*Patient Name*_____*Patient DOB*_____

# *Patient Agreement*

## Welcome to Mind to Mindful

Our dedicated psychotherapists and staff are committed to providing the highest quality care for each patient. Set forth below is our Patient Agreement, which establishes guidelines for your participation in treatment with us. Please read the following paragraphs carefully and ask your psychotherapist if you have any questions. If, after reading and considering the terms of this Patient Agreement, you agree to everything set forth below, please sign where indicated.

## Treatment - What to Expect

Your initial session with your psychotherapist will be an evaluation lasting approximately 55 minutes. The purpose of this evaluation is to determine your needs so that we can determine the most appropriate treatment plan and whether we will be able to meet your specific needs. Following the initial evaluation, your psychotherapist will discuss the assessment with you and make recommendations regarding psychotherapy and which specialist within our group, if any, can provide the recommended treatment.

## Our Professionals

Our professional team is comprised of Licensed Psychotherapists. Licensed psychotherapists have completed the coursework to become a Licensed Marriage Family Therapist (LMFT) or Licensed Clinical Social Worker (LCSW) and are registered with the California Board of Behavioral Sciences to provide psychotherapy in individual and group settings.

## Children and Appointments

We kindly ask that your children do not accompany you to appointments unless they are seen as a patient or are specifically requested to attend by your psychotherapist. Please note that we cannot have children waiting in our waiting area without the supervision of a parent, guardian, or caretaker.

## Cancellation Policy and No-Show Policy

We reserve your appointment time specifically for you and you alone. For this reason, we will remind you about each appointment as a courtesy. Our office asks for your consideration; please notify us two (2) business days in advance if you cannot make your scheduled appointment time or we may not be able to reserve additional appointment times. We may not be able to reserve additional appointment times if you fail to cancel without notice two (2) times in a twelve (12) month period.

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## Late Arrivals

If you arrive late for your appointment your psychotherapist will only be able to see you for the allotted time left of your scheduled appointment. At such times, it may be necessary to schedule an additional appointment to allow you and your psychotherapist to have sufficient time to address your treatment concerns. We may not be able to reserve additional appointment times for you if you arrive late for two (2) visits in a twelve (12) month period.

## Regular Attendance

Regular attendance at appointments is a critical part of your care/your child's care**.** We encourage you to make regular attendance a priority. We have limited resources and, to enable our psychotherapists to help as many clients as possible, we focus our treatment on those patients who demonstrate their commitment to treatment by regularly attending their scheduled therapy sessions. We reserve the right to terminate therapeutic care due to irregular attendance.

## Same Day Appointments

Most insurance companies do not pay for two mental health visits on the same day. If you schedule visits with your psychotherapist on the same day that you meet with your psychiatrist, **you may be expected to pay for one of these visits.**

## Fees and Payments

If you have a co-payment and/or deductible payment for psychotherapy sessions, payment is due at the time of session and is payable by check or money order.

## Contacting Your Psychotherapist

For routine calls to speak directly with your psychotherapist, please call _____. Typically, messages will be returned within one to two business days. Your psychotherapist will let you know when he/she is out of the office. While out of the office, your therapist will not return calls until he/she returns to the office.

## Emergencies and Urgent Consultations

For emergencies, do not call our offices. Please call 911 or go directly to the emergency room at the nearest hospital.

## Forms and Documents

All medical forms (such as disability forms, school forms, workers compensation forms, etc.) should be completed by your doctor rather than your psychotherapist.

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## Notice of Privacy Practices

You agree that you have been given a copy of Mind to Mindful's Notice of Privacy Practices, which describes the ways in which Mind to Mindful can use and disclose protected health information. You further agree that you have been given the opportunity to review and ask questions regarding the same. You understand that a copy of our Notice of Privacy Practices will be available in our offices upon request at any time. You further understand that when we amend our Notice of Privacy Practices, we will provide you with the amended version at your next scheduled visit.

## Limits to Confidentiality

Our psychotherapists maintain patient confidentiality except as mandated or permitted by law. In California, there are certain limits to the confidentiality of a psychotherapy patient. These include threat of harm to self or others, certain lawsuits, a court order, detention of a mentally disordered person for evaluation, and reasonable suspicion of abuse of a minor or dependent adult.

## Telehealth Treatment is Available

In addition to face to face visits, telehealth is available which allows our therapists to diagnose, consult, treat and educate using interactive audio, video or data communication regarding your treatment. If you are interested in telehealth, please consult with your therapist for more information.

# *Patient Agreement*

**NOTICE TO CONSUMERS**

Marriage and Family Therapists and Licensed Clinical Social Workers are licensed and regulated by the Board of Behavioral Sciences: (916) 574-7830

www.bbs.ca.gov

The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board by email at bopmail@dca.ca.gov, on the Internet at www.psychology.ca.gov, by calling 1-866- 503-3221, or by writing to the followingaddress:

Board of Psychology
1625 North Market Boulevard, Suite –215
Sacramento, California 95834

**Acknowledgement of Patient Agreement**

If any part of this Patient Agreement (including any attachments) is held to be unenforceable, the remainder of this Patient Agreement will remain in effect. This Patient Agreement, together with the attachments hereto, represents the entire agreement of the patient and Mind to Mindful (including all psychotherapists) with respect to the subject matter hereof.

By signing below you state that you have read and agree to this Patient Agreement in its entirety.

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

**Contact Information**

Please indicate below the means by which you consent to Mind to Mindful contacting you.

I give the staff of Mind to Mindful permission to contact me directly on my:

☐ Home phone _____

☐ Work Phone _____

☐ Cell phone _____

☐ Other _____

I give the staff of Mind to Mindful permission to leave a message for me on my:

☐ Home phone_____

☐ Work Phone _____

☐ Cell phone _____

☐ Other _____

I give the staff of Mind to Mindful permission to contact my emergency contact:

Emergency Contact Name: _____

Phone Number: _____

☐ I give the staff of Mind to Mindful permission to email me at the following email address:

_____

Email address

# *Patient Agreement*

## Consent for Treatment

I am voluntarily seeking psychotherapy by the psychotherapists at Mind to Mindful for the purpose of diagnosis and treatment, and I do hereby consent to such evaluations, treatments and/or diagnostic procedures as may be deemed advisable by my treating psychotherapist. I understand that there are both risks and benefits to psychotherapy and/or psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such evaluations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment or treatment of my child is designed to be helpful, it may at times be difficult or uncomfortable.

For Minor Patients: By signing below, you agree that you have legal custody and authority to consent to the child's treatment. You further agree that if you share custody of the child, all parties who have legal custody of the child have been made aware of, and consent to treatment at Mind to Mindful.

For Minor Patients 12 and over: The patient's consent and parental consent is required.

I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

By signing below you state that you have read and agree to this Consent for Treatment in its entirety.

Patient Name_____(please print)

Patient Signature_____Date _____

Parent/Guardian Signature_____Date_____

If not signed by the patient, please indicate:

Relationship:

☐ Parent or guardian of un-emancipated minor patient

☐ Health care surrogate or conservator of an incompetent adult or emancipated minor patient

Name of Patient: _____

☐ Both parents are aware and give consent for minor to attend therapy.

## Disclosure Authorization (Billing and Payment Activities)

**Patient Information**

NAME: _____

ADDRESS: _____

**Person/Organization Providing Information**

NAME: Mind to Mindful

**Person/Organization Receiving Information (Insurance)**

INSURANCE COMPANY: _____

MEMBERSHIP ID: _____

☐ I agree to inform Mind to Mindful of any changes to my insurance at the time of the change

Initial

**Detailed Description of Information to be Released:**

Entire Medical Record (***excluding*** psychotherapy notes, mental health records covered by CA Welfare & Institutions Code § 5328, HIV/Aids Test Results and Drug/Alcohol Treatment Program Information)

**Note: Signatures Required if Any of the Following are Checked:**

_____ Mental Health Records (covered by CA Welfare & Institutions Code §5328) Signature: _____

_____ Drug/Alcohol Treatment Program Information Signature: _____

**Purpose(s):** The purpose of the disclosure is so that Mind to Mindful can conduct billing and payment activities.

Unless sooner revoked, this authorization expires on the date that is one year from my last date of treatment by Mind to Mindful.

*Patient Name*_____ *Patient DOB*_____

## *Patient Agreement*

I understand:

- This authorization cannot be used to authorize the disclosure of information for marketing purposes or for the sale, license to use or lease of information; no remuneration shall be provided to the disclosing party in connection with this authorization.
- I authorize the use or disclosure of the information specified above for the purpose(s) listed above. I understand this authorization is voluntary.
- Treatment will not be conditioned on signing this authorization unless the purpose of my treatment is solely to create protected health information for disclosure to the party that is to receive the information pursuant to this authorization. In that event, the consequence of not signing this authorization is that treatment may not be provided.
- I may revoke, cancel or modify this authorization by providing written notification to the disclosing party at any time except to the extent that action has been taken in reliance on it. The authorization will stop or be modified on the date my notification is received.
- Unless I have specifically requested in writing that the disclosure be made in a specific format, the information may be disclosed in any manner deemed appropriate by the disclosing party and consistent with applicable law.
- I have a right to inspect and copy the information that is to be released.
- This information that has been disclosed could include information from records protected by Federal confidentiality rules (42 CFR Part 2). To the extent applicable, the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by

42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

- The organization I have authorized to receive the information may potentially further disclose the released information, which makes it no longer protected under the HIPAA Privacy Law. However, under California law, the recipient may not further disclose the information except in accordance with a valid authorization or another legally permitted purpose. The disclosing organization is not responsible for the conduct of any other entity.
- I understand that I have a right to receive a copy of this authorization.

I hereby authorize the disclosure of the information described above to the recipient listed above.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative Date

**If you are signing as a personal representative of an individual, describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____ _____

Signature of Witness Attesting to Identity & Authority Date

Internal Use Only: Patient given copy:_____

**INFORMED CONSENT TO TELEHEALTH**

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via video conference over the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____ Therapist: _____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to my therapist noted above. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Signature Date

Email: _____

Internal Use Only: Patient given copy:_____