Sunny M. Mueller, LPCC

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CALIFORNIA LPCC#610

Informed Consent - MINOR

This information is part of the Informed Consent procedure that allows you, the client or client's authorizing party, to be fully informed about the process of therapy with Sunny M. Mueller, LPCC. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents. Although these documents are long and sometimes complex, it is very important that you read them and ask about anything you need clarified.

The terms "you," and/or "your" indicate the adult client or in the case of a minor client, the client's authorizing party, whichever is applicable. The terms "I," "me," and/or "myself" refer to Sunny M. Mueller, LPCC.

By initialing each section, you are agreeing that you have read and understand the content contained therein.

Your Mental Health Provider: Sunny M. Mueller, LPCC

I am a Licensed Professional Clinical Counselor (LPCC #610) licensed in the State of California to provide professional clinical counseling services to adult and minor individuals pursuant to California Business and Professions Code section 4999.20 and Title 16, California Code of Regulations, Section 1820.5.

In addition to state licensure, I have earned the following designations:

- Certified Clinical Mental Health Counselor (CCMHC)
- National Certified Counselor (NCC)
- National Certified School Counselor (NCSC)
- American Association of Suicidology Certified Individual Crisis Worker
- Applied Suicide Intervention Skills Training (ASIST) Master Trainer
- Critical Incident Stress Management (CISM) Facilitator

Along with depression, anxiety, self-harming behaviours, and behaviour disorders, I specialize in the following mental health areas and populations:

- Crisis and Suicide
- Grief and Loss
- Trauma, Assault, and Violence
- Post-Traumatic Stress Disorder
- Adults
- Adolescents
- First Responders
- Veterans

I am a proud member in good standing in the following professional organizations and strictly follow the Code of Ethics of each designated with an "*":

- California Association of Licensed Professional Clinical Counselors (CALPCC)
- American Counseling Association (ACA)*
- American Psychological Association (APA)*
- California Psychological Association (CPA)*
- Los Angeles County Psychological Association (LACPA)*
- American Mental Health Counselors Association (AMHCA)*

- American Association of Suicidology (AAS)*
- California Peer Support Association (CPSA)
- Kern County Law Enforcement Foundation (KCLEF)

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I am likely to draw on various therapeutic approaches according, in part, to the concern that is being treated and my assessment of what will best benefit you. These therapies include, but are not limited to: solution-focused, trauma-informed care, behavioral, cognitive-behavioral, psychodynamic, existential, systems/family, mindfulness-based, developmental (adult, child, family), and/or psycho-educational.

I am a privately practicing professional, am completely independent in providing you with clinical services, and I alone am fully responsible for those services. My professional records are separately maintained, and no one may access the contents of said records without your explicit written permission.

INITIAL: _____

Professional Fees

The fee for an initial intake appointment is $135.00 (Current Procedural Terminology [CPT] 90791) payable by cash, check, credit/debit card, and/or some insurances, due at the time of services rendered.

The fee for regular therapeutic services is $115.00 per each 45-minute clinical session (CPT 90834), payable by cash, check, credit/debit card, and/or some insurances, due at the time of services rendered.

The fee for regular therapeutic services is $95.00 per each 45-minute clinical session (CPT 90834), if you are uninsured, not utilizing insurance/EAP, self-pay, and/or your insurance denies all coverage of fees for regular therapeutic services, due at the time of services rendered.

The fee for emergency therapeutic services (services without an appointment, after normal working hours, and/or on the weekend) is $150.00 per hour (CPT 90839) payable by cash, check, and/or credit/debit card due at the time of services rendered. Crisis mental health services *may* be covered by your insurance. If you wish to submit your claim directly to your insurance company for reimbursement, I will be happy to provide you with a receipt that contains all of the necessary information.

The fee for a subpoenaed witness appearance is $300.00 per hour for the time spent preparing for court, the time spent for transportation to/from court, and the time spent appearing in court. This fee is *not* reimbursable by insurance and is therefore your full legal responsibility. This fee must be paid by cash, check, and/or credit/debit card due at the time of services rendered.

Fees are due at the time of services rendered, including insurance co-pays and/or deductibles. All services are provided to you and not to any other entity. Therefore, you alone are liable for all applicable charges at the time of service. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure.

If for some reason you find that you are unable to continue paying for your therapy, please inform me as soon as possible. I will gladly help you to consider options that may be available to you.

A fee of $50.00 will be added to your account in the event a check is returned.

INITIAL: _____

No Surprises Act

Beginning January of 2022, health care providers are required by law to give clients who

- are uninsured
- are self-pay
- receive services from an out-of-network provider

a "Good Faith Estimate" of expected costs of services, before the service is provided, to reduce the likelihood that patients may receive a "surprise" medical bill.

Below you will find a Good Faith Estimate for the expected costs of three (3), six (6), nine (9), and twelve (12) months of once-per-week professional clinical counseling services for clients who are uninsured, are not utilizing insurance/EAP, are choosing to self-pay, insurance/EAP has denied all coverage of billed amounts, and/or are choosing a provider that is out-of-network. Please note that some insurances may cover, in full or partially, out-of-network providers. You will also be provided an individualized Good Faith Estimate.

- 3 months (13 weeks)
  - One (1) session per week for 13 weeks = 13 Sessions
  - 13 Sessions (CPT 90834) @ $95.00 each
  - *TOTAL EXPECTED COST: $1235.00*
- 6 months (26 weeks)
  - One (1) session per week for 26 weeks = 26 Sessions
  - 26 Sessions (CPT 90834) @ $95.00 each
  - *TOTAL EXPECTED COST: $2470.00*
- 9 months (39 weeks)
  - One (1) session per week for 39 weeks = 39 Sessions
  - 39 Sessions (CPT 90834) @ $95.00 each
  - *TOTAL EXPECTED COST: $3705.00*
- 12 months (52 weeks)
  - One (1) session per week for 52 weeks = 52 Sessions
  - 52 Sessions (CPT 90834) @ $95.00 each
  - *TOTAL EXPECTED COST: $4940.00*

INITIAL: _____

Billing Practices

Please inform me if you wish to utilize your health insurance or employee assistance program (EAP) to pay for services. The amount of reimbursement and the amount of any co-payments or deductible depends on your specific insurance plan and my out- or in-network status with said insurance, plan, and/or EAP. Insurance plans generally limit coverage to certain

diagnosable mental health conditions. You are responsible for verifying and understanding the limits of your insurance coverage. Whether your insurance will provide payment for the services provided to you is not guaranteed and you are fully responsible for any costs not covered or denied by your insurance.

I am happy to provide you with a "superbill" or receipt that contains all of the necessary information for you to submit your claim directly to your insurance company if you choose. Any insurance claims and reimbursements are your responsibility. Please discuss any questions or concerns that you may have about this with me.

I submit claims and send invoices at the beginning of each month for services rendered in the previous month. For example, claims and invoices dated in February are for services rendered in January.

If there are no payments to your account either through insurance or you personally, for 60 days or two billing cycles, and arrangements for alternate payments have *not* been agreed upon, I have the option to refuse further services and/or use 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 situations, 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, related costs will be included in the claim and/or your balance due.

INITIAL: _____

Sessions and Appointment Scheduling

Sessions are 45 minutes long and scheduled to occur as needed. I may suggest a different frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome and achievement of therapeutic goals.

INITIAL: _____

Rescheduling, Missed, or Cancelled Appointments

I know that situations may arise that will prevent you from keeping your scheduled appointment. Rescheduling, missing, or cancelling a scheduled appointment must be done by notifying me at least 24 hours in advance of the original appointment. If you do not provide me with at least 24 hours' notice in advance of your intent to reschedule, miss, or cancel a scheduled appointment, that time cannot be utilized to provide services to someone else. Since that time has been reserved for you, you are fully responsible for a $50.00 fee if 24-hour notice is not given.

I will wait 15 minutes for you to arrive for your appointment. If you do not contact me, your appointment is considered a missed or cancelled appointment and you are fully responsible for the $50.00 non-24-hour notice fee.

Insurance companies do *not* pay for missed or cancelled sessions.

INITIAL: _____

Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability Act, or HIPAA, was passed by Congress in 1996. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs
- Reduces health care fraud and abuse
- Mandates industry-wide standards for health care information on electronic billing and other processes
- Requires the protection and confidential handling of Protected Health Information (PHI)

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives clients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for client care and other important purposes.

INITIAL: _____

Protected Health Information (PHI)

Protected Health Information, or PHI, generally refers to demographic information, medical history, test and laboratory results, insurance information, and other data that a healthcare professional collects to identify an individual and determine appropriate care. It includes any information in a medical record that can be used to identify an individual, and that was created, used, or disclosed in the course of providing a health care service, such as a diagnosis or treatment. Identifying information includes, but is not limited to: names, geographic locators, dates, phone numbers, fax numbers, email addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, certificate numbers, vehicle identifiers/numbers, device identifiers/numbers, web universal resource locators (URLs), Internet protocol (IP) addresses, biometric identifiers, photographic images, and social media identifiers.

INITIAL: _____

Clinical Records

Pursuant to HIPAA, I keep Protected Health Information about you in a set of professional records. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in circumstances in that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider), you may examine and/or receive a copy of your clinical record, if you request it in writing.

Because these are professional mental health records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss

the contents. I am sometimes willing to conduct this review meeting without charge. There will be a copying fee of $0.25 per page. The exceptions to this policy are contained in the supplied *Notice of Privacy Practices* document. If I refuse your request for access to your clinical records, you have a right of review (except for information supplied to me confidentially by others) which I will discuss with you upon request.

Clinical records are stored securely in a locked file cabinet. For adults, records are kept for seven years after the termination of therapy. For minors, records are kept for ten years after the client's 18th birthday. Destruction of the clinical records is done so in a manner that preserves confidentiality.

Provisions have been made with a licensed clinician to access my records and psychotherapy notes (see below) and act as caretaker in the event I become incapacitated or die unexpectedly. The appointed clinician will take physical custody of your clinical records and psychotherapy notes and maintain confidentiality, storage, and destruction as outlined in this document.

INITIAL: _____

Psychotherapy Notes

Psychotherapy notes are personal notes that I may take during therapeutic sessions with you. They are kept separate from your clinical and billing records. HIPAA does not allow me to disclose most information contained in psychotherapy notes without your explicit written request and authorization. Psychotherapy notes are given a greater degree of protection due to the sensitivity information and because they are rarely useful to anyone other than the creator.

INITIAL: _____

Limits of Confidentiality

What we discuss during your therapy sessions is confidential. No contents of the therapy sessions, whether verbal or written, may be shared with another party without your explicit written consent. However, there are important limitations to confidentiality. If any of the following exceptions apply to you at any time, I will make every effort to fully discuss it with you before taking any action and I will only release the minimum information necessary to accomplish the intent.

The following is a list of exceptions/limitations to confidentiality:

- *Serious Threat to Health and/or Safety – Self*
  If you communicate to me a serious threat against your own health and/or safety and/or I have a reasonable suspicion to believe that you are in such a condition as to be a danger to your own personal health and/or safety, I may release information as necessary to family members, law enforcement, and/or others who may help provide protection and prevent the threatened danger and/or seek hospitalization for you. Once such a report is filed, I may be required to provide additional information.
- *Serious Threat to Health and/or Safety – Others (Duty to Warn and Protect)*
  If you communicate to me a serious threat of physical violence against an identifiable victim and/or I have a reasonable suspicion to believe that you are in such a condition as to be a danger to an identifiable victim's health and/or safety, I must and will make all

reasonable efforts to communicate that information to the potential victim, family members, law enforcement, and/or others who may help provide protection and prevent the threatened danger and/or seek hospitalization for you. Once such a report is filed, I may be required to provide additional information.

- *Abuse of Children*
  If I, in my professional capacity, have knowledge of or observe a child under the age of 18 I know or reasonably suspect has been the victim of child abuse, maltreatment, and/or neglect, I must and will immediately report such information to the appropriate local authorities which may include law enforcement, probation, child welfare, and/or others who may help provide assistance. Once such a report is filed, I may be required to provide additional information. If in my professional capacity, have knowledge of or observe a child I know or reasonably suspect has been the victim of emotional suffering or that emotional or psychological well-being is endangered in any other way (other than physical abuse, sexual abuse, or neglect), I may report such information to the appropriate local authorities which may include law enforcement, probation, child welfare, and/or others who may help provide assistance. Once such a report is filed, I may be required to provide additional information.
- *Abuse of the Elderly and/or Vulnerable Adults*
  If I, in my professional capacity, have knowledge of or observe an incident I know or reasonably suspect includes physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of and elderly person or dependent adult, I must and will immediately report such information to the appropriate local authorities which may include law enforcement, probation, adult/aging services, ombudsman, and/or others who may help provide assistance. Once such a report is filed, I may be required to provide additional information. If an elder or dependent adult credibly reports to me, in my professional capacity, that s/he has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, I must and will immediately report such information to the appropriate local authorities which may include law enforcement, probation, adult services, ombudsman, and/or others who may help provide assistance. Once such a report is filed, I may be required to provide additional information.
- *Minors*
  Communications between myself and clients who are minors (under the age of 18) are confidential. However, legal representatives of non-emancipated minor clients have the right to access the clients' records. Consequently, I, exercising personal judgment, may discuss the treatment progress of a minor client with the legal representative. Minor clients and their legal representatives are encouraged to ask any questions or address concerns about this with me.
- *Professional Consultations*
  I may occasionally find it helpful to consult other health and mental health professionals about you. During a consultation, I do not reveal the identity of my clients. The other professionals I consult with are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record which is Protected Health Information (PHI).
- *Insurance Providers*
  Insurance companies and other third-party payers are given information that they request regarding services to clients. The type of information that may be requested includes:

types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

- *Worker's Compensation*
  If you file a worker's compensation claim, I must and will, upon appropriate request, disclose information relevant to your condition to the worker's compensation insurer.
- *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 and will not release your information without one of the following:
    - Your written authorization or the authorization of your attorney or personal representative
    - A court order
    - 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.
    - A discovery request from another party to the court proceeding where that party has given you proper notice (when required) and has stated valid legal grounds for obtaining the PHI

  The fee for a subpoenaed witness appearance is $300.00 an hour for the time spent preparing for court, the time spent for transportation to/from court, and the time spent appearing in court. This fee is not reimbursable by insurance and is therefore your full legal responsibility. This fee must be paid by cash or check by you at the time of services rendered.
- *The Patriot Act of 2001*
  This federal law requires mental health providers (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents, and other items and prohibits the mental health provider from disclosing to the client that the FBI sought or obtained the items under the Act.
- *Health Oversight*
  If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.
- *Personal Defense*
  If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

INITIAL: _____

Minors

Clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parent/s or authorizing party unless I determine that their involvement would be inappropriate. In California, a client aged 12 or above may consent to mental health services if s/he is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to him/herself or others, or is the alleged victim of incest or child abuse. In addition, California clients aged 12

and above may consent to alcohol and drug treatment in some circumstances. Non-emancipated clients under 18 years of age and their parent/s or authorizing party should be aware that the law may allow parent/s or the authorizing party to examine the client's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the client, or to the client's physical safety or psychological well-being.

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors aged 12 and above and their parent/s or authorizing party about access to information. This agreement provides that during treatment, I will provide parent/s or the authorizing party with only general information about the progress of the treatment and the client's attendance at scheduled sessions. I will also provide parent/s or the authorizing party with a summary of the client's treatment after the termination of services. Any other communication will require the minor client's authorization and/or cooperation, unless I feel that the client is in danger or is a danger to someone else, in which case, I will notify the parent/s or the authorizing party of my concern. Before giving parent/s or the authorizing party any information, I will discuss the matter with the client, if possible, and do my best to handle any objections s/he may have.

INITIAL: _____

The Therapeutic Process

It is my intention to provide services that will assist you in your commitment to achieving improved personal functioning, relationships, self-image, mood, and/or the attainment of personal goals so you may experience your life more positively and fully. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Change will sometimes be easy and swift, but more often it will be slow and even frustrating at times. You may feel worse after counseling. You should understand that healing and growth is difficult, and some discomfort will likely be a part of the counseling process.

Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. We are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict or guarantee a specific outcome or result.

INITIAL: _____

Treatment Plan

Within about three sessions after the initiation of treatment, I will discuss with you my working understanding of the concern, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large

commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my techniques or procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan itself procedures, we should discuss them whenever they arise. You have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments by providing professional referrals.

INITIAL: _____

The Risks of Therapy

During therapy, remembering or talking about unpleasant events, feelings, or thoughts may result in your experiencing considerable discomfort or strong feelings. These may include feelings of anger, sadness, worry, fear, or experiencing anxiety, depression, and/or insomnia. I may challenge some of your worldviews, assumptions, and current perceptions. I may propose different ways of looking at, thinking about, or handling situations that may result in you feeling upset, angry, depressed, challenged, or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for you is viewed negatively by family and/or friends.

Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

INITIAL: _____

The Limitations of Therapy

Therapy carries both benefits and risks. Therapy sessions can significantly reduce the amount of distress you are feeling, improve your relationships, and/or resolve other specific issues. There is no guarantee that psychotherapy will yield positive or intended results for you.

INITIAL: _____

Length of Treatment

Generally, I recommend at least six months of treatment. However, the length of treatment depends on the specifics of your presenting concerns and the progress you achieve toward your therapeutic goals. The length of mental health treatment is always up to you and services can be stopped at any point you wish.

INITIAL: _____

Dual Relationships

A dual relationship is a relationship between therapist and client in addition to (or outside of) the therapeutic relationship. Not all dual relationships are unethical or avoidable. Bakersfield is a relatively small city and you may meet others who are receiving or have received my services. We may bump into each other out in the community. You should know that I will only respond to you if you greet me first and even then, I will not acknowledge working therapeutically with you without your written permission.

Therapy never involves sexual or any other contact that would impair my objectivity, clinical judgment, therapeutic effectiveness, and/or may be exploitative in nature. You have the right to expect that I will maintain professional and ethical boundaries by not entering into dual personal, financial, or professional relationships with you.

INITIAL: _____

Mental Health Provider Availability

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief (5-10 minutes) due to the belief that important issues are better addressed within regularly scheduled sessions. If phone calls become excessively frequent and/or long, however, charges may be incurred at 15-minute intervals at my hourly rate of $3.00 per minute. You may leave a voice mail for me at any time on my confidential voicemail or confidential email. If you wish for me to return your call, please be sure to leave your name and phone number(s), speaking slowly and clearly, along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal working days (Monday through Friday) within 24 hours. If you have an urgent, but non-life threatening, need to speak with me, please indicate that fact in your message and follow any instructions that are provided on my confidential voicemail and/or email.

Voicemail: 1.661.563.0638
Email: sunnymmueller.lpcc@outlook.com

I am generally available to return phone calls within approximately three (3) hours after receipt. I am unable to return phone calls after 8:00pm (20:00).

INITIAL: _____

Telehealth Benefits and Limitations

There are potential benefits and risks of telehealth treatment that differ from in-person sessions. Confidentiality still applies for telehealth services and nobody will record the session in any way. If screen-to-screen contact is chosen, we agree to use a videoconferencing that is HIPAA-compliant for our virtual sessions and I will explain how to use it. You will need a secure Internet connection and a webcam or smartphone during the screen-to-screen session. Using public or free Wi-Fi for screen-to-screen sessions increases the risk of losing confidentiality. It is important to be in a quiet, private space that is free of distractions for any telehealth communication. In the event of technical problems, I will contact you by other means to continue or reschedule the session. There is a possibility that your insurance carrier will not cover telehealth benefits.

INITIAL: _____

Electronic Communication

Although I have initiated precautions and encryption methods where applicable, electronic communications utilizing cel phones, email, faxing, and the Internet are not completely secure methods of communication and there is some risk that one's confidentiality could be compromised with their use. Text and Email use will be limited to administrative purposes (i.e.: appointment information, general information about services, etc.). I will not participate in counseling, personal conversations, or disclosure of confidential and/or private information in texts or emails.

INITIAL: _____

Social Media

I will not communicate with you or any clients through social media platforms such as, but not limited to, Facebook, Twitter, SnapChat, and/or LinkedIn.

INITIAL: _____

Emergency Situations

In the event of a medical/mental health emergency or an emergency involving an immediate threat to your safety or the safety of others, please call **911** to request emergency assistance.

The following resources are available to assist you in emergency situations:

- 911
- Bakersfield Police Department (Dispatch) 1.661.327.7111
- Kern County Sheriff's Department (Dispatch) 1.661.861.3110 (option #5)
- Any emergency room

The following resources are available to assist you in a crisis:

- Kern Behavioural Health and Recovery Services Crisis Hotline 1.800.991.5272
- National Domestic Violence Hotline 1.800.799.7233
- National Drug and Alcohol Hotline 1.800.662.4257
- National Suicide Prevention Hotline 1.800.273.TALK (8255)
- Rape, Abuse, Incest National Network 1.800.656.4673
- California Youth Crisis Line 1.800.843.5200

At my own discretion, I may be available for emergencies services. The fee for emergency therapeutic services (services without an appointment, after normal working hours, and/or on the weekend) is $150.00 an hour payable by cash, check, or credit/debit card by you due at the time of services rendered. Crisis mental health services may be covered by your insurance. If you wish to submit your claim directly to your insurance company for reimbursement, I will be happy to provide you with a receipt that contains all of the necessary information.

INITIAL: _____

Continuity of Care

In the event that I become unable to provide established counseling services to you due to incapacitation or death, provisions have been made with a licensed clinician to access my records as caretaker. The appointed clinician will contact you and provide resources to you to continue your mental health wellness journey.

INITIAL: _____

Termination of Therapy

If I do not believe I may be able to help you or your mental health challenges are outside my professional scope of practice, I will not accept you as a client. If I determine this is the case for you, I will inform you immediately and assist you in finding appropriate alternative services by providing you with referrals. If at any point during psychotherapy, I determine that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and, if I have your written consent, I will provide s/he with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, and we will do this together. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

INITIAL: _____

Alternatives to Therapy

If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral(s), changing your treatment plan, or terminating your therapy.

INITIAL: _____

Conflict Resolution and Mediation

I will work diligently to make sure that you have a positive counseling experience. However, if a conflict occurs, it is agreed that any disputes shall be negotiated directly between you and I. If these negotiations are not satisfactory to either of us, then we agree to mediate any differences with a mutually acceptable third-party mediator. If these results are unsatisfactory to either of us, then we shall move to arbitration, and then binding arbitration, with an arbitrator mutually agreeable to both of us. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory in result to either of us.

INITIAL: _____

Complaints

You may complain if you feel I have violated your rights or have other concerns by contacting me at:

Sunny M. Mueller, LPCC
9530 Hageman Road, Suite B, #174
Bakersfield, CA 93312
661.563.0638
sunnymmueller.lpcc@outlook.com

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board at:

Board of Behavioural Sciences
1625 North Market Blvd., Suite S200
Sacramento, CA 95834
916.574.7830
www.bbs.ca.gov

You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by contacting them at:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775
www.hhs.gov

INITIAL: _____

Consent for Treatment Agreement

I am an adult and I agree to be treated by SUNNY M. MUELLER, LPCC and grant authority to SUNNY M. MUELLER, LPCC to perform any examinations, diagnostic procedures, treatment, or other services which may, during the course of care, be deemed helpful to my welfare. I understand that I may refuse any or all services if I so choose. I also understand that active involvement is essential to the success of treatment and that SUNNY M. MUELLER, LPCC may make changes in treatment including, upon proper notification, termination of treatment.

I understand that participation in treatment can result in a number of benefits including improving interpersonal relationships and resolution of the specific concerns that prompted treatment. I understand that treatment may involve remembering or talking about unpleasant events, feelings, or thoughts that may result in experiencing considerable discomfort or strong negative feelings. I understand that SUNNY M. MUELLER, LPCC may challenge some of my personal assumptions and current perceptions and by doing so may cause me to feel discouraged.

I understand that attempting to resolve issues that prompted treatment in the first place may result in changes that were not originally intended. I understand treatment may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. I understand that there is no guarantee that treatment will yield positive or intended results.

I understand I have the right to ask about any of the methods or activities used by SUNNY M. MUELLER, LPCC in the course of my treatment, their possible risks, and/or the expertise in employing them.

I understand that the records regarding treatment are the property of SUNNY M. MUELLER, LPCC and that such records or other information about treatment may be released only upon my explicit written authorization. I understand that there are important exceptions to the confidentiality of my protected health information.

I understand that SUNNY M. MUELLER, LPCC may consult with other mental health professionals to assure proper treatment and the most appropriate services.

I understand that if I am involved in legal proceedings, SUNNY M. MUELLER, LPCC will not be called on to testify in court by myself, my attorney, or anyone acting on my behalf, nor at any other legal proceeding, nor will a disclosure of the medical and/or psychotherapy records be requested.

I understand I am financially responsible for all services rendered to/for me by SUNNY M. MUELLER, LPCC including, but not limited to: therapeutic services, co-pays, deductibles, and/or any other fees not covered/denied by my insurance.

I acknowledge that I have read this document carefully, understand, and agree to the provisions therein. I have been given the opportunity to ask any questions about this form and its contents and have received satisfactory answers. I am consenting to treatment voluntarily and I understand I can revoke this consent in writing at any time. If I revoke this agreement, SUNNY M. MUELLER, LPCC is still bound by the terms therein unless an action in reliance has been taken; there are obligations imposed by my health insurer to process claims; or I have not satisfied any financial obligation I have incurred. This consent was updated February 01, 2022.

Client Name (PRINT)

Authorizing Party (PRINT)

Authorizing Party (SIGNATURE) DATE

Reason for Authorizing Representation:
☐ Client is a minor
☐ Client is deceased
☐ Other: _____

Type of Authorizing Representation:
☐ Parent
☐ Legal Guardian
☐ Estate Representative
☐ Other: _____