Privacy & Confidentiality

Clear Horizons, LLC is bound by the provisions of the Minnesota Data Privacy Practices Act and the Health Insurance Portability and Accountability Act. Your information will not be shared with another entity, person, including family members without your verbal and written consent. In the event, that you would like your therapist to communicate with another on your behalf, your therapist will request that you complete an Authorization of Release of Information. The only exception to this privacy is if a court of competent jurisdiction orders a specific release of records or as provided by law.

Rights

Clear Horizons, LLC values your right to data privacy of your medical information. You have the right to review information that is part of your file. Clear Horizons, LLC follows the Minnesota Data Privacy Practices Act and the Health Insurance Portability and Accountability Act. As part of the protection of your rights in receiving health care, upon request you should expect the following:

1. An explanation for collection of information
2. Information of how your data will be used
3. Be told the benefits and risks of supplying the requested information
4. Be shown all information gathered for your treatment
5. Contest the accuracy of information in your file

All information submitted to Clear Horizons, LLC for your treatment will be held in the strictest confidence as we follow the Minnesota and the U.S Department of Health and Human Services laws.

Responsibilities

Clear Horizons purpose is to provide competent treatment and support to you, as our client. Clear Horizons will provide treatment to you based on how you want to progress in the future. We will be able to help you best if you are able to actively participate in the following ways:

1. Be honest with yourself and your therapist (according to your level of comfort)
2. Keep your appointments
3. Call if you cannot keep your appointments
4. Participate in the development of your treatment plan
5. Follow recommendations

Thank you for allowing Clear Horizons, LLC to support you on your journey towards health

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date