



CLIENT BILL OF RIGHTS

1. I understand that my case record will include but not be limited to the following: (1) the presenting problem(s) or diagnoses; (2) the fee arrangement, (3) the date of substance of each billed contact or service; (4) any testing data, results, and interpretations; (5) all permission forms; (6) other health, school, or treatment records provided to Dr. Heinsz.
2. I understand that I am entitled to a truthful, understandable, and appropriate account of my situation or that of my child.
3. I understand that I should be fully informed to the purpose and nature of treatment procedures. I also understand that I have the freedom of choice regarding services offered.
4. I am entitled to discuss the nature and anticipated course of therapy, fees, confidentiality limits, and the handling of my confidential information in accordance with HIPPA regulations.
5. When family members are involved in treatment, I understand that Dr. Heinsz should clarify which individual(s) are the clients and what the therapist's role will be with each member.
6. I understand that Dr. Heinsz cannot enter into relationships that involve familial, social, emotional, supervisory, political, administrative, or legal relationships with clients nor can she enter into barter arrangements that could impair her objectivity.
7. I understand Dr. Heinsz will inform me in writing if she is unable to continue providing services, should physical or professional impairment occur or should a dual relationship arise.
8. In the event that treatment needs to be interrupted long-term or terminated due to illness, career change, therapist's relocation, client financial limitations, client refusal to pay for services rendered, or due to issues arising outside of psychologists' realm of training, Dr. Heinsz will make every attempt to make an appropriate referral to another professional. The client's welfare will be taken into consideration when planning for continuity of care.
9. I understand that termination of services by Dr. Heinsz may be initiated if it is reasonably clear that client is no longer benefiting from, in need or, or is being harmed by continued services.
10. I understand that Dr. Heinsz will safeguard the confidential information obtained in the course of serving her clients unless written consent of the client has been obtained.
11. I know Limits of Confidentiality exist related to (a) parental right to guardian's information particularly in regards to Safety Issues; (b) threats to harm self or others; (c) reasonable suspicion of abuse or neglect of a child, a vulnerable adult, or an elder; (d) subpoenaed case records; (e) subpoena to testify; and (f) when a third-party referral is involved, the extent to which the third party has access to confidential information must be determined.
12. If a professional consult is deemed necessary for the welfare of the client, reasonable steps to assure that confidentiality is respected will be taken. When client is also receiving services elsewhere, I understand that Dr. Heinsz will request permission to coordinate treatment with the other provider so as to minimize confusion or conflict.
13. When individuals participate in group, couples, or family therapy, Dr. Heinsz cannot guarantee that others will respect each clients' right to privacy and may disclose personal information inappropriately.