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## Positive Change Counseling Center

Phone: 619.733.1085

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### **INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES**

Welcome to our practice. This packet contains important information about our professional services and business policies. We believe that a person who understands and participates in his or her care can achieve better and quicker results. Please read this carefully and jot down any questions you might have so that we can discuss them at our next meeting.

#### **Introduction**

Our therapists are Licensed Marriage and Family Therapists in the state of California. We specialize in working with couples, adolescents, adults, and families. We offer individual, couples and family therapy.

#### **Therapeutic Services**

Sessions are typically forty-five (45) minutes in length. Duration of treatment will depend on your needs, your treatment goals, and other factors related to your treatment responsibilities. As with any type of growth or change process, individual factors can significantly impact the rate and the degree of effectiveness of the therapeutic process. We will discuss your progress throughout treatment, including expected length of therapy.

#### **Fees**

Your EAP is responsible for payment in full. As an EAP referral you are eligible for \_\_\_ sessions at no cost to you. If you would like to continue therapy at the end of the allowed sessions, I would be happy to discuss my fees with you at that time, or to make appropriate referrals to professionals in the community.

Please be advised: if your EAP provider denies payment for services rendered, you will be responsible for payment in full.

#### **Cancellation Policy**

If you are unable to attend your session for any reason, please notify us at least 24 hours in advance. Failure to do so will result in a fee of \$50.00 and will be expected to be paid at your next session. Insurance companies typically do not reimburse for missed sessions, therefore this will be your responsibility.

#### **Privacy and Confidentiality**

*Confidentiality:* All therapy sessions are strictly confidential. There are specific situations in which a Marriage and Family Therapist is mandated or permitted by law to reveal information obtained during therapy to another person(s) or agencies without your permission. Exceptions to confidentiality are: Adult/Elder Abuse, Child Abuse and Danger to self or others.

*Minors Right to Privacy:* In our practice, we promote open communication between children and parents; however, when this does not occur, parents are encouraged to understand the importance of confidentiality within the therapeutic relationship.

*Electronic Communication:* Many people feel comfortable communicating via e-mail. However, there may be risks involved. There is no guarantee that spyware or other such programs will work 100% of the time. All e-mails will be stored on a password protected account that only your therapist will have access to.

**Health Insurance and Confidentiality of Records**

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form provided to you with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposed of treatment and payment. Positive Change Counseling Center has no control or knowledge over what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

**Mediation and Arbitration**

By signing this contract you are agreeing that all disputes arising out of or in relation to this agreement to provide psychotherapeutic services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration.

**Emergency Procedures**

Should you feel that your situation requires immediate attention, our therapists are available to return your phone calls between 9:00am and 5:00pm, Monday through Friday. You may leave a confidential message on our voicemail. If you feel that you are in crisis and we are not immediately available, you may call your local crisis intervention center at: 1-800-479-3339, or 9-1-1. If we do speak by phone, you may be billed a pro-rated fee for the time.

**AGREEMENT FOR SERVICES**

***After reading and understanding the information above, please acknowledge your consent to begin services by initialing and signing the following agreement:***

I have read, understand, and agree to the policies and procedures described above. \_\_\_\_\_ (initial)

I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with the policies of this office. **I understand that a 24-hour notice is required for cancellation of my scheduled appointments.** I agree to pay the \$50.00 fee for any missed appointments or late cancellations. \_\_\_\_\_ (initial)

I understand that I am financially responsible for all fees for services beyond my allowed EAP benefits at the time of my scheduled appointment. \_\_\_\_\_ (initial)

I have been informed and understand the limits of confidentiality, which include mandated reporting situations and have read the "Notice of Privacy Practices". \_\_\_\_\_ (initial)

By signing below, I consent to psychotherapy with Positive Change Counseling Center.

_____	_____	_____	_____
<b>Printed Name</b>	<b>D.O.B.</b>	<b>Signature</b>	<b>Date</b>
_____	_____	_____	_____
<b>Printed Name</b>	<b>D.O.B.</b>	<b>Signature</b>	<b>Date</b>