Authorization For Release of Information

I/We, _____, hereby authorize

Kate Messina, PhD, LCSW/WisdomPath Way Institute to exchange information with:

_____

(Name of person or organization)

The type of information to be disclosed: Evaluations _____ Diagnosis _____ Treatment Plan_____

Course of Treatment_____ Other _____

This consent is in effect until_____.

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I/We have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____

Print Name of Client or Personal Representative Date

_____

Signature of Client or Personal Representative Date

_____

Print Name of Client or Personal Representative Date

_____

Signature of Client or Personal Representative Date

WisdomPath Way Institute
5150 Sunrise Blvd, Suite G5
Fair Oaks, Ca 95628
916 965-3807/916 335-9038

NOTICE OF POLICIES AND PRIVACY PRACTICES
AND
CONSENT TO PSYCHOTHERAPY SERVICES AND/OR WPW RP COACHING

PLEASE REVIEW CAREFULLY

I. CONFIDENTIALITY

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent. My formal HIPAA Secure/Compliant Mental Health Record generally describes the services provided to you and contains the dates of our sessions, your diagnosis as applicable, functional status, symptoms, prognosis, and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes; however, I do not routinely disclose information in such circumstances, so I will require your permission in advance at the onset of our relationship by signing the WisdomPath Way Release of Information form. You may revoke your permission, in writing, at any time, by contacting me.

WisdomPath Way Institute also provides you with a written Consent for Psychotherapy Services and/or WisdomPath Way Consent for WPW RP Coaching Services that provides you with a general overview of the process of either engaging in psychotherapy or WPW RP coaching.

Confidentiality and Conjoint or Marital Therapy: No Secrets Policy

In order to protect all parties engaged in conjoint or marital therapy, I have a ***No Secrets*** policy. No information may be disclosed to me outside the presence of the other member that cannot be openly shared. Information that cannot be openly shared puts a therapist in a 'secret keeping' position that compromises the integrity of the therapist.

Any permission to release information regarding conjoint therapy sessions must be granted by both parties.

Confidentiality and Social Media: In order to protect your right to privacy and to preserve the therapeutic relationship, I do not accept 'friend' requests or requests to 'follow' on any social media format. I will never search for information about you online in any manner and will assume that any and all information that you would like me to have will be provided by you directly to me.

II. LIMITS OF CONFIDENTIALITY/POSSIBLE USES AND DISCLOSURES OF MENTAL HEALTH RECORDS WITHOUT CONSENT OR AUTHORIZATION

There are some important exceptions to the rule of confidentiality required by law. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

Emergency: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by California law to report the matter immediately to the California Department of Social Services.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by California law to immediately make a report and provide relevant information to the California Department of Welfare.

Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena if you wish to. At that time, we may both require the services of attorneys in order to know how best to protect your right to confidentiality.

Serious Threat to Health or Safety: Under California law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. ELECTRONIC COMMUNICATION: As per HHS-HIPAA regulations you and I may be permitted to communicate via unencrypted emails and/or texts, which may include confidential information beyond setting/cancelling appointments if:

1. You have been informed that texting is an unencrypted digital communication that may put your confidentiality at risk and you request texting as a form of communication.
2. You have been informed that although WisdomPath Way Institute does NOT have an encrypted HIPAA compliant email server for receiving and sending emails and you know that your email server may not be encrypted and you request emails as a form of communication.

____Please initial here that you have been informed of the limitations to confidentiality posed by digital communication, that you accept the risk, and that you request digital communication in order to communicate with your therapist.

____Please initial here that you have been informed of the limitations to confidentiality posed by digital communication, that you do not accept the risk, and that you do not want digital communication in order to communicate with your therapist.

IV. PROFESSIONAL FEES AND LATE CANCELLATION/NO-SHOW POLICY:

The fee for a 50-minute session with Dr. Kate Messina is $120.00. Accepted payment methods are check, cash, or credit card payment through IVY PAY, which is a HIPAA secure/compliant payment system for psychotherapy services.

You may elect to make payment per session with cash or check; however, your credit card information will be collected and kept on file with IVY PAY at your first session. In the event of a no-show or late cancellation your credit card will be charged for the full amount of the missed session. In the event of non-payment for a session, unless otherwise agreed upon, your card will be charged for the full session fee within the following 24 hours.

____ By checking here, I confirm that I have been informed, understand, and agree that my card will be charged for the full amount for no-shows, late cancellations, and any session in which I did not provide alternative payment.

V. PROFESSIONAL RECORDS

I am required to keep appropriate records of the services that I provide. Your records are maintained in a secure location in the office. I keep very brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis (if applicable), topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.
Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

VI. PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless the child has been informed that I will share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance. All other communication will require the adolescent's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

VII. CONTACTING ME

I make every effort to be responsive to any telephone, email, or text message contacts; however, I am often not immediately available. Please leave a message on my confidential voice mail and/or via email/text and your call/email/text will be returned as soon as possible, and generally within 24-hours.

If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call because you or your child are unable to stay safe please, go to your local hospital emergency room or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences.

VIII OTHER RIGHTS:

Complaints/Concerns. If you are unhappy with the therapeutic process, I encourage you to talk with me so that I can respond to your concerns. Your concerns will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and you are always free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to be informed that therapy never includes sex and to expect that I will not attempt to have a social or sexual relationship with you.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Notice of WisdomPath Way Policies and Privacy Practices and agree to the terms.

I consent to accept these policies as a condition of receiving mental health services and or WPW RP Coaching for myself and/or my minor child(ren).

_____
Name of Minor Child if applicable _____

_____ _____ _____
Client Name or parent (Please Print) Date Client Signature

_____ _____ _____
Client Name or parent (Please Print) Date Client Signature

Please initial below that you been provided with a copy of this form or initial below that you do not require a copy at this time.

_____ I have been provided a copy of Notice of Privacy Practices that reflect the policies of Kate Messina, PhD, LCSW at WisdomPath Way Institute.

_____I do not require a copy at this time.

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