Jamie Pedersen
Licensed Professional Clinical Counselor (CA LPC23)

Informed Consent for Psychotherapy

New Client
Welcome! Thank you for choosing me as your psychotherapist. This is an opportunity to acquaint you with information relevant to psychotherapy, confidentiality and office policies. I will be glad to answer any questions you have regarding any of these policies.

About Therapy
The major goal is to help you identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:
1. Increasing personal awareness of obstacles and strengths.
2. Taking personal responsibility to make the changes necessary to attain your goals.
3. Identifying specific psychotherapy goals.
4. Utilizing all available community, medical and self-help resources.

Appointments
Appointments are usually scheduled for 45-50 minutes. The practice's hours are by appointment only. Clients are generally seen weekly or more/less frequently as progress dictates and you and I agree. You may leave me a voicemail 24 hours a day but I only return calls during regular business hours, Monday through Friday. In the event of an emergency you may call your primary care physician, your psychiatrist, the local emergency room, the suicide crisis hotline at 916-368-3111, or Sutter Center for Psychiatry at 916-386-3000.

Confidentiality
Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:
1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities.
4. If I am ordered by a court to release information as part of a legal involvement.
5. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
6. In natural disasters whereby protected records may become exposed.
7. As required by the Patriot Act.
8. When otherwise required by law.

You will be asked to sign an **Authorization for Release** of information so that I may speak with other healthcare professionals or to family members.

Record Keeping
A clinical chart is maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Fees
Each 55-60 minute session is $180 and 90 minute sessions are $250. Patients with insurance are responsible to pay their co-pay at the beginning of each session. Any legal or document services including talking with an attorney and writing reports are billed at $250 per hour and will require a credit card authorization or prepayment for the first hour. Court time, including my travel time, will be billed at $350 per hour plus expenses with a minimum 2 hours' time that must be paid before the court session with the balance due immediately after the court session.

Cancellations and Missed Appointments
You will be billed for any sessions that you cancel with less than a 24 hours' notice. You may leave messages 24 hours per day. You will be billed $180.00, not just a co-payment, which you authorized the therapist to charge the credit card on file for the billed amount. Please note that insurance companies do not reimburse for failed appointments. I will only wait 15 minutes past our start time if you are late.

Initials _____

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Payments

Payment is due at the time of the session unless other arrangements have been made. I authorize my therapist to charge the credit card on file for billable services, including copays, sessions, or fees not reimbursed by your insurance including cancellation or missed appointments. If I am not on your insurance company list of providers you still may be able to use your insurance for your session, provided your policy includes an out-of-network therapist provider benefit. Please contact your insurance provider to confirm this prior to our session. For privacy, confidentiality or other reasons, you may decide to not use your insurance. If not using a credit or HSA card for copayment/deductible fees, please indicate how you with to make payment (all session fees are due at the time of service):

☐ CASH ☐ CHECK **Initials** _____

Complaints

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform me immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and the Board of Behavioral Sciences to file a complaint.

Treatment Agreement

It's important that we develop a treatment plan so that both parties know what we are working on and with whom we are working. Usually our first three sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. A referral to an outside support group or treatment program may be suggested or required. For example, a referral to a substance abuse recovery group, a grieving support group or a parenting group may be a necessary part of your treatment plan. We will review progress and if necessary, reassess our treatment plan and decide if I can still be helpful to you. You are expected to take an active role in therapy, which includes regular feedback to your therapist.

Telehealth Services

Sometimes, having a face-to-face meeting is not always possible. As such, with enough advance notice, I can and will facilitate a counseling session with you over the phone or computer. The charge for this is the same as it would be if you came into the office. Please review and sign the **Consent for Telehealth Services** form below if you agree to telehealth services.

I understand that I am responsible for notifying the therapist of any health conditions that the patient or other session attendees may have or have recently been in contact with that could pose a risk of communication in an in-person session. Such conditions include but are not limited to fever, cough, congestion, runny nose, difficulty breathing, nausea or other conditions that may be communicable in an enclosed environment. Please notify the therapist who can arrange a telehealth session or reschedule your appointment.

Initials _____

Consent for Counseling

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. I understand that I may withdraw from counseling at any time. I have also received a copy of the **Office Notice of Privacy Practices** which describes how medical information about me may be used and disclosed and how I can get access to this information.

Name (please print) _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Consent for Telehealth Services

I understand that Telehealth involves the use of electronic communications between the therapist and myself or patient who I represent. The therapist will provide options for approved Telehealth services.

I understand that I need access to an electronic device that is compatible with the audio/video software and has a good internet connection throughout the appointment to have an efficient Telehealth session.

I understand there are potential risks to using Telehealth Service technologies, including unauthorized access, unauthorized disclosure of personal information, interruptions, and technical difficulties.

To help maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. I understand the therapist will not record the appointment and I also agree to not record the appointment. I understand that the therapist is not responsible for the risks of this technology, including but not limited to the quality of or unauthorized access to the communications during the Telehealth consultation.

I understand that I may request a Telehealth consultation for an appointment at any time.

I understand that my therapist may request me to engage in a Telehealth consultation. I understand that I have the option to cancel the appointment at no charge if this request of my therapist is a change to a previously scheduled in person appointment.

I understand that the conferencing technology used to affect such a consultation will not be the same as a direct client / therapist visit due to the fact that I will not be in the same room as my therapist. I understand that a Telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a safe location of my choosing.

I understand that my therapist or I can discontinue the Telehealth consult/visit, if it is felt that the communication connections are not adequate for the situation.

I understand that my therapist and telehealth service provider are NOT an Emergency Services and in the event of an emergency, I will use a phone to call 911. I understand that any telehealth service or technology provider used do not provide any medical or health services or advice, including but not limited to urgent medical services.

I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regards to this procedure. My questions have been answered and the risk, benefits and any practical alternatives have been discussed with me in a language which I understand.

By signing the following I agree to allow the patient to participate in telehealth services:

_____
Patient Name (please print)

_____ _____
Signature of Patient (if Patient is 12 or older) Date

_____
Name of Patient Representative and Relationship to Patient (please print)

_____ _____
Signature of Patient Representative Date

_____
Name of Patient Representative and Relationship to Patient (please print)

_____ _____
Signature of Patient Representative Date

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Parent/Guardian Consent for Patient Refreshments

Applicable if the patient is 18 years of age or older and not under the care of a guardian.

All patients should be aware that offered refreshments may contain nuts and other ingredients that could be harmful to those with food allergies.

I may make available water, soda and snacks to my clients during sessions. Bottled water will be offered unless otherwise noted.

If the patient has ANY food allergies my policy is to not offer any form of snacks.

☐ DO NOT provide refreshments to the patient.

Otherwise, bottled water will be offered in addition to the authorized items below (check all that apply):

☐ The patient DOES NOT have a food allergy or dietary restriction.

☐ I authorize the therapist to offer the patient snacks, including items that may contain nuts or other ingredients that could be harmful someone with food allergies.

☐ I authorize the therapist to offer the sodas to the patient.

List any other refreshment restrictions:

_____

_____

_____

By signing the following, I give the therapist permission to offer the refreshments noted above:

_____
Patient Name (please print)

_____
Name of Patient Representative and Relationship to Patient (please print)

_____ _____
Signature of Patient Representative Date

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Credit Card Authorization

I authorize Jamie Pedersen, LPCC to bill this credit card for professional services including:

My copayment / coinsurance and/or deductible responsibilities

Any denials of coverage by my insurance

Missed session fees

Legal or other services

Initials _____

If you would like to make other payment arrangements please note them here or discuss them with me prior to our session.

_____

_____

Credit Card Type (Please check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

Credit Card Number (Please make sure the information is accurate and complete):

_____
Card Number

_____ _____
Card Expiration Date (MM/YY) 3-4 Digit CCV Code

_____
Card Holder Name (as it appears on the card)

_____
Billing Street Address

_____ _____
City, State Zip code

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event the indicated person, company or association fails to pay for any part or the full amount of these charges. I am an authorized user of the credit card and I will not dispute the payment with the credit card company so long as the transaction meets the terms of the authorization.

_____ _____
Card Holder Signature Date

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Notice of Privacy Practices

REGARDING YOUR Protected Health Information (PHI). You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide the PHI to you in the format you requested.

E-mail is a popular and convenient way to communicate but popular e-mail services may not be secure or may not utilize encryption technologies to prevent someone else from accessing your personal health information over the internet. The federal government U.S. Department of Health and Human Services website can provide additional information.

I understand the risks of unencrypted email and do hereby give permission to Jamie Pedersen to send me personal health information via unencrypted e-mail (this includes communications regarding appointments)

_____	_____	_____
Client or Parent Signature	Date	E-mail address

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 5 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have our denial reviewed. If you request copies of your PHI, we will charge you $.25 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES. If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES: If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza- Room 322, San Francisco, CA 94102, Voice Phone (415) 437-8310, FAX (415) 437-8329, TDD (415) 437-8311. A complaint must be submitted in writing. You will not be retaliated against or penalized for making a complaint.

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Notice of Privacy Policies

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI) We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, we are legally required to follow the privacy practices described in this Notice.
However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI on file with us already. Before we make any important changes to our policies, we will promptly change this Notice and post a new copy of it in our office. You can also request a copy of this Notice from us, or you can view a copy of it in our office.

III. HOW WE MAY USE AND DISCLOSE YOUR PHI. We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization; for others, however, we do not. Listed below are the different categories of our uses and disclosures along with some examples of each category.
A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:
1. **To obtain payment for treatment.** We can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care services that we have provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process my health care claims.
2. **For health care operations.** We can disclose your PHI to operate our Center. For example, we might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we're complying with applicable laws.
3. **Other disclosures.** We may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.
4. **Other disclosures.** We may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.
B. Certain Uses and Disclosures Do Not Require Your Consent. We can use and disclose your PHI without your consent or authorization for the following reasons:
1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, we may make a disclosure to applicable officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, we may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, we may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures