4944 Sunrise Blvd., Suite J-5 • Fair Oaks, CA 95628 • (916) 827-0071 • www.duffytherapy.com

INFORMED CONSENT

About Me: I, Christina Duffy, am a licensed Marriage and Family Therapist (No. 86699, CA). Since 2008, I have been committed to providing innovative, culturally competent, strength-based, heart-centered counseling services. I am also the founder of a non-profit counseling agency called River Rock Counseling.

Fees: Fees are to be paid before each session. If for some reason you find that you are unable to continue paying for your therapy, please inform me and I will help you consider any options available.

Payments: Pay by credit card, Venmo, PayPal, Square, Cash App, or Health Savings Account.

Insurance: If you have insurance and you choose me as an "out of network provider," I will email you a bill that has all the necessary information for your insurance company for your reimbursement. You will be responsible for paying the fee per session. Information likely disclosed to insurance companies include: Dates of treatment, diagnosis, and progress.

Cancellation Policy: You are responsible for payment of the agreed upon session fee for any missed session(s). You are also responsible for payment of the agreed upon session fee for any session(s) for which you failed to give me at least 24 hour's notice of cancellation, but exceptions apply. Such notices should be left on my voice mail (916-827-0071) or emailed to christina@duffytherapy.com.

Phone Contacts: Telephone or email communications between sessions are welcome when they are urgent or in regards to scheduling. If events arise in between your therapy appointments that are especially upsetting to you and you wish to speak with me, please call my confidential voicemail (916-827-0071) or email me (christina@duffytherapy.com). I may discuss the situation briefly by phone or set up a special appointment to discuss it more in depth.

Emergency Contact: I have a confidential voicemail system (916-827-0071) that allows my clients to leave a message at any time. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. If I am unable to respond quickly enough, please call the Crisis Support Services 24-HR Crises Hotline at 1-800-273-TALK (8255) or, in the event that you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911, or go to the nearest ER.

Limits to Confidentiality: All information shared during therapy sessions remains strictly confidential, with the following exceptions: (1) I am required to report instances of actual or suspected child, elder, or dependent abuse; (2) when I have determined that a client presents a serious danger of physical violence to another person or (3) when a patient is dangerous to him or herself; (4) if the material is court ordered; (5) if a pregnant woman is using restricted substances; or (6) if my client was neglected or abused by a health care provider. In addition, (7) a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items.

Couples / Family Therapy: Therapists generally have a "no secrets policy" for couples and family therapy, although exceptions apply (e.g., see Minors and Confidentiality below). What that means is I reserve the right, *only* if I feel it is in the best interest of the relationship or family, to disclose confidential information given to me, by a client *individually,* in the couple/family therapy session.

Minors and Confidentiality: Treatment with a minor often progresses best when the child can be assured of confidentiality. I may discuss the treatment progress of a minor client with the parent or guardians, but preferably not details that would decrease trust between the minor and therapist. By signing this form as a parent or caretaker, you are acknowledging that you consent to a confidential

relationship between your minor child and myself. Therefore you are agreeing not to request access to my records regarding this minor child. If you are a minor and your parents are consenting for your treatment, your parents/guardians legally have access to information about your treatment. You have the right to request that information be kept from them. If you are a minor, 12 years or older, and you are consenting for your own treatment, your parents/guardians legally *do not* have access to information about your treatment. “Limits to Confidentiality” apply to you as well as the other terms and conditions in this agreement.

About the Therapy Process: It is my intention to provide professional services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result. Please understand that there are potential risks and benefits associated with any form of counseling, and that despite your efforts and my efforts, your condition may not improve or it may become worse.

Litigation and Contact with Third Parties: In the event of any legal proceedings that you are currently involved in, or know you will be involved in, prior to your therapy with me, you agree that you will disclose that to me. I prefer not to get involved with client’s litigation or other dealings with third parties and I do not interact with my client’s attorneys. If you, your attorney, or anyone else acting on your behalf wants you to participate in therapy with me for the purpose of testifying in court or any other proceedings, you agree to disclose that information to me prior to the onset of therapy.

Telehealth / Telemedicine: You consent to engaging in telemedicine (e.g., phone, email, text, and video) with me as part of your therapy or counseling. You understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. You understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

You understand that you have the following rights with respect to telemedicine:

(1) You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment nor risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) The laws that protect the confidentiality of your medical information also apply to telemedicine. As such, you understand that the information disclosed by you during the course of your therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where you make your mental or emotional state an issue in a legal proceeding.

You also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your written consent.

(3) You understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of your therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, you understand that telemedicine based services and care may not be as complete as face-to-face services. You also understand that if your therapist believes you would be better served

by another form of psychotherapeutic services (e.g. face-to-face services) you will be referred to a therapist who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of therapy, and that despite your efforts and the efforts of your therapist, your condition may not be improve, and in some cases may even get worse.

(4) You understand that you may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) You understand that you have a right to access your medical information and copies of medical records in accordance with California law.

HIPPA Notice of Privacy Practices: By signing this form, you acknowledge receipt of the HIPPA Notice of Privacy Practices that I have made available on my website for you to read or download.

Agreement: Your e-signature or signature indicates that you have read this Informed Consent agreement for services carefully, had explained to you where necessary, and that you fully understand, agree to abide by the terms and conditions of this agreement, and consent to participate in psychotherapy. Moreover, you agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. This agreement will serve as “Consent to Treat a Minor Child” if need be.

Please email this completed form to christina@duffytherapy.com. Thank you for trusting in my services and taking the time to look over this consent form.

CLIENT #1:

Signature _____ Date _____

Full Name _____

Email _____ Phone _____

Address _____

CLIENT #2:

Signature _____ Date _____

Full Name _____

Email _____ Phone _____

Address _____