CONSENT TO TREATMENT

Welcome to the Center for Individual & Family Therapy, a Christian counseling center. The following is an agreement to enter in to an INITIAL INTAKE/TREATMENT PROCESS.

INITIAL INTAKE SESSION: The first session is an initial intake. It is sometimes necessary to refer you to another CIFT clinician who can better meet your needs. If, for some reason we are not able to help you at CIFT, we will provide referrals to an outside therapist.

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 charge for the appointment time.**

ELECTRONIC COMMUNICATION AND EMERGENCY PROCEDURES: If you choose to contact your therapist electronically, your therapist will not respond in kind without prior written authorization from you. If your therapist is in agreement, you may authorize your therapist to communicate with you through email and/or text messaging as a supplement to communication via telephone. Emails and text messages should be limited in nature and will not take the place of in session communication. Please note, email and text messages, like most forms of electronic communication, are not completely secure or confidential. Therefore, CIFT cannot guarantee confidentiality of any therapeutic content, including but not limited to information regarding danger to one's self or others, if communicated through email or text message. Please note, sending an email or text message does not mean your therapist has had the opportunity to read your message. Your therapist will only review and respond to emails or text messages within normal business hours, which are Monday through Friday from 9am to 7pm. Emails and texts sent outside of normal business hours will generally be responded to either the next business day or as soon as the therapist deems necessary for all non-emergency communication. In case of an emergency, please ***first*** call 911 or proceed to the nearest hospital emergency room; then, if possible, you may contact your therapist about emergency issues.

TREATMENT: CIFT therapists approach treatment by employing varying schools of thought including, but not limited to, EMDR (Eye Movement Desensitization Reprocessing), Cognitive-Behavioral (CBT), Psychodynamic, and Family System therapies. EMDR therapy was originally developed to treat trauma symptoms. It utilizes bilateral stimulation for treatment of a variety of symptoms and conditions. Cognitive-Behavioral therapies look at the interaction of thoughts and behaviors while Psychodynamic therapies explore intra-psychic processes and their interplay with interpersonal relationships. Family System therapies view the family as an emotional unit and examines the feedback loop between each individual in the family and the family as a whole. Although the research suggests that these and other treatment approaches can be helpful, please note that therapy may be a challenging process and no outcome can be guaranteed. You may not feel better or happier and disruptions to relationships may take place. Your therapist is available to discuss these issues, including therapeutic approaches, at any time during your treatment.

PAYMENT & FEES: **Payment is expected 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. **Payments are made by credit/debit cards only**. Upon request, 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. Fees for any extra time required by the therapist for legal proceedings will be charged at a higher rate than session fees. If you do not pay your fee, we are legally permitted to contact a collection agency.

I, the client, agree to be responsible for the payment of $_____ per session (45 minutes) which is payable at the time of the session (credit or debit card only). I understand that I am responsible for full payment, even though I may be reimbursed by my insurance company.

Client Initials _____

LIMITS ON CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and protected by law. Your therapist may not reveal any information to anyone without written permission by all parties, except where disclosure is required by law. In most situations, your therapist can only release information about your treatment if you sign a written Authorization Form. **However, your therapist is permitted or required to disclose information without either your consent or authorization under the following circumstances**:

- **ABUSE:** Your therapist is legally mandated to report any incident that leads to a reasonable suspicion of abuse or neglect of any individual that is under the age of 18, that is over the age of 65, or that is physically or intellectually dependent on another person. Child abuse also includes, but is not limited to, persuading a minor into any kind of obscene sexual conduct or the creation, distribution, or accessing of imagery depicting a minor in any kind of obscene sexual conduct.
- **SAFETY THREAT:** If you communicate a serious intent of significant physical harm toward yourself or an identifiable victim, your therapist must make reasonable efforts to prevent that harm. Additionally, if your therapist receives information that you communicated a serious intent of physical harm toward yourself or identifiable victim from a family member or significant other, your therapist must make reasonable efforts to prevent that harm as well. Reasonable efforts to prevent harm may include releasing information to the potential victim(s), your family members, and/or law enforcement.

- **CONSULTATION:** Your therapist may seek advice from other professionals. During a consultation, he or she will make every effort to avoid revealing the identity of any client. The other professionals are also legally bound to keep the information confidential. Your therapist may or may not discuss these consultations with you.
- **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 to them.
- **LAWSUITS:** If a client files a lawsuit or a complaint with a governmental agency that tenders his or her mental condition, or is involved in certain family law disputes, the psychotherapist-patient privilege may be waived and the therapist may be required to provide records or testimony. You should consult with your attorney about the possible impact of such litigation on the psychotherapist-patient privilege. If there is a complaint or suit by the client against the therapist, the privilege will be waived.
- **ADMINISTRATIVE STAFF:** Your therapist may need to share protected information with the administrative staff for 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.
- **SECURITY POLICY REGARDING ELECTRONIC INFORMATION:** Electronic transmission and storage of confidential information always entails security risks. It is our general policy to use it for scheduling purposes only to the greatest degree possible.

PARENTS AND CLIENTS WHO ARE MINORS: A client over 12 years of age may independently consent to psychological services if he or she is mature enough to participate in such services, or the minor would present a danger 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 have a negative effect on the minor client's 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 a record of client's attendance at scheduled sessions. Therapists will encourage parent participation when appropriate.

PRE-LICENSED THERAPISTS:

I understand that my therapist is a: ❑MFT Trainee ❑Registered Associate MFT ❑Registered Associate PCC ❑Doctoral Student ❑Registered Psychological Assistant and, therefore, is not licensed, but is functioning under supervision by a licensed professional. I acknowledge that my treatment will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to treatment records.

_____ _____ _____ working under the direct supervision of

Therapist name Degree Registration number

_____ _____ _____ , has my permission to audio and/or

Supervisor name Degree License number

video record any and all counseling sessions that I participate in at CIFT. I agree that these audio and/or video recordings are not part of my file and I am not guaranteed a right of access to these recordings. I give my consent for any and all audio and/or video recordings made during counseling sessions that I participate in at CIFT to be viewed by my therapist and his/her supervisor and supervision group. I understand that any and all audio and/or video recordings will be viewed as discussed herein and then quickly deleted or destroyed.

Client Initials _____

TERMINATION OF THERAPY: It is within the client's right to terminate therapy at any time. The therapist may choose to terminate therapy if the client is threatening or abusive to the therapist, not complying with the treatment plan, not paying for services, or if the therapist believes the client is no longer benefiting from the therapy. In the event of termination, the therapist will try to provide the client with several referrals, unless the client has already obtained other services or declines to get referrals. It is usually advisable, but not required, to have a termination session to process the work.

This is the entire agreement between the parties and cannot be changed except in writing by both parties. **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 Director of Clinical Services at 714-558-9266.

_____ _____ _____

Client Signature Client Name (Please Print) Date

_____ _____ _____

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

Teletherapy Informed Consent Form

I,_____, hereby consent to engage in teletherapy with _____. I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Psychotherapy Services Agreement which I received with this consent form.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and confidentiality cannot be guaranteed.
4. I understand that teletherapy-based services and care may not be as complete as face-to-face services, and if the therapist believes I would be better served by another form of therapeutic service (e.g.: face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that I may benefit from teletherapy, but the results cannot not be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. During our first session, the therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour support.
6. I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; the information security on my computer; and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my therapy sessions.

I have read, understand and agree to the information provided above.

_____ _____

Client or Guardian Signature Date

_____

Client Printed Name

Therapist-Client Arbitration Agreement

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the therapist including any spouse or heirs of the client and any children, whether born or unborn, at the time of the occurrence giving rise to any claim.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the clinician, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the therapist to collect any fee from the client shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the therapist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Procedures and Applicable Law: A demand of arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Revocation: This agreement may be revoked by written noticed delivered to the therapist within 30 days of signature. It is the intent of this agreement to apply to all psychological services rendered any time for any condition.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement and I have a right to receive counseling and mental health services without signing this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Therapist or Authorized Rep. Signature Date

By: _____ _____
Client's or Client Representative Signature Date

_____
Print Name of Therapist
Center for Individual & Family Therapy

By: _____
Print Client's Name

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