Chino Hills Psychological
14712 Pipeline Ave, Ste B
Chino Hills, CA 91709
Fax (909) 606-8855
Voice and Text (909) 730-6400

Consent for Purposes of Treatment, Payment & Healthcare Operations

Confidentiality

My "protected health information" means health information collected from me and created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. Storage of this information may be done in a HIPPA approved manner, either written or in electronic data.

I consent to the use or disclosure of my protected health information by the therapist for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conducting health care operations of the therapist. I understand that analysis, diagnosis, or treatment of me may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The therapist is not required to agree to the restrictions that I may request. However, if the therapist. agrees to a restriction that I request, the restriction is binding on the therapist. I have the right to revoke this consent, in writing, at any time, except to the extent that the therapist has acted in reliance on this Consent. If information collected in the treatment involves Child Abuse, a danger to self or a danger to another person, an appropriate action or report will result.

Psychotherapy Sessions

A session is 45-50 minutes in length. An evaluation can last from 2 to 4 sessions. Appointments will be scheduled at the time we agree on. Once an appointment hour is scheduled, I will be expected to pay for it unless I provide at least 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].

Professional Fees

I understand that the hourly fee is $200.00 per therapy session or the amount agreed to in the Insurance agreement. Payment is accepted for each session at the time it is made, unless we agree otherwise or unless I have insurance coverage which requires another arrangement. All co-payments are due at the end of each session. I hereby authorize billing and payment by my insurance if applicable. Amounts not paid by Insurance are my responsibility and due once the insurance has completed paying their portion.

Legal Proceedings

All conferences with third parties such as attorneys, judges, social workers, or teachers will be charged at the hourly, including document reviews. All written reports for purposes of legal proceedings will be charged at the hourly rate. If I should be required. to serve as a witness in court proceedings, I understand that I will be required to pay a rate of $1200 for half day and $2400 for full day reservation.

I have been provided with a copy of the Notice of Privacy Practices, and I understand that I have a right to review Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the doctor. This Notice of Privacy Practices also describes my rights and duties of the doctor with respect to my protected health information.

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Signature of Patient or Guardian Printed Name of Patient