Rancho
Counseling Center

Informed Consent

As we begin to work together, it is important to clarify the nature of our therapeutic relationship including the extent and limits of confidentiality.

Risks and Benefits of Therapy:

Psychotherapy is a process in which the therapist and client discuss a myriad of issues, events, experiences for the purpose of creating positive change so the patient can experience life more fully. Psychotherapy is a joint effort between client and therapist. Progress and success may vary depending on the particular problems or issues being addressed, as well as other factors.

Participating in therapy may result in a number of benefits, including, but not limited to improvement in mood, a decrease in negative thoughts and behaviors, improved interpersonal relationships, increased self-confidence, and improvement in work, social, and family settings. Such benefits may require substantial effort on the part of the client, including consistent attendance and active participation in the therapeutic process, including honesty, and a willingness to change feelings, thoughts and behaviors. I understand there is no guarantee that therapy will yield any or all of the benefits listed above.(Initial) _____

Therapy may result in changes that were not originally intended. Therapeutic process may also involve discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, fear, anger, etc. There may be times in which the therapist will challenge my perceptions and assumptions, and offer different perspectives. I am aware that any decision on the status of his/ her personal relationships is the responsibility of the client. (Initial) _____

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. I agree to address any concerns I have regarding my progress with my therapist. Brief therapy is goal directed, problem focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made towards accomplishment of that goal(s) in a time efficient manner. You will take an active role in setting and achieving treatment goal(s). Your commitment and consistent attendance is necessary for you to experience a successful outcome. It is possible that during the course of your therapy, other issues may surface, possibly resulting in extended therapy. (Initial) _____

Limits of Confidentiality:

All information between clinician and client is held strictly confidential. However, the following are legal exceptions to confidentiality.

1. The client presents a physical danger to self.
2. The client presents a danger to others.
3. There is suspicion/knowledge of child, elder or dependent adult abuse and/or neglect.
4. The client authorizes a release of information with a signature.
5. A judge orders the release of client's records.

_____
Initial

Mental Health Disclosure

Emergency Situations

We understand that occasionally, emergency situations occur. If you are experiencing an emergency that poses a threat to yourself or someone else, please contact 911 and/or Access & Crisis Line immediately. It is important to note that RCC's therapists are unable to provide phone sessions. If you're experiencing issues that need to be discussed urgently and you would like to see your therapist sooner than your next scheduled appointment, our office staff will do their best to accommodate you if there is an available opening. We maintain an active wait list for each therapist.

_____
Initial

Crisis Number: 951-686-4357

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the client. I legally authorize on the client's behalf, the practitioner/group to deliver mental health care services to the client. I also understand that all policies described apply to the client I represent.

_____ _____
Parent/Guardian Signature Parent/Guardian Signature

_____
Client Signature

Rancho Counseling Center
29645 Rancho California Rd. Suite 133
Temecula, CA 92591
Phone: 951-693-9800 Fax: 951-693-9801

Financial Policy:

Here at Rancho Counseling Center (RCC) we are happy to have you as a client. We will do everything in our professional capacity to provide you with the best possible care. Please understand that payment of your bill is considered part of your treatment. **RCC will verify your insurance; however it is not a guarantee of benefits or payment by your insurance company. If for any reason your insurance denies your claim(s), you are 100% responsible for payment.** RCC will bill your insurance, however you are responsible for co-payment/cost share and deductibles according to your benefit plan. These amounts may vary during the course of your treatment as set by your plan. Co-payments/cost shares are due and payable at each appointment. If at any time during your treatment you become ineligible for coverage by your insurance you will be 100% responsible for your bill.

In an effort to eliminate the need for collection services, and help make the co-payment process easier for you Rancho Counseling Center has a credit card authorization form that is optional. Billing will be automatic for office visits, copays/cost share, deductibles and missed appointment/late cancellation fees, unless a prior arrangement has been made.

Minor Patients:

The parent/guardian accompanying the minor will be responsible for full payment. For minors not accompanied to their follow up sessions, non-emergency treatment will be denied if payment is not received at time of service.

Missed Appointments/Cancellation Policy:

Appointments that have been scheduled must have at least a 24-hour notice of cancellation. Appointments can be cancelled using our 24-hour voicemail system, as listed below, to notify us of the cancellation. For appointments that are missed or cancelled without 24-hour notice you will be charged $50 fee. Please help us serve you better by keeping scheduled appointments.

Additional Fees and Services:

All additional services are at the discretion of your provider and should be discussed in detail with your clinician. For additional services such as letters, forms, reports, completed by your provider and/or request of records there is a set fee. Listed in this packet is the pricing information related to the type of form requested. Please note that payment is to be collected prior to the completion of document(s).

_____ _____

Signature of Client, Legal Guardian/Legal Representative | Client Name (if different from signature)

_____ _____

Name (Printed) | Date

_____

Relationship to Client

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Rancho Counseling Center additional Fees

Copy of Records: $25.00 (allow up to 10 working days for this request)

All other reports/forms are priced based on the complexity of the report and the amount of time it takes. The minimum charge is $50.00 and will go up from there.

Client Litigation:

The goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict. The process of psychotherapy depends on trust and openness during the therapy sessions. Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on any therapist at Rancho Counseling Center to testify in court or at any other proceeding, nor will disclosure of the psychotherapy records be requested unless otherwise agreed upon. You should be aware that you might be waiving the psychotherapist-client privilege if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-client privilege with your attorney.

Records and Record Keeping:

Your therapist may take notes during session, and will also produce other notes and records, regarding your treatment. These notes constitute clinical and business records, which by law, the therapist is required to maintain. Such records are the sole property of Rancho Counseling Center. The therapist will not alter his/her normal record keeping process at the request of any patient. Should you request a copy of the therapist's records, such a request must be made in writing. The therapist reserves the right, under California law, to provide you with a treatment summary in lieu of actual records. The therapist also reserves the right to refuse to produce a copy of the record to another treating health care provider. The therapist will maintain your records for seven years following termination of therapy. However, after seven years, your records will be destroyed in a manner that preserves your confidentiality.

_____

Initial

Termination of Therapy:

Your therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest and failure to participate in therapy. You have the right to terminate therapy at your discretion, as well. Upon either party's decision to terminate therapy, your therapist will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate positive termination experience and give both parties an opportunity to reflect on what has been done. Your therapist will also attempt to ensure a smooth transition to another therapist in offering referrals to you.

Policy Regarding Consent for the Treatment of a Minor:

Therapists generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, the therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Consent for Treatment:

I authorize and request my clinician to provide treatment that may include psychological exams and/or diagnostic procedures now or during the course of my treatment. I understand the purpose of these procedures will be explained to me upon my request. I understand that my continued participation implies voluntary informed consent and I have the right to refuse services at any time.

_____

Initial

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Client Rights and Responsibilities

As a client, you have the right to:

- receive prompt, competent and courteous treatment from provider and staff
- inquire about your provider's credentials and experience, and be provided with documentation
- obtain a clear explanation of your insurance company's criteria for determining medical necessity
- confidentiality of your medical records to the extent protected by state and federal law, unless you sign a release of information and/or your insurance requires information from your records for managed care purposes
- obtain an explanation regarding legally required expectations to confidentiality
- access your own treatment records
- receive a clear explanation from your provider about the recommended treatment plan and the expected length of treatment
- participate in decision-making regarding your treatment
- refuse or terminate treatment at any time
- be treated with respect, dignity and have your need for privacy recognized
- receive an explanation from you provider of any consequences that may result from refusing treatment
- know and understand the medications prescribed for you (e.g. what they are for, how to take them properly and possible side effects)
- obtain a clear explanation from your insurance company to determine the reason that a service is not medically necessary
- appeal any denial of care by your insurance company
- file complaints with your insurance company, the State Department of Insurance, or California Department of Corporations if you experience problems with your insurance company or provider
- suggest ways to improve policies and procedures to your insurance company or your provider
- receive a complete explanation of your provider's fees and charges

As a client, it is your responsibility to:

- furnish information needed by your insurance company and your provider, which allows rendering of proper treatment
- actively participate in developing mutually agreed upon treatment goals and strategies for achieving those goals
- follow the plan you have agreed upon with your provider
- read your Evidence of Coverage or other material outlining your mental/behavioral health benefits
- ask questions to ensure your understanding of covered benefits, limitations and any authorization procedures, and comply with the rules and conditions as stated
- pay any co-payments and/or fees at the time of service
- demonstrate courtesy and respect to your provider, and the providers' staff

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

You have the right to:

Get a copy of your paper or electronic medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this • We will provide a copy or summary of your health information, usually within 30 days of your request. We charge a reasonable, cost-based fee.
Correct your paper or electronic medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request , but we'll tell you why in writing within 60 days
Request confidential communication	• You can ask us to contact you in a specific way (for example, cell or office phone) or send mail to a different address • We will say "yes" to all reasonable requests.
Ask us to limit the information we share	• You can ask us **not** to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care
Get a list of those whom we've share your information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you ask us to make). We'll provide one accounting a year free but will charge a reasonable, cost-base fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you believe your privacy right have been violated	• You can complain if you feel we have violated your rights by contacting us. • You can file a complaint with the U.S Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W, Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

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Your choices for the way we use and share information:

In these case, you have both the right and choice to tell us to:	➢ Share information with your family, close friends, or others in your care ➢ Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these case we *never* share your information unless you give us written permission:	➢ Marketing purposes ➢ Sale of your information ➢ Most sharing of psychotherapy notes
In the case of fundraising:	➢ We may contact you for fundraising efforts, but you can tell us not to contact you again.

We may use and share your information as we:

Treat you	➢ We can use your health information and share it with other professionals who are treating you.	**Example:** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	➢ We can use and share your health information to run our practice, improve your care, and contact you when necessary	**Example:** *We use health information about you to manage your treatment and services*
Bill your services	➢ We can use and share your health information to bill and get payment from health plans or other entities	**Example:** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/index.html.**

Continued on next page

Help with public health and safety issues	• We can share health information about you for certain situations such as: ➢ Preventing disease ➢ Helping with product recalls ➢ Reporting adverse reaction to medications ➢ Reporting suspected abuse, neglect or domestic violence ➢ Preventing or reducing a serious threat to anyone's health or safety
Do research **Comply with the law**	• We can use or share your information for health research • We will share your information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with medical examiner and funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement and other governmental request	• We can use or share health information about you: ➢ For workers' compensation claims ➢ For law enforcement purposes or with a law enforcement official ➢ With health oversight agencies for activities authorized by law ➢ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena

Note: Rancho Counseling Center will never share any substance abuse treatment records without your written permission per 42CFR Part 2.

Acknowledgement of Receipt Notice of Privacy Practices

I, _____, hereby acknowledge that I have been offered a copy of the Rancho Counseling Center Notice of Privacy Practices, have been given an opportunity to review the notice, and am aware that if I have any questions related to the notice I may contact Rancho Counseling Center for clarification.

_____ _____

Signature of Client, Legal Guardian/Legal Representative | Client Name (if different from signature)

_____ _____

Name (Printed) | Date

_____

Relationship to Client

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Rancho Counseling Center
Demographics Form

HIPPA: 164.502 Use and disclosures of protected health information: general rules

Standard. A covered entity or business associate may not use or disclose protected health information except as permitted or required by this sub part or by subpart C of part 160 of this subchapter

Client Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code:

Home Phone: _____ O.K to call? Yes Sex: Sex

Cell Phone: _____ O.K to call? Yes Gender Identity: Indenifies as Male

Email: _____ O.K to send emails: Yes

SSN: _____ Birthdate: _____

Marital Status: _____ Sexual Orientation: Straight or heterosexual

Emergency Contact: _____ Phone: _____

Realtionship to patient: _____

Employment Status: Full Time

Employer: _____

Work Address: _____

Name of Primary Care Physician: _____

Address of Primary: _____

Phone number of Primary: _____

Insurance Information

(If Client is not the Main Subscriber of Insurance, other wise skip to Ins. ID# and Group #)

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Birthdate: _____

Employment Status: FT PT RET Not EMP Student

Employer: _____

Work Address: _____

Insurance Company: _____ Medical Group: _____

Member ID # (SSN): _____ Group #: _____

I authorize the release of information to referring profesional & to an insurer for the purpose of remuneration of provider

Signature: _____ Date: _____

Credit Card Authorization Form

(Please print legibly and complete)

All charges will appear on your credit card statement as
Rancho Counseling Center Inc.

If you have any questions please contact Sharon at 951-693-9800.

Date: _____

Client's Name: _____

Cardholder's Name: _____

Cardholder's Address: _____

_____

Phone: _____ Email: _____

Card Number: _____

Expiration Date: _____ CSC#: _____

I authorize Rancho Counseling Center to keep my signature and credit card information on file.

This authorization will be used to pay co-payments, outstanding payments, deductibles and missed appointment/late cancellation fees when not paid at time of service.

_____

CARDHOLDER'S SIGNATURE DATE

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Cancellation Policy

Consistent attendance is crucial to the success of psychotherapy. All scheduled appointments require 24-hour notice of cancellation. Please use our 24-hour voice-mail (951-693-9800) system to notify us of cancellations or changes in your schedule. For missed appointments, you will be charged a $50.00 fee. Missing more than 3 appointments could result in referring you back to the insurance company for reassignment to another counselor.

I hereby understand and agree to the terms and conditions of this policy.

Client Signature_____

Date_____

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Rancho Counseling Center

Symptom Checklist (GAD/PHQ9)

Client's Name: _____

Please state the reason you're seeking therapy: _____

_____

_____

_____

Please take a few minutes to complete this survey. Circle the number that applies to you. The numbers range from 0-5 depending upon the severity of the symptom.

	0 (no problem)	1	2	3	4	5 (severe problem)
Nervousness	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5
Poor memory	0	1	2	3	4	5
Poor concentration	0	1	2	3	4	5
Worry all the time	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Feelings of dread	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Sadness	0	1	2	3	4	5
Crying Spells	0	1	2	3	4	5
Loss of interest in activities	0	1	2	3	4	5
Weight loss	0	1	2	3	4	5
Extreme tiredness	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Suicidal thoughts & plans	0	1	2	3	4	5
Suspiciousness	0	1	2	3	4	5
Hearing voices	0	1	2	3	4	5
Feelings of hopeless/helplessness	0	1	2	3	4	5
Loss of interest in sex	0	1	2	3	4	5
Impulse control problems	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5

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Emergency Numbers

If you are experiencing an emergency that poses a threat to yourself or someone else, please contact 911 and/or Access & Crisis Line or the Suicide Hotline immediately.

Crisis Line: 951-686-HELP

951-686-4357

Suicide Hotline: 1-800-273-8255

I, _____ , hereby acknowledge that I have been offered a copy of Emergency Numbers, as well have been given an opportunity to review the numbers, and am aware that if I have any emergency that I am to call one or more of the provided emergency numbers.

_____

Client/Guardian Signature

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