**Informed Consent for Services**

Center for Integrated Care is a Marriage and Family Therapy Corporation. Our therapists consist of Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Associate Marriage and Family Therapist, Associate Social Worker, PsyD, etc. that provide individual, couple, group, and family therapy in order to assist in treating symptoms that may cause an impairment in personal, social, educational, vocational, and relational functioning. By signing below, you agree to participate in therapy services and work towards the established treatment goal.

We DO NOT provide medication support, prescription recommendation, or legal advice as these do not fall within our scope of practice. We also DO NOT participate in any legal court hearings, provide information to attorneys, or make any recommendations for court as this can affect the therapeutic process. You (client or parent/guardian) and I (therapist) have the right to cancel services at any time without affecting patient right to future care or treatment.

Telemedicine services may be provided upon request and verbal consent from a patient who resides in the state of California. Telemedicine is the use of HIPAA compliant devises permitting two-way, real-time, interactive communication between the patient and Therapist at a distant site within the state of California in order to improve mental health functioning. Consenting to this service means patient consents to telemedicine with his/her therapist as part of the psychotherapy treatment. Patient understands that, just like face to face therapy, telemedicine is bound by the laws of the State of California.

Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Patient understands that any risks involving patient's designated location of service is the patient's responsibility. There will be no dissemination of any personal identifiable images or information from the telemedicine interaction to other entities without further written consent, all information transmitted, messages exchanged will be through a secured website that is HIPAA compliant, where sessions are NOT recorded.

Telemedicine has risks and consequences including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons. In addition, telemedicine-based services and care may not be as complete as face-to-face services. However, if the therapist believes patient would be better served by face-to-face services, patient will be referred out or provided with such a service. Telemedicine like psychotherapy has potential risks and benefits that despite patient and therapist efforts patient's condition may not improve and in some cases may even get worse before they get better. Patient may benefit from telemedicine; however, results cannot be guaranteed.

**Scheduling/Cancellation Policy**

There is a minimum of 24-hour prior notice for cancellations. Any appointments missed without prior cancellation will be subject to a fee. More than 2 missed appointments without prior notification will be subject to termination of services. Sessions are usually once a week for 50-60 minutes, however they can be more or less frequent if needed. Therapist is able to be contacted by telephone, however if they are not available leave a message on our confidential voice mail.

**Emergency/Safety**

In an emergency contact, 911, Access 1-800-854-7771, 1-800-SUICIDE, or proceed to the nearest hospital. For your safety and the safety of others, weapons or dangerous objects are not permitted and we reserve the right to ask that these be removed. Our obligation to provide a safe environment for patient care overrides the patient’s right to privacy.

**Financial obligations**

Therapy services are billed to Insurance or made at time of service (e.g. cash patients, co-payments) that includes up to 50-60 minutes of therapy. Payment arrangements are made between therapist and client or parent/guardian and paid prior to rendering of services. For cash patients: Payment is made prior to each session and paid at the time of service or in advance. Non-covered service fees may apply for record requests, treatment letters, court appearances, consultation with other entities per clients/caregiver’s request and authorization, etc.

Additional fees may apply for Telehealth facility fee services. As all insurance plans vary there is no guarantee that telemedicine services will be covered. Should your insurance company decline reimbursement, you are personally responsible for all charges. Therefore, please contact your insurance carrier to ensure coverage prior to receiving services as we cannot ensure coverage due to complexity of some insurance plans. If your account has not been paid for more than 90 days and other arrangements have not been made, there will be late fees and we may take legal action to secure payments, which time, late fee, and legal fee costs will be added to the claim.

**Confidentiality**

The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. Communication between therapist and patient are mostly kept confidential except for instances of court subpoena, potential harm to self or others, and child/elder/disabled abuse. Therapists are mandated reporters for child/elder/disabled abuse that will need to be reported to appropriate parties. Information can also be released upon patient or parent/guardian’s written consent. Another disclosure would be required if we should need to provide requested information to insurance companies for billing or continuation of services. Our therapists may also consult with other professionals regarding your case as well as with their supervisors for continuation of care, however identifying information will be kept confidential unless legally or professionally mandated. Information can also be provided to seek legal means to collect for unpaid services, however it would only include information that is necessary.

Information may be released without authorization if a request is made by an agent representing the Federal Bureau of Investigation under the Patriot Act (Section 215). Our therapists may also consult with other professionals regarding your case, however identifying information will be kept confidential unless legally or professional mandated. If you are a minor, your parents may have rights to access your records and therapists would only disclose information that is discussed between us or in cases of high-risk situations, such as self harm or harm to others.

 Also minors 12 years old and over have a right to consent to their own services if they are mature and intelligent enough to participate in services in the opinion of the treating professional. Health & Safety Code § 124260.

**Disclaimer of Warranty:**

To the maximum extent permitted by applicable law, Center For Integrated Care is provided “AS IS” without warranties, conditions, representations or guaranties of any kind, either expressed, implied, statutory or otherwise, including but not limited to, any implied warranties or conditions of merchantability, satisfactory quality, title, noninfringement or fitness for a particular purpose. Center For Integrated Care does not warrant the operation of its offerings will be uninterrupted or error free. You bear the entire risk as to the results, quality and performance of the service should the service prove defective. No oral or written information or advice given by Center For Integrated Care authorized representative shall create a warranty. This disclaimer of warranty constitutes an essential part of the Service Agreement.

RIGHT TO ARBITRATE: In order to preserve the integrity and effectiveness of the therapeutic setting, the provider and patient agree that any controversy or claim arising out of, relating to, or resulting in any manner from interpretation of performance of the terms of this therapeutic relationship, will be settled by arbitration in accordance with the prevailing commercial arbitration rules of the American Arbitration Association or its successor, and that the judgment or any award rendered in arbitration will be ﬁnal and binding upon the parties and may be entered in any court having jurisdiction. Arbitration under this provision shall be the sole and exclusive remedy of these parties. Patient will submit a written request to arbitrate any such controversy or claim in accordance with the rules within six months of the event giving rise to the controversy, or the right to arbitrate any claim in connection with such controversy is waived.

**Appeals and Grievances:**

Patient understands that you have the right to request reconsideration or transfer of provider that can be made through your insurance or directly to the Center and that you risk nothing in exercising that right. Grievance forms/contact information can also be provided for your respective insurance carrier. You can submit your complaint/grievance to Center For Integrated Care at any time by contacting our center at 323-879-9176.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, clinical social workers, associate mental health counselors, professional clinical counselors, or psychologists. You may contact the Board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

**Receipt of Privacy Practices**

I acknowledge receipt of the HIPPA Notice of Privacy Practices by initializing here \_\_\_\_\_\_\_\_\_\_.

I consent to email/text communication that is limited to scheduling, inquiry of services, billing, administrative items, and coordination of care and I understand the risks that not all electronic communication is secure, private, confidential, and safety cannot be guaranteed. Initials\_\_\_\_\_\_\_.

**I have read the above Agreement and Informed Consent for Services and I fully understand the terms and conditions and agree to comply with them as signed below.**

**This form was translated into \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and accepted/declined a copy.**

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**Client name**

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**Client signature/Date**

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**Parent/Guardian Signature/Date**

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**Therapist provider Signature/Date**