

CATHERINE E. BURNS, PH. D.
LICENSED PSYCHOLOGIST – DOCTORATE

INFORMED CONSENT AND CLIENT'S DISCLOSURE CONFIRMATION

ADULT

Client's Name: _____ Date of Birth: _____

- A. I voluntarily consent to evaluation and/or treatment of the above named client by Catherine E. Burns, Ph.D. I understand that I am consenting and agreeing only to those services that Dr. Burns is qualified to provide within the scope of her training. I acknowledge that no guarantees are being made to me as the result of the treatment. I also understand the Dr. Burns is an independent contractor.
- B. I acknowledge that no guarantees have been made to me as to the result of the treatment or evaluation.
- C. I understand that Dr. Burns may consult with other clinicians for the purposes of professional development and coverage and that such consultations are also bound by the rules of confidentiality. I understand that Dr. Burns may discuss my care in peer supervision and provide information to a covering clinician to facilitate continuity of care.
- D. I authorize Dr. Burns to communicate with my insurance company for care authorization and care coordination upon request from the insurance company.
- E. I understand that treatment is confidential with exceptions. These exceptions include, but are not limited to: disclosure to insurance companies and managed care companies for reimbursement purposes; disclosures required by law, such as suspicion of abuse or neglect of children, disabled or elderly individuals, risk of imminent harm, or duty to warn; and disclosure to other health care professionals to facilitate my care and treatment or as described above. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- F. I have been given the professional qualification and experiences of Catherine E. Burns, Ph.D., her professional policies, a listing of actions that constitutes unprofessional conduct according to Vermont statutes, and the methods for making a consumer inquiry or filing a complaint with the Office of Professional Regulation.
- G. In addition, I have received and been informed of client privacy rights as outlined under HIPPA. These rights include:
 - a. The right to be informed of the various steps and activities involved in receiving services.
 - b. The right to confidentiality under federal and state laws related to the receipt of services.
 - c. The right to humane care and protection from harm, abuse, and neglect.
 - d. The right to make an informed decision about whether to accept or refuse treatment.

- e. The right to contact and consult with counsel and select practitioners of my choice at my expense.
- H. I understand that I may revoke this consent at any time except to the extent that treatment as already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid as provided in the benefit plan.
- I. I have read this document and understand and consent with the content.

Clients' Signature

Date

Catherine E. Burns, Ph.D.
Licensed Psychologist - Doctorate

Date