April Forella, MS, LMHC, APCC
Associate Professional Clinical Counselor 4678
Employed & Supervised by: Jennifer Stubblefield, Licensed Marriage & Family Therapist #81059
242 W. Main St., #104, Tustin, CA 92780
(949) 386-1294

CHILD INFORMED CONSENT

TREATMENT INFORMATION AND AUTHORIZATION

I authorize treatment and assume financial responsibility for my child's treatment. I understand that it is customary to pay for professional services at the time they are tendered, unless prior arrangements have been agreed upon. I understand that the responsibility for payment remains with me regardless of my insurance coverage. In the event of my default; I also agree to pay for collection costs and reasonable attorney's fees that may be required to effect collection of default and that I will be informed prior to my account being turned over for collection.

I understand that my child's appointment times have been reserved for him/her, which prevents others from reserving that time and if I cancel the same day as my appointment I am responsible for a $75 cancellation fee.

GENERAL INFORMATION REGARDING THERAPY

As a general rule, information this child shares in therapy sessions is confidential, unless they give consent to disclose certain information. However, there are exceptions to this rule that are important to understand prior to starting with the therapy process. In some situations, it is required by law or professional guidelines that information discussed in therapy has to be disclosed. Some of those situations are described below.

1. If they report having a plan to harm them self based on the evaluation of that plan, confidentiality can be broken in order to protect them from harming themself.
2. If they report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person they intend to harm.
3. If you they are involved in activities that could cause harm to them self or someone else, even if they do not *intend* to harm them self or someone else, based on the evaluation of that behavior, confidentiality can be broken.
4. If they report that they are being abused-physically, emotionally or sexually- or that they have been abused in the past, the law requires that this be reported to the Child Protective Services.
5. If they are involved in a court case and a request is made for information about their therapy, information will be disclosed with the parent/guardian's written consent unless the court *requires* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you.
6. If you agree that information can be shared with a specific person or entity, then we will discuss the limits of what will be shared, and how that information will be shared.

Except for situations as described above, parents/guardians will not be told of specific information disclosed in therapy

Also, parents and guardians may be able to be more helpful if they have general ideas about themes of therapy (such as autonomy, important privileges, achievements, or the status of symptoms) and the therapist may have specific suggestions for parents that do not involve breaking the child's privacy. Parents are strongly urged to respect the privacy of this child's treatment and the related records.

SCHOOLS & TEACHERS

Information will not be shared with this child's school, including that they are even seeing a therapist, unless parents/guardians give permission. If someone from their school wants to talk about their treatment, or if it is decided that talking to someone at their school would be beneficial, then parents will be asked to give their permission for that. If your school wants information about the treatment, and you do not want to give permission, then that will be discussed in a session.

PHYSICIANS & DOCTOR'S OFFICES

Your medical doctor may have been involved in referring you for this child's therapy, may have prescribed medication for them, or may be considering prescribing medication. It may be important to coordinate with their doctor or doctor's office regarding their progress or status, especially when medication is involved or there are other health issues. Again, parent/guardian permission will be required for such a consultation to occur and it will be important to discuss what information will be disclosed. The only time information can be shared with their medical doctor without permission is if they are engaged in harmful or risky behavior that creates a concern about their safety.

Therapy sessions are normally 50 minutes. On some occasions a double session or other time period may be discussed and arranged in advance. Same day cancellation will result in a fee of $75 dollars.

I have received, read and understand this policy/intake form.

_____

Client Name

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. **HOW I WILL USE AND DISCLOSE YOUR PHI.**

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples. A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. **For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
5. **Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:
    a) When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
    b) If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
    c) If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

d) If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
e) To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
f) If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
g) If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
h) If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
i) If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
j) For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
k) For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
l) For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
m) For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
n) For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
o) Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
p) If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
q) If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
r) If disclosure is otherwise specifically required by law.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Jennifer Stubblefield at (949) 500-9513

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003. I acknowledge receipt of this notice

_____	_____	_____
Name	Signature	Date

CONSENT TO TREAT MINOR
GUARANTEE OF PAYMENT & ASSIGNMENT OF INSURANCE BENEFIT

Therapist Name or Therapist's Supervisor's Name: _____

Client's Name: _____

Date of Birth: _____ Today's Date: _____

I/We hereby authorize and request the above-named therapist and/or his/her supervisor to counsel the above-named minor.

I/We understand that our minor will be provided with counseling and/or professional psychological services, and I/We hereby agree to assume full responsibility for payment of all reasonable charges by the above-named therapist and/or his/her supervisor in rendering such services, as agreed upon in advance of service.

I/We agree to the assignment of all insurance benefits directly to the above-named therapist and/ or his/her supervisor including psychological and minor medical benefits (whether in-patient or out-patient) to which I/We or the minor are entitled, including any government-sponsored programs, any private insurance, or other health plans.

I/We understand that I/We are financially responsible for all charges whether or not paid by said insurance, and do authorize the above named therapist and/or his/her supervisor to release all information necessary to secure the payment of these benefits.

I/We assume full responsibility for the same day cancellation fee of $75 for missed sessions.

I/We agree that a copy of this assignment is as valid as the original.

Signature of Parent/Guardian: _____ Signature of Parent/Guardian: _____

Relationship to Minor: _____ Relationship to Minor: _____

Address: _____ Address: _____
(Street & Number) (Street & Number)

_____ _____
(City) (State) (Zip Code) (City) (State) (Zip Code)

Phone Number: _____ Phone Number: _____

AUTHORIZATION TO BILL CREDIT CARD FOR SERVICES

To Our Clients:

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time of check in. That information will be held securely until your insurance has paid their portion and have notified both you and us of how much, if any, is your portion. A statement will be mailed to you regarding any remaining balance. If a balance becomes delinquent, the credit card will then be charged to avoid the collections process.

This will be advantage to you because you will no longer have to write out and mail us a check. It will be an advantage to us as well because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody to keep down the cost of health care.

Much like when you check into a hotel or rent a car, you are asked for a credit card, which is imprinted and later used to pay your bill.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,
Stubblefield & Associates

Full Name on Credit Card (Please Print):_____

Card Billing Address: _____
(Street Number & Name) (City) (State) (Zip Code)

Type of Credit Card: _____
(Visa, MasterCard, American Express, Discover)

Card Number: _____ **Expiration Date:** _____
(Month/Year)

CSC: _____ **For American Express, it's the four digits on the front of the card. For MasterCard, Visa or Discover, it's the last three digits in the signature area of the back of your card.**

Client Signature: _____**Date:**_____

For client convince, if you would like to authorize Stubblefield & Associates to charge your card at time of service (initial here)_____.