



Apple Tree

Early Intervention Center
Family Counseling Center, Division

Consent to Consultation & Treatment

Welcome to Apple Tree Family Counseling Division. 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 completing necessary assessments, with an additional \$20 fee for individual services and \$35 for couple and family services.

Please be aware that during or after the first consultation it is sometimes necessary to determine if the appropriate services can be provided. If for some reason we are not able to help you at Apple Tree Counseling Center, Division, your file can be transferred to an outside therapist with your written permission.

INTERVENTIONS AND TREATMENT MODELS:

Client will receive interventions and treatment approaches that are appropriate to meet their individual needs. Treatment modalities and approaches that may be used depending on treatment goals are Cognitive Behavior Therapy, Eye Movement Desensitization Reprocessing (EMDR), Family Systems, Experiential and Structural. The treatment process looks different for every participant. It is also normal to experience feelings of increased distress during the beginning stages of the treatment process. Change is difficult, but with appropriate interventions, full disclosure, consistency and a commitment to the process change is inevitable.

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 24 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



Apple Tree

Early Intervention Center
Family Counseling Center, Division

a \$35.00 charge for returned checks. Fees for writing expert testimony for court purposes will be charged at a higher rate than session fees.

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I, the client, agree to be responsible for the payment of \$ 120.00 per session (45-50 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 Apple Tree Counseling Center 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



Apple Tree

Early Intervention Center
Family Counseling Center, Division

- 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.

NO SECRETS CLAUSE: This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit). During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.



Apple Tree

Early Intervention Center
Family Counseling Center, Division

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination. We, the members of the (couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with our therapist at Apple Tree Counseling Center, Division, and that we enter couple/family therapy in agreement with this policy.

Client Initials _____

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 Associate
- Associate Clinical Social Worker



Apple Tree

Early Intervention Center
Family Counseling Center, Division

- 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.

Kathleen Shanahan, MA, MFTA, #IMF87529 (therapist) working under the direct supervision of (supervisor) **Toni Dunning, MA, LMFT #MFC51248**, 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 client's 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. Your 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 Director, Carol Thompson at 714-826-4957.

Client's or Client Representative Signature

Date

Client's Name

Print

(If Representative, Print Name and Relationship to Client)

Client's Signature

Date



Apple Tree
Early Intervention Center
Family Counseling Center, Division

Client's Signature

Date

Client's Name

Print

Forms\ Consent to Consultation-Treatment

**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

An APPLE TREE FAMILY COUNSELING CENTER, DIV 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 APPLE TREE FAMILY COUNSELING CENTER, DIV such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of APPLE TREE FAMILY COUNSELING CENTER, DIV, 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.



Apple Tree

Early Intervention Center
Family Counseling Center, Division

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, Child Protective Services, 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



Apple Tree

Early Intervention Center Family Counseling Center, Division

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 Director, Carol Thompson at 714-826-4957.
- 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 February 29, 2016. APPLE TREE FAMILY COUNSELING CENTER, DIV 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



Apple Tree
Early Intervention Center
Family Counseling Center, Division

feel free to discuss any concerns you may have with your therapist as they arise or contact our Director at 714-826-4957.

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