -For health oversight activities
   - -For research purposes
   - -To avoid harm
   - -For specific government functions
   - -For workers' compensation purposes
   - -Appointment reminders and health related benefits or services
   - -I am required to furnish PHI to an agency, if you have been referred to me by an agency, HMO, PPO, or other third party payor,
   - -If you are under 18, your parents or legal guardians have the right to be informed of your psychological condition, progress & treatment.

2. **CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT** (disclosures to family, friends, or others).

3. **OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION** (Any other situation not described in sections III A, B, C in the **Notice of Privacy Practices).**

4. **PATIENT RIGHTS**

   Although your health record is the physical property of *Steven Rowe, LMFT,* you have the following rights with regard to the PHI contained therin:
   - -The right to request to limits on uses and disclosures of your PHI.
   - -The right to choose how I send PHI for you.
   - -The right to see and get copies of your PHI.
   - -The right to get a list of your disclosures I have made.
   - -The right to correct or update your PHI.
   - -The right to get this notice by e-mail.

5. **APPOINTMENTS**

Appointments are scheduled directly through me. **If you are unable to keep an appointment, you will need to cancel a minimum of 24 hours in Advance. You, will be responsible for payment in full if you do not cancel in advance or if you do not show for your Appointment.**

6. **EMERGENCIES**

If you have a **true emergency situation,** you may contact me by leaving a voicemail on my office/cell telephone number, which is (323) 572-4472. Due to the possibility of technological malfunction, the quickest and safest way to get attention for emergencies is to dial **9-1-1.**

7. **YOUR SIGNATURE BELOW INDICATES THE FOLLOWING:**

-I have read and I understand these procedures.
-I authorize treatment for myself as the patient.
-I authorize communication between *Steven Rowe, LMFT* and other attending health care providers for coordination of care as needed.
-I authorize *Steven Rowe, LMFT* to communicate the above-mentioned PHI, in accordance with my **Notice of Privacy Practices**, in person, by telephone, by written material, e-mail, text, or facsimile. Once PHI leaves my office I relinquish any liability arising from their release.
-I understand that I have the right to terminate treatment with *Steven Rowe Therapy* at any time, and if I choose to return to *Steven Rowe, LMFT* as my psychotherapist, an open door return policy will apply when/if availability is appropriate.
-A photocopy of this release is considered as valid as the original.
-This authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon.

_____
Patient/Responsible Party (please print)

_____
Patient/Responsible Party (SIGNATURE)

_____
Date