Patient Name_____ DOB_____

FREE YOUR MIND

MARRIAGE & FAMILY THERAPY

Patient Agreement

Welcome to Free Your Mind Marriage & Family Therapy

Our dedicated psychotherapists and staff are committed to providing the highest quality care for each patient. Set forth below is our Informed Consent, which establishes guidelines for your participation in treatment with us. Please read the following paragraphs carefully and ask your psychotherapist if you have any questions. If, after reading and considering the terms of this Informed Consent, you agree to everything set forth below, please sign where indicated.

Treatment – What to Expect

Your initial session with your psychotherapist will be an evaluation lasting approximately 60 minutes. The purpose of this evaluation is to determine your needs so that we can determine the most appropriate treatment plan and whether we will be able to meet your specific needs. Following the initial evaluation, your psychotherapist will discuss the assessment with you and make recommendations regarding psychotherapy and which specialist within our group, if any, can provide the recommended treatment.

Our Professionals

Our professional team is comprised of Licensed Psychotherapists. License psychotherapists have completed the coursework to become a Licensed Marriage Family Therapist (LMFT) or Licensed Clinical Social Worker (LCSW) and are registered with the California Board of Behavioral Sciences to provide psychotherapy in individual and group settings.

Children and Appointments

We kindly ask that your children do not accompany you to appointments unless they are seen as a patient or are specifically requested to attend by your psychotherapist. Please note that we cannot have children waiting in our waiting area without the supervision of a parent, guardian, or caretaker.

Treatment of Minors

We require that both parents or legal guardians sign to consent for treatment of a minor. We require a copy of current Custody Orders and/or proof of legal guardianship for the minor, if applicable, prior to the commencement of therapy. Please provide your therapist with a copy, either by email or fax, prior to the initial session so that our records are complete.

Professional Consultation and Supervision

Professional consultation is an important component of a healthy therapy practice. As such, therapists regularly participate in clinical, ethical, and legal consultations with appropriate professionals, including

consultation with the treatment team at Free Your Mind Marriage & Family Therapy. Additionally, in accordance with California State Law Licensing Regulations, all pre-licensed therapists receive individual and group supervision. Therefore, confidentiality will not be maintained during consultation with the supervisor and other professional persons hired by the Practice for the purpose of staff training. (California Code of Regulations, Title 16)

Cancellation Policy and No-Show Policy

We reserve your appointment time specifically for you and you alone. For this reason, we will remind you about each appointment as a courtesy. Our office asks for your consideration; please notify us with one (1) business day in advance if you cannot make your scheduled appointment time or we may not be able to reserve additional appointment times. We may not be able to reserve additional appointment times if you fail to cancel without notice two (2) times in a twelve (12) month period.

Late Arrivals

If you arrive late for your appointment, your psychotherapist will only be able to see you for the allotted time left of your scheduled appointment. At such times, it may be necessary to schedule an additional appointment to allow you and your psychotherapist to have sufficient time to address your treatment concerns. We may not be able to reserve additional appointment times for you if you arrive late for two (2) visits in a twelve (12) month period.

Regular Attendance

Regular attendance at appointments is a critical part of your care/your child's care. We encourage you to make regular attendance a priority. We have limited resources, and to enable psychotherapists to help as many clients as possible, we focus our treatment on those patients who demonstrate their commitment to treatment by regularly attending their scheduled therapy sessions. We reserve the right to terminate therapeutic care due to irregular attendance.

Same Day Appointments

Most insurance companies do not pay for two mental health visits on the same day. If you schedule visits with your psychotherapist on the same day that you meet with your psychiatrist, you may be expected to pay for one of these visits.

Fees and Payments

If you have a co-payment and/or deductible payment for psychotherapy sessions, payment is due at the time of session is payable by cash, check, or credit card. You may provide a credit card to have on file with your psychotherapist.

Contacting Your Psychotherapist

For routine calls to speak directly with your psychotherapist, please call _____. Typically, messages will be returned within two (2) business days. Your psychotherapist will let you know when he/she is out of the office. While out of the office, your therapist will not return calls until he/she returns to the office.

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Emergencies and Urgent Consultations
We are unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or mental health assistance, please be aware of the following resources:

- 911 or go to the nearest emergency room
- Orange County WarmLine: (877) 910-9276 or (714) 991-6412
- CAT – Centralized Assessment Team: (866) 830-6011
- Suicide Prevention Line: (877) 7-CRISIS or (877) 727-4747

Forms and Documents
All medical forms (such as disability forms, school forms, workers compensation forms, etc.) should be completed by your doctor rather than your psychotherapist.

Notice of Privacy Practices
You agree that you have been given a copy of Free Your Mind Marriage & Family Therapy's Notice of Privacy Practices, which describes the ways in which Free Your Mind can use and disclose protected health information. You further agree that you have been given the opportunity to review and ask questions regarding the same. You understand that a copy of our Notice of Privacy Practices will be available in our office upon request at any time. You further understand that when we amend our Notice of Privacy Practices, we will provide you with the amended version at your next scheduled visit.

Limits of Confidentiality
Our psychotherapists maintain patient confidentiality except as mandated or permitted by law. In California, there are certain limits to the confidentiality of a psychotherapy patient. These include threat of hard to self or others, certain lawsuits, a court order, detention of a mentally disordered person for evaluation, and reasonable suspicion of abuse of a minor or dependent adult.

Telehealth Treatment is Available
In addition to face to face visits, telehealth is available which allows our therapists to diagnose, consult, treat and educate using interactive audio, video or data communication regarding your treatment. If you are interested in telehealth, please consult with your therapist for more information.

Termination of Treatment and Complaints
Therapy has been shown to be beneficial to those who undertake it. If at any time, you have questions or concerns regarding the services you receive, we strongly encourage you to discuss them with you therapist. If you feel that your therapist is not a good fit for you or that you may benefit by going to another therapist for various reasons, please call our office and we will be happy to reassign you to another therapist. Also, you have the right to decide to end treatment. If you are thinking about ending therapy, we encourage you to discuss it with your therapist so that we may minimize terminating treatment against medical advice. If termination is indicated, we can provide you with names of other mental health providers.

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Your therapist has the right to terminate therapy due to, but not limited to, the following reasons: untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, a client's needs are outside the therapist's scope of competence or practice, or a client is not making adequate progress in therapy.

Acknowledgement of Patient Agreement

If any part of this Patient Agreement (including any attachments) is held to be unenforceable, the remainder of this Patient Agreement will remain in effect. This Patient Agreement, together with the attachment hereto, represents the entire agreement of the patient and Free Your Mind Marriage & Family Therapy (including all psychotherapists) with respect to the subject matter hereof.

By signing below, you state that you have read and agree to this Patient Agreement in its entirety.

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

Patient Agreement

Contact Information

Please indicate below the means by which you consent to Free Your Mind Marriage & Family Therapy contacting you.

I give the staff of Free Your Mind Marriage & Family Therapy permission to contact me directly on my:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Other Phone: _____

I give the staff of Free Your Mind Marriage & Family Therapy permission to leave a message for me on my:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Other Phone: _____

I give the staff of Free Your Mind Marriage & Family Therapy permission to contact my emergency contact:

Emergency Contact Name: _____ Phone Number: _____

☐ I give the staff of Free Your Mind Marriage & Family Therapy permission to email me at the following email address:

_____
Email Address

Patient Name_____ DOB_____

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Consent for Treatment

I am voluntarily seeking psychotherapy by the psychotherapists at Free Your Mind Marriage & Family Therapy for the purpose of diagnosis and treatment, and I do hereby consent to such evaluations, treatments and/or diagnostic procedures as may be deemed advisable by my treating psychotherapist. I understand that there are both risks and benefits to psychotherapy and/or psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such evaluations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment or the treatment of my child is designed to be helpful, it may at times be difficult or uncomfortable.

For Minor Patients: By signing below, you agree that you have legal custody and authority to consent to the child's treatment. You further agree that if you share custody of the child, all parties who have legal custody of the child have been made aware of, and consent to treatment at Free Your Mind Marriage & Family Therapy.

For Minor Patients 12 and over: The patient's consent and parental consent is required.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

By signing below, you state that you have read and agree to this Consent for Treatment in its entirety.

Patient Name: _____ (Please Print)

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

If not signed by the patient, please indicate:

Relationship:

☐ Parent or guardian of un-emancipated minor patient

☐ Health care surrogate or conservator of an incompetent adult or emancipated minor patient

Name of Patient: _____

☐ Both parents are aware and give consent for minor to attend therapy.

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Disclosure Authorization (Billing and Payment Activities)

Patient Information

Name: _____

Address: _____

Person/Organization Providing Information

Name: Free Your Mind Marriage & Family Therapy

Person/Organization Receiving Information (Insurance)

Insurance Company: _____

Membership ID: _____

☐ I agree to inform Free Your Mind Marriage & Family Therapy of any changes to my insurance at the time of the change.

Detailed Description of Information to be Released:

Entire Medical Record (**excluding** psychotherapy notes, mental health records covered by CA Welfare & Institutions Code § 5328, HIV/Aids Test Results and Drug/Alcohol Treatment Program Information)

Note: Signatures Required in Any of the Following are Checked:

☐ Mental Health Records (covered by CA Welfare & Institutions Code § 5328) Signature: _____

☐ Drug/Alcohol Treatment Program Information Signature: _____

Purpose(s): The purpose of the disclosure is so that Free Your Mind Marriage & Family Therapy can conduct billing and payment activities. Unless sooner revoked, this authorization expires on the date that is one year from my last date of treatment by Free Your Mind Marriage & Family Therapy.

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I understand:

- This authorization cannot be used to authorize the disclosure of information for marketing purposes or for the sale, license to use or lease of information; no remuneration shall be provided to the disclosing party in connect with this authorization.
- I authorize the use of disclosure of the information specified above for the purpose(s) listed above. I understand this authorization is voluntary.
- Treatment will be conditioned on signing this authorization unless the purpose of my treatment is solely to create protected health information for disclosure to the party that is to receive the information pursuant to this authorization. IN that event, the consequence of not signing this authorization is that treatment may not be provided.
- I may revoke, cancel or modify this authorization by providing written notification to the disclosing party at any time except to the extent that action has been taken in reliance on it. The authorization will stop or be modified on the date my notification is received.
- Unless I have specifically requested in writing that the disclosure be made in a specific format, the information may be disclosed in any manner deemed appropriate by the disclosing party and consistent with applicable law.
- I have a right to inspect and copy the information that is to be released.
- This information that has been disclosed could include information from records protected by Federal confidentiality rules (42 CFR Part 2). To the extent applicable, the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- The organization I have authorized to receive the information may be potentially further disclose the released information, which makes it no longer protected under the HIPAA Privacy Law. However, under California law, the recipient may not further disclose the information except in accordance with a valid authorization or another legally permitted purpose. The disclosing organization is not responsible for the conduct of any other entity.
- I understand that I have a right to receive a copy of this authorization.

I hereby authorize the disclosure of the information described above to the recipient listed above.

_____	_____
Patient Name	Patient Date of Birth
_____	_____
Signature of Patient	Date
_____	_____
Signature of Parent/Guardian or Personal Representative	Date

**If you are signing as a personal representative of an individual, describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____ _____

Signature of Witness Attesting to Identity & Authority Date

Internal Use Only: Patient given copy: _____