



2029 S. Elms Rd  
Swartz Creek, MI 48473  
(810) 285-8429 Phone  
(810) 204-4950 Fax  
www.rootedinlovelc.com

# Rooted in Love

COUNSELING SERVICES, LLC

## *Consent To Treatment Agreement*

I do hereby seek and consent to take part in the treatment by a Therapist at Rooted In Love, LLC. I understand that developing a treatment plan with this Therapist and regularly reviewing our work toward meeting the treatment goals is in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this Therapist. I understand that my case may be discussed in group consultation for assessment, diagnosis and evaluation of treatment and progress.

In the event that the individual Therapist believes that I am in danger physically or emotionally, to myself or another person, I specifically consent for him/her to warn the person in danger and to contact medical and law enforcement personnel immediately. I am aware that I may stop my treatment with this Therapist at any time. The only thing I will still be responsible for is paying for the services that I have already received and have been provided to me through Rooted In Love, LLC. I understand that I may lose other services or may have to deal with other problems if I stop treatment (For example, if my treatment has been court-ordered, I will have to answer to the court.)

**I know that I MUST call to cancel an appointment AT LEAST 24 hours (1 day) before the time of the scheduled appointment. If I DO NOT cancel and DO NOT show up for the scheduled appointment, I will be charged a \$100.00 non-refundable fee for that appointment.**

## *Telehealth Consent*

I have a right to confidentiality with Telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy and/or medication management services at Rooted In Love, LLC. Any information disclosed by me during the course of my therapy, therefore, is considered confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.

I also understand that if I am in such a mental or emotional condition to be considered a danger to myself or others, my Therapist has the right to break confidentiality to prevent the threatened danger. I understand that dissemination of any personally identifiable images, or information from the Telehealth interaction, to any other entities shall not occur without my written consent.

I understand that while Psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my Therapist believes I would be better served by another form of Psychotherapeutic services, such as in-person treatment, I will be referred to schedule in office appointments, or referred to a Therapist in my geographic area that can provide such services.

*Client Printed Name:* \_\_\_\_\_

*Parent/Legal Guardian Printed Name:* \_\_\_\_\_

*Client Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Parent/Legal Guardian Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_



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## ***Consent to the use of AI Medical Scribe Platform Freed***

At Rooted In Love, LLC, our office has opted to use the Freed note-taking system as part of our efforts to provide excellent care to clients. Freed's note-taker temporarily records sessions and uses this recording to automatically generate a progress note (a required form of clinical documentation). After a progress note is generated, the recording is automatically deleted from Freed's servers and database.

Use of this technology allows your therapist to be fully present during your sessions, without having to slow down to take notes or trying to remember important information during the session. This allows them to focus all of their attention on your care.

Freed's software is HIPAA compliant and SOC 2 Type 2 certified, which means an external third-party auditor reviews Freed's systems, policies, and processes on an ongoing annual basis to ensure Freed meets certain data privacy and security standards.

By signing this consent form, you are agreeing to allow your clinician to record your sessions and utilize software to assist them in generating progress notes to document these encounters.

Patient Printed Name: \_\_\_\_\_

Parent/Legal Guardian (If Applicable) Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

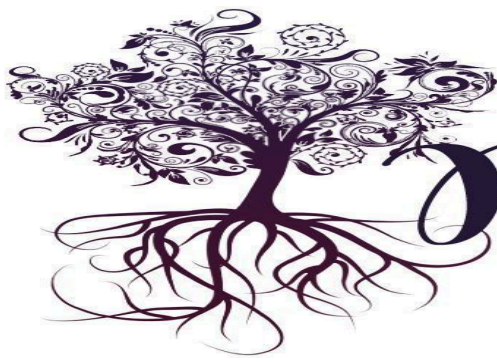
## ***Patient HIPAA Notice of Confidentiality and Patient Rights & Procedures***

### **Rights-**

No client-identifying information (including your present in a program) may be released or disclosed without your informed, written consent. This includes oral as well as written information. This legislation also requires that Rooted In Love, LLC release only the minimum necessary information to meet the purpose of the release/requested information. All materials released must contain a notification of privacy and confidentiality statement indicating that the information CANNOT be used for any purpose other than that stated any MAY NOT be re-released by the receiving party. A court may only receive information from your record with a subpoena and court order.

\*Under Federal law you have the right to determine what information is to be shared and for what purpose, with your signature used to authorize the release.

\*You have the right to request that Rooted In Love, LLC communicate your medical information to you in a specific way or specific location (i.e., "Only by mail at work").



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- \*You have the right to refuse to authorize release of information; however, if you refuse you will be advised of the impact this may have on Rooted In Love, LLC's ability to treat you, to obtain insurance coverage or funding, and how this may result in additional consequences outside of Rooted In Love, LLC (ie., refusing to release information to probation).
- \*You have the right to revoke your authorization at any time, except as it has already been acted on.
- \*You have the right to know what information has been released with your authorization, to review your clinical records within a reasonable length of time following a request, and to receive copies at a reasonable fee upon your signed consent. Request forms are available upon request.
- \*You have the right to reasonable notice of changes in counseling services or charges.
- \*You have the right to file a grievance without fear of retaliation if you feel your rights have been violated or your case has been inappropriate.
- \*You have the right to choose from available Therapist's and to change Therapist's after services have begun, within the limits of health insurance or other payment agreements.
- \*You have the right to coordinate transfers when there will be a change in the provider of services.

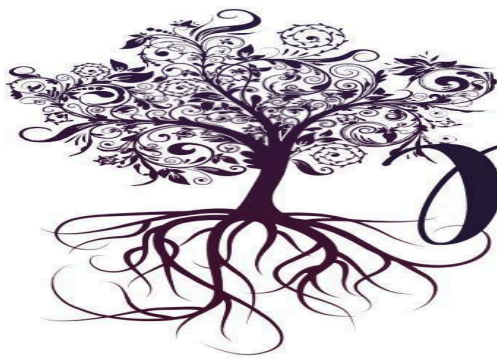
## **EXCEPTIONS FOR WHEN YOU MAY NOT WAIVE YOUR PRIVACY RIGHTS**

1. Professional staff are mandated to report all KNOWN or SUSPECTED cases of child abuse and/or neglect.
2. Staff are required to request that a Vulnerable Adult Release of Information be signed by all adult clients entering treatment who are considered vulnerable. The purpose is to report abuse or neglect to the County and to develop an Abuse Prevention Plan.
3. Professional staff are required to report if there is SUBSTANTIAL REASON to believe that you may do harm to yourself or others.
4. Professional staff may report information in an emergency situation when you are unable to provide authorization to assure you receive appropriate medical care or other services to address the emergency, or to the Coroner's Office in case of death. Staff are required to document the information disclosed and to notify you and your representative of any disclosures as soon as possible following the emergency situation.
5. Staff will report crimes committed by clients on Rooted In Love, LLC property or against other clients or staff.

## **The following information is needed in order to provide the services you need:**

- \*Program costs and dates of service provided to you
- \*Determination of your ability to pay for services you receive
- \*Preparation for billing to insurance companies, funding agencies or to you
- \*Information regarding your problems and their severity in order to determine your need for services from Rooted In Love, LLC, or referral to a more appropriate agency if/when it is a service not provided by Rooted In Love, LLC
- \*Diagnosis and goals to be attained through a service/treatment plan
- \*Objectives towards goal attainment and progress notes in client record, as well as any correspondence regarding your case
- \*A summary or letter at completion of evaluation, counseling, or treatment, and arrangements for follow-up contact to determine effectiveness of services you received
- \*Case and record review conducted regularly by Rooted In Love, LLC staff for quality improvement purposes;
- \*Preparation of state and county reports using demographic information for purposes of funding and licensing; and
- \*General non-identifying information to approve researchers trained in collection, maintenance and research reports as it applies to all laws regarding privacy and confidentiality.

**You have the right to choose not to provide the above information; however, should you choose not to, Rooted In Love, LLC may not adequately deliver the services you request or it may make you ineligible to receive those services.**



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## PROCEDURES

1. All staff are trained upon hire, and annually thereafter, regarding privacy and confidentiality regulation and of the penalties and consequences if these laws are not strictly enforced.
2. All Client records are maintained in a secure room when not in use and may be accessed by authorized personnel only.
3. All records are maintained for a period of 7 years following last contact or for 7 years past a clients 18th birthday if the client was a minor at last record.
4. Billing and clinical records are maintained separately.
5. Files are transported between sites by a bonded courier in locked boxes or by staff with special authorization only.
6. Any request for information must be a valid, signed and legal release of information or by a subpoena and court order, and must be approved by the Office Manager, Program Director, or Chief Executive Officer prior to release. An attorney may be consulted to determine the validity of the release.
7. Violation of this legislation is a crime and suspected violations may be reported to the proper authorities

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## Privacy Practices

### **What are your rights regarding the information we have about you?**

- You may see and copy medical or other private information we may have about you. You may have to pay for the copies.
- You may give other people permission to see and have copies of information about you.
- You may question if the information we have about you is correct.
- You have the right to ask us to share your information with you in a certain way or in a certain place.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.

### **What are our responsibilities?**

- We must let you know our legal duties and privacy practices, which we are doing by providing you with this notice.
- We may not use your information for reasons other than the reasons listed on this form unless we get written permission from you. We may not share your information with individuals and agencies other than those listed on this form unless we get written permission from you.
- We are required to follow the terms of this notice, but we may change our policy in the future. We might do this, for example, because privacy laws change and require us to change our practices.

### **What privacy rights do children have?**

If you are under 18, your parents may see information about you and allow others to see this information, unless you have asked that this information not be shared with your parents. You must make this request in writing and say what information you want withheld and why. If the agency agrees that sharing the information is not in your best interest the agency will not share the information with your parents. If the agency does not agree, the agency may share the information with your parents if they ask for it.



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## Rights and Responsibilities

### **AS A CLIENT, PLEASE KNOW THAT YOU HAVE THE RIGHT:**

- To be treated in a professional, courteous, and caring manner that respects and appreciates differences related to race, ethnicity, national origin, gender, sexual orientation, religion, personal values, age, disability, and economic or veteran status.
- To receive complete information regarding diagnosis, treatment, and prognosis of your health concern in language you can understand.
- To receive information you need to participate in decisions about your care, and to give consent before any diagnostic or treatment procedure is performed.
- To decline treatment, to the extent permitted by law, and to be informed of the consequences of making this decision.
- To expect that your privacy will be respected and confidentiality protected to the greatest extent permitted by law. Our agency or staff will not release information outside of Rooted In Love, LLC without your written permission, except upon court order, as required by law (as in the case of certain communication diseases and reports of child abuse), or as required, in our judgement, to protect you or others from physical danger.
- To ask for and receive an explanation of any fees billed by Rooted In Love, LLC.
- To raise concerns and recommend changes regarding service delivery, to any person without fear of interference, coercion, discrimination or retaliation.

### **AS A CLIENT, PLEASE KNOW THAT YOU HAVE THE RESPONSIBILITY:**

- To provide accurate and complete information about current and past health issues, medications, and other matters pertaining to your health.
- To ask questions in order to make sure you understand your diagnosis, treatment, expected outcome, and any instructions.
- To be involved in treatment planning and to follow a mutually agreed upon plan, including completing treatment assignments and returning to follow-up appointments.
- To keep your appointment, or change or cancel with at least 24 hours' notice, to allow others to have access to treatment.
- To use services wisely, be aware of costs, and pay for all services at the time they are delivered or billed.
- To sign the releases and consents necessary in order to determine, coordinate and authorize particular treatment services.
- To be respectful and courteous of others, including Rooted In Love staff, interns, volunteers, visitors and other clients.

## **EFFECTS OF COUNSELING**

Most clients can expect to benefit from counseling, making positive changes in their thoughts, feelings, and/or behaviors. Some however, may not find counseling or assistants, and a very few may have negative counseling experience. Even the most successful counseling therapy may at times be uncomfortable, stressful and emotionally painful, as you deal or your family members deal with difficult issues, as you make personal adjustments in your thoughts and behaviors, changes may also occur in your relationships with others.

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By signing this, I acknowledge that I understand and agree to the provided information. I will contact the office staff of Rooted In Love, LLC if I have any questions or concerns regarding this provided information.

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**Signature**

**Date**

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**Signature**

**Date**