

IV. INFORMED CONSENT

I have chosen to receive treatment through an insurance company, HMO, or under a benefit plan managed by_____

I understand that my therapist, Lois Greifer, Ph.D., and my insurance company, HMO, or managed care representatives may exchange information pertaining to my treatment, to the extent that such disclosure is necessary for authorization of sessions, case management, coordination of treatment, quality assurance, utilization review purposes and claims processing.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that my therapist will inform me when and if information about my care has been requested.

Print Name_____Signature_____
Date_____