INFORMED CONSENT FOR TREATMENT

PROFESSIONAL SERVICES
POLICIES AND PROCEDURES

Confidentiality Concerns:

According to state law, confidentiality and privileged communication remain the rights of the client of psychologists, psychiatrists, licensed clinical social workers and licensed marriage, family therapists. The client, or the parents/guardians/legal caretakers, must give a signed written authorization to release any written or oral material to any other person or organization. However, there are legal **Limits of Confidentiality** which are:

1. If an individual intends to take harmful or dangerous action against another human being, or against himself/herself, it is the therapist's duty to warn the person and/or family of the person who is likely to suffer the results of harmful behavior; or the family of the client who intends to harm himself/herself of such an intention. (Tarsaoff Decision - California Courts)
2. When there is reasonable suspicion of child abuse or elder abuse the therapist, as a legal mandated reporter, is legally responsible to report such suspicion to Child Protection Agencies or Elder Protection Agencies. California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, and emotional and psychological abuse. All actual or suspected acts of child abuse must be reported to the appropriate agency.
3. There may be a need to release evaluation and treatment information to the referral agency and third party payer requests for information. If so, the therapist will clarify this with the client.
4. If legal proceedings are involved in which the client's mental or psychological condition is a concern the Judge may sign a subpoena for treatment records.
5. For minor children and adolescents: parents/guardians/legal caretakers have the right and responsibility to know evaluation and assessment, treatment plan, treatment concerns and overall progress, and discharge conditions. All efforts will be taken to ensure confidentiality of sessions with minors that will secure the therapeutic relationship.

Appointments and Fees:

Appointments are made on a reserved basis exclusively for each client; therefore, **a** minimum of 24 hours advance notice is required for a cancellation. The client will be charged **FULL FEE** if there is a same day cancellation or a no show. "FULL FEE" is defined as the complete fee for service rather than the regular co-pay.

All fees and co-payments are due and payable by the responsible party when professional services are rendered. The responsible party remains accountable for any charges that are not covered by insurance or other payer system; for example, telephone calls, crisis interventions.

The client or the responsible individual for the client is personally responsible for any debts incurred for services rendered. The purpose of insurance carrier coverage is to provide the client, with a partial or complete reimbursement for fees for services rendered. This reimbursement is governed by the policy covering the client. The insurance company is in no way obligated for any debt incurred for professional services rendered. The service providing the processing of client claims is not a guarantee of reimbursement by the client's insurance carrier for any claims submitted on his/her behalf. The client or the responsible individual for the client is fully responsible for this financial obligation.

Assessment, Diagnosis, and Treatment Plan Development:

The initial appointment is of the purposes of assessment, diagnosis and treatment plan development. Where appropriate, the therapist will discuss the three areas with the client. When appropriate, the client will be involved with the therapist in the formulation of the treatment plan and, at a later date, the discharge plan. One of the purposes of treatment is for the client to become increasingly responsive and responsible in his/her own life. To this purpose, the client and therapist will work together to achieve this throughout the treatment duration.

Insurance Utilization:

In utilizing insurance mental health benefits any protected health information will be used for treatment purposes which includes billing and payment for services, assessment, diagnosis, treatment plan, request for additional visits, and discharge planning and summary. The transmission of such information may include regular US Postal Service, email, voice mail, faxing, electronic billing, or other reasonable method of transmission of information.

Verbal Therapist To Client Contact:

Therapist to client contact (or therapist's office staff) for purposes of scheduling rescheduling, billing clarification, follow up regarding client cancellation or no show, or other client issues will be communicated via telephone, voice mail, email, fax, or other communication methods that the client provides as acceptable forms of contact. Reasonable precaution will be observed when leaving information with someone other than the client. Please inform the therapist if extra precautions are necessary.

Written Therapist To Client Contact:

Therapist to client written contact (or therapist's office staff contact) will be for the purposes of treatment concerns including billing concerns. Written correspondence will be sent to the client's home address unless otherwise specified by the client. Correspondence will indicate the business name and business mailing address. Please inform the therapist if extra precautions are necessary.

Client To Therapist Contact:

Clients may contact the therapist by telephone during regular business hours Monday through Friday, 9:00 am to 5:30 pm. After hours, weekends, and holidays, the therapist may be contacted by Text or Voice Mail. Reasonable client to therapist contact includes scheduling issues, clarification of a previous session (i.e. therapeutic assignment, concept/principle clarification, information giving or receiving, etc.), or a necessary immediate update with therapist feedback. Crisis calls that are not life threatening are also appropriate (i.e. recent diagnosis of a serious illness; notice of a pending death or loss of a loved one; serious change of status of self or family; or other life-changing events that necessitates therapeutic support or guidance). Immediate life-threatening circumstances must be first handled by calling 911, securing police, medical or other emergency intervention services, and securing client or family member safety. After such emergency and safety intervention services have been secured, the therapist may be contacted if necessary. All calls will be charged at the rate of $25.00 per fifteen minutes after the first fifteen minutes.`

Professional Consultation:

In order to maintain the high level of specialized professional psychotherapeutic services, the therapist may seek consultation from other licensed health care providers. This is solely for the purpose of seeking additional professional expertise, therefore, any identifying client data will not be revealed.

Acknowledgment, Acceptance, and Signature of Informed Consent:

I have read and understand the **Informed Consent Professional Services Policies and Procedures** and I accept all terms of this document. My signature indicates that I am sufficiently and in good faith informed of the treatment conditions, policies, and procedures for both the professional treatment services and the financial responsibility for such services.

I give my informed consent for Deborah A. Corona, L.M.F.T. to provide counseling and psychotherapeutic services for:

____ Myself DOB_____

_____ _____

Signature Date