1/5 Consent Forms - Shirley Kahenzadeh, LCSW - LCS 23427

CONSENT TO TREATMENT

I authorize and request my therapist to carry out psychological and/or psychiatric examinations, treatment, and/or diagnostic procedures now and during my treatment as it becomes advisable. I understand that the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I understand that while the course of my treatment is designed to be helpful, my therapist can make no guarantee about the outcome of my treatment. The therapeutic process may bring up uncomfortable feelings and reactions, that these are a normal response to treatment and will be part of the work between my therapist and myself.

Confidentiality and Limits of Confidentiality
All information provided to your therapist is strictly confidential. The major exceptions to this are:
Your therapist is required by law to report suspected child, elder, dependent adult abuse to the authorities.
Your therapist is required by law to take measures to protect any person you tell your therapist that you intend to harm.
Your therapist my break confidentiality to protect you if you if you intend to attempt suicide.
You sign an authorization to release confidential information to a specific person for a specific reason.

After Hour Emergency Contact
In the case of an emergency use the number that you have been provided to reach your therapist. If they cannot be reached for any reason at that time, then proceed to call 911 or go to the closest emergency room for treatment. You may be charged for any telephone consultation with your therapist over 5 minutes.

Financial Terms, Insurance coverage and Co-payments
You are responsible for obtaining prior authorization for treatment from your insurance company. Failure to do so, and/or lapses in insurance coverage will result in you assuming the full self-pay fee for the services delivered. The self-pay fee is _____ per 45-minute session. If your therapist is billing for the services provided through your currently active policy with your insurance company, they are bound to utilize the insurance company's fee structure for services that they pay for.

Fees will be charged by your therapist for the production of records and/or letters at the rate of $185.00 per hour, using 15 minute increments. You will be required to meet your deductible and make all co-payments as outlined in your insurance policy. All payments will be made at the time of service. I assign all applicable medical insurance benefits to my therapist and authorize my therapist to release all information required to secure payment.

Cancellation and Missed Appointments Policy
Scheduled appointments are reserved especially for you. If an appointment is missed or cancelled with less than 24 hour notice (late cancellations) you are responsible for the full fee. Your insurance company cannot be billed for the missed or cancelled appointment.

Acknowledgement of Receipt of Notice of Privacy Practices
By signing this form, you acknowledge receipt of the Notice of Privacy Practices. This notice provides you with information about how your therapist may use and disclose your protected information. I encourage you to read it in full. This notice is subject to change. If the notice changes you may receive a copy of the revised policy by contacting Shirley Kahenzadeh. Please contact Shirley Kahenzadeh with any questions.

By signing below, I acknowledge having read and understand the above consent to treatment

Printed Name	
Signature	Date

TELEHEALTH CONSENT FORM

I hereby consent to engage in Telehealth with Shirley Kahenzadeh. I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education and management, and self-management of a patient's health care.

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Notice of Privacy Practices I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
4. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.
   I have read and understand the information provided above and understand that I have the right to have all my questions regarding this information answered to my satisfaction. This page is in addition to, and not replacing, the intake paperwork signed and reviewed at the onset of treatment.

By signing below, I acknowledge having read and understand the above consent to telehealth treatment:

Printed Name	
Signature	Date

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Client Email/Texting Informed Consent Form

A. Risk of using email/texting: The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Email and texts can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
8. Encrypted messages are the most protective form of communication; however, I do not presently use an encryption program.
9. My computer and cell phone are password protected.

B. Conditions for the use of email and texts: Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. Therapeutic communication through email should be kept at a minimum. Please call to schedule an appointment.
4. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
5. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts, with the exception of office clinicians and staff, without the client's/parent's/legal guardian's written consent, except as authorized by law.
6. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
7. Provider is not liable for breaches of confidentiality caused by the client or any third party.
8. Email and text communication to change or schedule and appointment is acceptable. However, it is the client's/parent's/legal guardian's responsibility to follow up by phone if patient did not receive a response within 48 hours.
9. If abovementioned guidelines are not adhered to, I will terminate the email/text relationship as necessary.

Client Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text.

_____ Yes, I have read the above and consent to unencrypted, but confidential email/text correspondence.
_____ No, I am not interested in email/text correspondence.

Printed Name	
Signature	Date

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Notice of Privacy Practices

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.

Your therapist is legally required to protect the privacy of your Protected Health Information (PHI), information that can be used to identify you regarding your past, present, or future health or condition, provision of health care to you, or payment of this health care. Your therapist must provide you with this "Notice of Privacy Practices" that explains how, when, and why your therapist will "use" and "disclose" your PHI. A "use" of PHI occurs when your therapist shares, examines, utilizes, applies, or analyzes such information within the practice; PHI is "disclosed" when it is released, transferred, has been given to, a third party outside of the practice.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent:

1. For treatment: Your therapist can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care.
2. To obtain payment for treatment: Your therapist can use and disclose your PHI to bill and collect payment for the treatment and services provided to you. Your therapist may also provide your PHI to billing companies, claims processing companies, and others that process health care claims.
3. For health care operations: Your therapist can disclose your PHI to evaluate the quality of health care services you received or the performance of the health care professionals who provided services to you. Your therapist may also provide your PHI to accountants or attorneys to ensure compliance with applicable laws. • Other disclosures: Your therapist may disclose your PHI if you need emergency treatment, as long as your therapist tries to get your consent after treatment is rendered.

Certain Uses and Disclosures Do Not Require Your Consent:

4. When disclosure is required by federal, state or local law; by judicial or administrative proceedings; or by law enforcement: For example, your therapist may make a disclosure to applicable officials when a law requires a report of information to government agencies and law enforcement personnel about victims of abuse or neglect, or when ordered in a judicial or administrative proceeding.
5. For public health activities: For example, to report information about you to the county coroner. • For health oversight activities: For example, to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
6. For research purposes: In certain circumstances, to provide PHI in order to conduct medical research.
7. To avoid harm: In order to avoid a serious threat of harm your therapist may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm.
8. For specific government functions: Your therapist may disclose PHI of military personnel and veterans in certain situations and for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
9. For workers' compensation: To comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services: Your therapist may use PHI to provide appointment reminders or inform you of treatment alternatives or other health care services /benefits offered.

Certain Uses and Disclosures Require You to Have the Opportunity to Object:
Your therapist may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Other Uses and Disclosures Require Your Prior Written Authorization:
In any other situation not described above, your therapist will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke it in writing to stop any future uses and disclosures of your PHI by your therapist.

Rights You Have Regarding Your PHI : The Right to Request Limits on Uses and Disclosures of Your PHI

You have the right to ask that your therapist limit uses and disclosures of your PHI. However, your therapist is not required to accept the request: If your therapist does accept it, s/he will abide by it except in emergency situations. You may not limit uses and disclosures your therapist is legally required or allowed to make.

The Right to Choose How Your Therapist Sends PHI to You
You have the right to ask that your therapist send information to you to at an alternate address or by alternate means (e.g., e-mail instead of regular mail). Your therapist must agree if the PHI can easily be provided to you in the format you requested.

The Right to See and Receive Copies of Your PHI
In most cases, you have the right to see or receive copies of your PHI. Your request must be in writing. Your therapist will respond within 30 days of receiving the written request. If the request is denied, your therapist will explain why, in writing, and tell you how to have the denial reviewed. If you request copies of your PHI, you will be charged not more than $.25 for each page. Your therapist may provide you with a summary of the PHI if you agree to that and to the cost in advance.

The Right to a List of Disclosures Your Therapist Has Made
You have the right to a list of instances in which your therapist has disclosed your PHI. The list will exclude uses or disclosures to which you have already consented, uses and disclosures made for. National security purposes, to law enforcement personnel, or disclosures made before April 15, 2003. Your therapist will respond to your request within 60 days & The list will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure; to who PHI was disclosed; a description of information disclosed; and the reason for the disclosure. The list will be provided at no charge, but for more than one request per year, you will be charged a reasonable, cost-based fee.

The Right to Correct or Update Your PHI
If you believe that there is a mistake in your PHI or that important information is missing, you have the right to request a correction or add the missing information. You must provide the request in writing. Your therapist will respond within 60 days of receiving your request to correct or update. Your therapist may deny your request in writing if the PHI is correct and complete; not created by your therapist; not allowed by law to be disclosed; or not part of the records. The written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file such a statement, you have the right to request that your request and the denial be attached to all future disclosures of your PHI. If your therapist approves your request, the change to your PHI will be made, you will be told that the change has been made, and others that need to know about the change to your PHI will be told.

The Right to Get This Notice by E-Mail
You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

How to Complain About Your Therapist's Privacy Practices
If you think your therapist has violated your privacy rights or if you disagree with a decision your therapist has made about access to your PHI, you may file a complaint with the person listed below or send a written complaint to the Secretary of the Department of Health and Human Services. Your therapist will take no retaliatory action against you if you file a complaint about your therapist's privacy practices. If you have any questions or complaints about this notice or your therapist's 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: Shirley Kahenzadeh 310-285-9300.

By signing below, I acknowledge receipt of the Notice of Privacy Policy:

Printed Name	
Signature	Date