DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Client #:_____

Consent for Treatment
I voluntarily consent to evaluation, diagnostic testing, and/or therapy services provided by David Hoy & Associates clinical staff. I acknowledge that if there are multiple providers working on my case, they will be communicating and coordinating my treatment. I am aware that the practice of psychotherapy is not an exact science and that no guarantees have been made to me as to the result of evaluation or treatment in this program.

- ☐ I consent to telehealth therapy with my therapist from David Hoy & Associates. (Telehealth clients only)

Notice of Privacy Practices and Patient Bill of Rights
In compliance with HIPAA legislation, I have been provided an opportunity to review David Hoy & Associates Privacy Practices, and the Patient Bill of Rights.

Confidentiality
I understand that any assessments, tests, or inventories I may complete are voluntary and will be kept confidential to be used in the course of my treatment. If any information is used for research purposes, absolutely none of my personal information will be included in the research or any other documentation.

Insurance
I am responsible for providing David Hoy & Associates with insurance information that is complete and current. I consent to the release of clinical or other information necessary to an insurance company or 3rd party payer for purposes of payment as indicated by MN law. I authorize payment of insurance or 3rd party medical benefits to David Hoy & Associates for services rendered.

Cancellation of Appointments
I understand that I must give the provider a 24 hour notice of any cancelled appointments. If I fail to keep my scheduled appointments, I may not receive future services.

Financial Policy
When I receive services from David Hoy & Associates, I undertake a personal obligation and responsibility for my account. I am responsible for knowing my insurance benefits. I understand that it is my responsibility to provide David Hoy & Associates with current and complete information. I will pay all co-pays, co-insurance and deductibles owed to David Hoy & Associates as documented in the Explanation of Benefits (EOB) provided by my insurance company.

Transportation (In-Home services ONLY)
I give permission to David Hoy & Associates to provide transportation to our family as needed. I understand that transportation is for In-Home services only and is valid for the duration period of service with this agency. I understand that David Hoy & Associates staff carries appropriate vehicle insurance; however, I release David Hoy & Associates and their staff from liability.

Email or Texting
I understand that David Hoy & Associates email, as well as texting, is not secure, therefore, should I choose to use either of these options to communicate with David Hoy & Associates it is voluntary and at my own risk. I understand that should I choose to email or text David Hoy & Associates, it is in my best interest to abstain from including personal or private information.

- ☐ I consent to send/receive text messages
- ☐ I consent to send/receive email

Safe Harbor Agreement For Children in Therapy

Parties: The parties to this agreement are:_____ and

_____

("the parents" of _____)

and _____ ("the therapist").

1. Goal. The therapeutic goal is to permit the children to have a place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns or issues without fear that what they say will be used to inform or interfere with any ongoing or future court case.

2. Safe Harbor. In order to effectuate the stated goal, the parties acknowledge the importance of the therapist's office being a safe harbor – a place where parties can be truthfully assured that what they say will not be disclosed to third parties.

3. AGREEMENT: Therefore, to create the safe harbor for the children, the parties agree as follows:

a. No court/no depositions. Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or his/her notes to a trial, hearing, deposition or arbitration.
b. No interrogations. Neither parent shall, nor will either parent permit his or her attorney to, demand answers from the therapist about the content of the therapy.
c. No disclosure. The therapist agrees that she/he shall not divulge to either parent, to either attorney, to the Judge, or to any third party, any matter relating to the content of therapy (except required disclosures under the Child Abuse Reporting Act).
d. Enforcement. Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to Squash a subpoena.

BY CONSENTING TO TREATMENT AND SIGNING THIS FORM, I AM AGREEING TO THESE POLICIES.

Client Name:_____ Client Date of Birth:_____

_____
Client Signature Date

_____
Parent or Legal Guardian Signature Date

_____
Parent or Legal Guardian Signature Date

_____
Provider Signature Date