LOS ANGELES FAMILY THERAPY

INFORMED CONSENT CONTRACT

CONFIDENTIALITY

All sessions, including telephone or email contacts are confidential to persons outside of the therapy with some exceptions:

I am required by law to disclose confidential information if any of the following conditions exist:
*You are a danger to yourself or others.
* You seek treatment to avoid detection or apprehension, or enable anyone to commit a crime.
*I was appointed by the court to treat you. (This is not the same as being court-referred.)
*I receive a court order. (This is not the same as a subpoena.)
*Your contract with me is for the purpose of determining sanity in a criminal preceding.
*Your contract with me is for the purpose of establishing your competence.
*You are under the age of 16 and a victim of a crime.
*You are a minor and I reasonably suspect you are the victim of a crime.
*You are a person over the age of 65, or a dependent adult, and I believe you are the victim of physical, financial abuse, neglect, isolation or abduction. I may also report emotional abuse.
*You file suit against me for breach of duty, or I file a suit against you.
* You have filed a suit against someone and have claimed mental/emotional damages as part of the suit.
*You waive your rights to privilege (as in the case of a subpoena) or give consent.
*Your insurance company paying for services has the right to review all records.
* If you are being seen by an intern, the supervisor will be allowed to discuss the case with the intern therapist.

All records, written information, or any electronic data are marked CONFIDENTIAL and are kept under lock and key. No one inside or outside the office will have access to your case except me/my supervisor. Computer files are also confidential and kept on our individual computers; that, includes insurance records, all password protected.

WHAT TO EXPECT FROM TREATMENT

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. In the beginning, we will discuss your concerns and goals for therapy. If possible, I will give you an approximate time for length of therapy. Because

feelings will be explored, you may feel a range of emotions that can be intense at times. This is part of a normal process and does not mean there is something bad or wrong with you. The hope is that the experience and expression of feelings will bring to the surface "what is right" with you. While therapy should end through mutual agreement once desired goals have been reached, you have the right to end therapy at any time. Please feel you always have the right to ask questions of me. Therapy only works if you have trust and confidence in me and feel my respect and concern for you.

LEGNTH OF SESSION

In accordance with accepted professional behavior. I will discuss a fee with you before the first session. The therapy session/hour is normally 50 minutes, but occasionally a longer session may be recommended. (In counseling children or adolescents, confidentiality is a necessity; as much as possible, in order for the therapeutic process to work. While you as parent or guardian have a legal right to information, I will speak with you in a general way unless there is a danger to the child's life. This is conveyed to the child as well. Usually I ask the child and parent to meet with me together so that the parent can voice concerns or ask questions. Sessions with minors may only last 30-45 minutes, depending upon age.)

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone, and I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by my voice mail that I monitor frequently. I will make every effort to return your call within 24 hours of the day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. [In emergencies, call 911 immediately.] If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. *Please note that on phone calls that go beyond 15 minutes you will be charged based on my hourly rate. You may also contact me by email. If you choose to do so, please be aware of confidentiality issues. As mentioned I will keep emails, and electronic documents, under password protection, but you are responsible for the confidentiality of incoming emails and electronic information on your end.

PROFESSIONAL FEES/ BILLING AND PAYMENTS

My hourly fee will be negotiated in the first session. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. [In circumstance of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situation, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

CLIENT AGREEMENT AND POLICIES

Payment policy: I agree to make payment at the time of service. Because some insurance companies pay many months in arrears or not at all, I understand that I am responsible for the total fee. There will be a $25.00 service charge on all returned checks. In the event that my account goes to collections, there will be a 20% collection fee added to my balance. If you wish to pay with credit card, you may also do so, and it may be charged to avoid collection fees

Cancellation policy: I agree to cancel appointments only in the event of extreme necessity. There is a 24-hour cancellation policy. I must cancel within the hours of 9AM - 5PM Monday through Friday to avoid being charged. I understand I will be charged full fee unless I provide 24 hours advance notice.
In the case of insurance, last minute cancellations will need to be paid in full by me since insurance is not responsible for a late cancel or "no show." If I am a credit card customer, my credit card will be charged.

Participation in treatment: I acknowledge that it is my choice to participate in psychotherapy (or to have my child participate), and agree to participate fully and voluntarily. Also, the therapist and I have discussed my case (or my child's case) and I was informed of the risks, approximate length of treatment, alternative methods to treatment, and the possible consequences of the chosen treatment.

Attendance: I understand that regular attendance will produce the maximum possible benefits, and realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate treatment, which I am free to do at any time, I will discuss termination before ending treatment.

Treatment Outcomes: While I expect benefits from this treatment I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

Confidentiality: I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. The *Notice of Privacy Practices* provides information about how I may use and disclose you protected health information. I encourage you to read it in full.

The Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (818) 660-5583 7120.

I acknowledge receipt of the Notice of Privacy Practices of

Los Angeles Family Therapy/ Zainy Pirbhai, MFT

Signature:_____ Date:_____

(client/parent/conservator/guardian)

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. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice,

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (www.soultenders.com). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (www.soultenders.com).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can 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 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. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I 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.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need 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 such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Copy of Your PHI. In most cases, you have the right to inspect and copy the PHI that I that I have on you, but you must make the request to inspect and copy such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.