CONSENT TO CONSULTATION/TREATMENT

Welcome to the Center for Individual & Family Therapy a Christian counseling center. The following is an agreement to enter into a CONSULTATION/TREATMENT PROCESS. During the consultation process both you and your therapist may mutually agree to decide to move into psychotherapy treatment together.

CONSULTATION PROCESS: First sessions are a consultation, which usually include: Completing necessary paperwork, meeting with a therapist and taking a Personality Assessment Inventory (PAI) with an additional $20 fee.

Please be aware that after the first consultation it is sometimes necessary to refer you to another CIFT clinician that can better meet your needs. If this occurs, your file will automatically be transferred to that CIFT clinician. If for some reason we are not able to help you at CIFT, your file can be transferred to an outside therapist with your written permission.

APPOINTMENTS: It is your responsibility to notify your therapist at least 48 hours in advance if you are unable to attend your appointment. **Cancellations of appointments less than 48 hours in advance and "no shows" are subject to the full fee for the appointment time.**
Your therapist may offer communication through email or texting for the purpose of scheduling only. Emails to your therapist may not include therapeutic content or information regarding danger to one self or others. Your therapist is not available 24 hours a day, in case of emergency, please call 911 or go to the nearest emergency room.

PAYMENT & FEES: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Services are rendered and charged to the client, not to the insurance company. Your therapist will provide you with a receipt to submit to your insurance company for reimbursement. You may also incur charges for phone calls lasting more than 15 minutes, letters and testing fees. Your fee may be subject to an annual increase. There is a $20.00 charge for returned checks. Fees for writing expert testimony for court purposes will be charged at a higher rate than session fees.

I, the client, agree to be responsible for the payment of $_____per session (45 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. **Client Initials _____**

LIMITS ON CONFIDENTIALITY: In certain situations a therapist is mandated or permitted by law to take actions that he/she believes are necessary to attempt to protect client or others from harm, and he/she may be required to reveal limited information about a client's treatment. Those situations can include: child abuse, danger to self, threat of violence to others, and elder/dependent adult abuse.

PRIVACY: The law protects the privacy of all communications between a client and a therapist. In most situations, your therapist can only release information about your treatment if you sign a written Authorization Form that meets state law requirements. **However, your therapist is permitted or required to disclose information without either your consent or authorization under the following conditions**:

- **CONSULTATION:** Your therapist may seek advice from professionals. During a consultation, he or she will make every effort to avoid revealing the identity of clients. The other professionals are also legally bound to keep the information confidential. Your therapist may not discuss these consultations with you. All consultations are noted in your Clinical Record.
- **CONTRIBUTION TO KNOWLEDGE:** Our therapists may write books, teach and/or lecture at various venues. We are also a training site for pre-licensed therapists. On occasion CIFT therapists may use disguised case data for writing, teaching or training purposes only. No identifying information is included.
- **ADMINISTRATIVE STAFF:** Your therapist may need to share protected information with administrative staff for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. Staff members have been given training about protecting your privacy and know not to release any information outside of the practice without the direction from a professional staff member.
- **COLLECTION:** If you do not pay your fee, we are legally permitted to contact a collection agency.
- **GOVERNMENT AGENCIES:** If a government agency is requesting the information for health oversight activities pursuant to their legal authority, your therapist may be required to provide it for them.
- **LAWSUITS:** If a client files a complaint or lawsuit against his/her therapist, relevant information may be disclosed regarding that client without client consent in order for the therapist to defend himself/herself.

PARENTS AND NON-EMANCIPATED MINOR CLIENTS 12 years of age or older can consent to psychological services subject to the involvement of their parents or guardian:

- Unless the therapist determines that parental involvement would be detrimental.
- A client over 12 years of age may independently consent to psychological services if he or she is mature enough to participate intelligently in such services, and/or the minor client either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse.
- Clients over 12 years of age may independently consent to alcohol and drug treatment in some circumstances.
- Non-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his/her physical safety or psychological well-being.
- It is our policy to request an agreement between minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment, the therapist will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. Therapists will encourage parent participation when appropriate.

PRE-LICENSED THERAPISTS:
I understand that my counselor is an: ❑ MFT Trainee ❑ MFT Intern
❑ Associate Clinical Social Worker ❑ Doctoral Student ❑ Psychological Assistant
and therefore is not licensed, but is functioning under the supervision of his/her supervisor. I acknowledge that my counseling will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to treatment records. I have received the business card of my therapist, with the supervisor's information.

_____ (therapist) working under the direct supervision of

_____ (supervisor), have my permission to audio/video-tape counseling sessions to be used for supervision purposes.

I understand that my sessions will be taped only with my knowledge, will be used only for supervision purposes, and will be erased as soon as this purpose is fulfilled. **Client Initials**_____

TERMINATION OF THERAPY: It is to the client's advantage that a decision to end therapy will be discussed candidly and thoroughly with the therapist in advance of leaving. It is within the clients right to terminate therapy at any time.

Please note that therapy may be a challenging process. During treatment it is possible that you may feel worse before you begin to feel better. You therapist is available to discuss these issues anytime during your treatment.

Your signature below indicates that you have read this agreement and agree to its terms. Please feel free to discuss any concerns you may have with your therapist or our Clinical Director at 714-558-9266 x953.

_____ _____
Client's or Client Representative Signature Date

_____
Print Client's Name

_____
(If Representative, Print Name and Relationship to Client)

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

_____
Print Client's Name

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS PER HIPAA REQUIREMENTS. PLEASE REVIEW IT CAREFULLY.

I. Disclosures for Treatment, Payment and Health Care Operations

A CIFT therapist may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances, he or she can only do so when the person or business requesting your PHI provides a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment"* is when a therapist or another healthcare provider diagnoses or treats you. An example of treatment would be when a therapist consults with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- *"Payment"* is when a therapist obtains reimbursement for your healthcare.
- "*Use*" applies only to activities within CIFT such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of CIFT such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

A therapist may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment and payment operations, your therapist will obtain an authorization from you before releasing this information. You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until we receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

A therapist may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever a therapist, in his or her professional capacity, has knowledge of or observe a child he or she knows or reasonably suspects has been the victim of child abuse or neglect, he or she must immediately report such to a police department, sheriff's department, county probation department, or county welfare department. Also, if a therapist has knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, the therapist may report such to the above agencies.
- **Adult and Domestic Abuse:** If a therapist, in his or her professional capacity, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult; if a therapist is told by an elder or dependent adult that he or she has experienced these; or if a therapist reasonably suspects such, the therapist must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

  A therapist is not required to report such an incident if the therapist has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect and the therapist is not aware of any independent evidence that corroborates the statement that the abuse has occurred; (a) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservator ship because of a mental illness or dementia; and (b) in the exercise of clinical judgment, the therapist reasonably believes that the abuse did not occur.
- **Health Oversight:** If a complaint is filed against a therapist with the California Board of Psychology or the California Board of Behavioral Science, the Board has the authority to subpoena confidential mental health information from the therapist relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without (a) your written authorization or the authorization of your attorney or personal representative; (b) a court order; or (c) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a

copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrator of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Therapist's Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request/denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

V. Complaints

- If you are concerned that a therapist has violated your privacy rights, or you disagree with a decision he or she has made about access to your records, you may contact the Clinical Director at 714-558-9266.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 1, 2005. CIFT reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that our therapists maintain. We will provide you with a revised notice by U.S. Mail. Please feel free to discuss any concerns you may have with your therapist as they arise or contact our Clinical Director at 714-558-9266 x953.

Signature	Client Name (Please Print)	Date
Client Representative Signature	(If Rep., Print Name & Relationship to Client)	Date

PERSONAL DATA

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Cell Phone (_____)_____ Home Phone (____)_____Work Phone(_____)_____

May we call you at home? Y❑ N❑ At Work? Y❑ N❑ Email: _____

Person to notify in case of emergency_____Phone Number_____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy?

Y ❑ N ❑ Don't Know ❑ Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5

Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $_____per session which is payable at the time of the session.

Client Signature _____

Therapist Initials_____

FAMILY INFORMATION

Marital status – current: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

Parents: Father: Age_____ Occupation_____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y❑ N❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y❑ N❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hearing/Seeing things that are not there	❑	❑	❑	❑

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

PERSONAL DATA

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Cell Phone (_____)_____ Home Phone (____)_____Work Phone(_____)_____

May we call you at home? Y❑ N❑ At Work? Y❑ N❑ Email: _____

Person to notify in case of emergency_____Phone Number_____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy?

Y ❑ N ❑ Don't Know ❑ Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $_____per session which is payable at the time of the session.

Client Signature _____

Therapist Initials_____

FAMILY INFORMATION

Marital status – current: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

Parents: Father: Age_____ Occupation_____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y❑ N❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y❑ N❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hearing/Seeing things that are not there	❑	❑	❑	❑

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments: