New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

The therapists and staff wish to welcome you to our office and thank you for selecting us for your care. We at **New Hope** are honored by the trust that you place in us and we will do everything to help you through this difficult time.

Our Staff

Our vision is to help those who are seeking emotional and/or spiritual growth. We know the responsibility to hurting people is great; therefore, each member of our staff is professionally trained and has extensive experience in a variety of specialty areas.

Our Philosophy

There is an answer to the problems we face daily and no need to continue with the pain and suffering which constantly drain our energy and direction in life. With a rapidly changing society and all the external and internal pressures, both families and individuals can at times feel alone, alienated, frustrated and even tom apart.

We believe there is hope for change. Our goal at **New Hope** is to provide comfort, hope and healing in times of struggle, confusion and despair. We help bring individuals and families to a place of peace, hope and understanding.

We at **New Hope** have joined together and committed ourselves to help individuals and families change in their time of need.

Before You Begin

Before beginning treatment, we are providing you with these written explanations so that the therapists are able to refer to them during your initial appointment. We understand that paper work is the last thing you are probably concerned with at this time, but we have found that clients have found it very helpful to have a full understanding of procedures and policies. In fact, many clients see that many of the policies were implemented for their protection. As well, many clients have found that this information gives them more choices during their counseling process.

Further more, we want you to be fully aware of procedures, and policies which will help you in consideration of treatment options. We take pride in giving each client the individualized attention they require and full disclosure about treatment options and financial matters before treatment. So, read each page carefully and sign where indicated.

Your therapist will be with you shortly. May God richly bless you.

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

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

At New Hope Christian Counseling Centers we are committed to treating and using protected health information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information
Each time you visit New Hope Christian Counseling Centers, a record of your visit is made. Typically, this record contains your symptoms, diagnosis, treatment, and a plan for future care and treatment. This information, often referred to as your health or medical record, serves as a:

* Basis for planning your care and treatment

* Legal document describing the care you

* A tool with which we can assess and continually maintain

* Means by which you or a third-party payer can verify that services billed were actually provided.

* Means of communication among the many

* A tool in educating health professionals

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. Your PHI can be used without your consent for the following reasons:

1. Treatment: We can use and disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who are involved in your care.
2. To Obtain Payment: We can use and disclose PHI to bill and collect payment for services. This may include the insurance company, claims processing individual or companies.
3. Health Care Operations: We can use PHI to operate our practice, such as evaluating performance of health care professionals or provide information to our accountant, attorney or consultants to further health care operations.
4. Patient Incapacitation or Emergency: If you are incapacitated or if an emergency exists consent is not required as long as we try to get your consent after treatment is rendered.
5. Federal, State or Local Laws Require Disclosure: For example, law enforcement and law require us to report information about victims of abuse or neglect.
6. Judicial or Administrative Proceedings Require Disclosure: Disclosure may be made if you are involved in a lawsuit, workers' compensation case or in response to a subpoena.
7. Law Enforcement Require Disclosure: warrant.
8. Public Health Activities Require Disclosure: We may provide PHI to report to a government official an adverse reaction to a medication.
9. Health Oversight Activities Require Disclosure: We may provide PHI if the government is conducting investigations or inspections of a health care provider or organization.
10. To Avert a Serious Threat to Health or Safety: We may have to use or disclose PHI to avert a serious threat to the health or safety of others and this information will be made only to someone able to prevent the threatened harm from occurring.

Certain Uses & Disclosures Require You to Have the Opportunity to Object:

Specialized Government Functions: If you are in the military, we may disclose PHI for national security purposes, including protecting the President of the United States or persons conducting intelligence operations.

To Remind You About Appointments and to Inform You of Health-Related Benefits or Services: We may use or! disclose your PHI to remind you about your appointments, or to inform you about treatment alternatives, or other! health care benefits that we can offer to benefit you.

Disclosure to Family, Friends or Others: We may provide PHI to 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.

Other Uses & Disclosures Require Your Prior Written Authorization
In any other situation not described in section A & B above, we will need your written authorization before using or! disclosing any of your PHI. If you chose to sign an authorization, you can later revoke it in writing to stop any future! uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI. (our Health Information Rights) though your health record is the physical property of New Hope Christian! Counseling Centers, the information belongs to you.

A. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. You have the right to request restrictions & limitations on uses and disclosures for treatment,payment, health care operations, disclosures to family and friends. Submissions must be made in writing however we are not legally required to accept them. If we do not accept Item we will put them in writing and abide by them except in emergency situations.

B. Obtain a paper copy of this notice on information practices upon request & the right to have confidential information sent to by alternative means or at alternative locations.

C. Inspect and received a copy your health record as provided for in 45 CFR 164.524. We will respond to your request within 30 days of receiving the written request. In certain situations, we may deny your request and will tell you in writing the reasons for the denial. For request of copies of PHI, there is a charge of $.25 per page. A summary or explanation of the PHI may be given as long as there is an agreed upon cost in advance.

D. Obtain an accounting disclosures of your health information as provided in 45 CFR 164.528. Accounting of Disclosures will be responded to within 60 days of receiving the request and will include disclosures made in the last six years unless you request a shorter time. No charge will be made for the list although we may charge you a reasonable, cost-based fee for each additional request. Amend your health record as provided in 45 CFR 164.528. If you believe there is a mistake, or a piece of information is missing provide the request in writing and we will respond within 60 days. We may deny your request if the PHI is correct and complete, not created by us, not allowed to be disclose or not part of the record. Written denial will state the reasons for the denial and explain your right to file a written disagreement with the denial. You have a right to receive a paper copy even if you agreed to have it sent via email.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE COUNTY OF RIVERSIDE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: APRIL 14, 2003

The County creates records of health care to provide quality care and comply with legal requirements. The County understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires the County to keep your health information private and to provide you this notice of our legal duties and privacy practices. The law also requires the County to follow the terms of this notice.

This notice outlines the limits on how the County will handle your health information. Under federal law, the County must provide a copy of this notice when you receive health care and related services from the County, or participate in certain health plans administered or operated by the County. The County reserves the right to change practices and make new provisions effective for all health information it maintains. You may request an updated copy of this notice at any time.

A. Use and Disclosure – General

Generally, except as otherwise specified below, the County may use and disclose the following health information, as allowed by state and federal law:

1. **For treatment.** The County uses and discloses health information to provide you health care and related services. For instance:
   - Nurses, doctors, or other County employees may record your health information, and they may share such information with other County employees.
   - The County may disclose health information to people outside the County involved in your care who provide treatment and related services.
   - The County may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.
   - In emergencies, the County may use or disclose health information to provide you treatment. The County will make its best effort to obtain your permission to use or disclose your health information as soon as reasonably practical.
2. **For payment.** The County may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.
3. **For health care operations.** The County may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.
4. **For health plan administration.** As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, the County may disclose limited information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

B. Use and Disclosure Requiring Your Authorization

On a limited basis, the County may use and disclose health information only with your permission, as required by state and federal law:

1. From mental health records.
2. From substance abuse treatment records.

C. Use and Disclosure Requiring an Opportunity for You to Agree or Object

In certain cases, the County may use and disclose health information only if it informs you in advance and provides an opportunity to agree or object, as required by state and federal law:

1. The County may include your name, location in the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.
2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief to notify your family about you.

D. Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object

In specific cases, the County may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

1. As required by law.
2. For public health activities, which may include the following:
   - Preventing or controlling disease, injury or disability;
   - Reporting births and deaths;
   - Reporting abuse or neglect of children, elders and dependent adults;
   - Reporting reactions to medications or problems with products;
   - Notifying people of recalls of products they may use; or,
   - Notifying a person exposed to or at risk to contract or spread a disease or condition.
3. For mandated reporting of abuse, neglect or domestic violence.
4. For health oversight activities necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
5. To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.
6. To law enforcement:
   - To identify or locate a suspect, fugitive, material witness, or missing person;
   - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; or,
- In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.

7. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.
8. For organ donation once you are deceased.
9. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.
10. To avert serious threats to the health and safety of you or others.
11. Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.
12. To determine your eligibility for or entitlement to veterans benefits.
13. To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.
14. To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.
15. To determine your eligibility for or enroll you in government health programs.
16. For Workers Compensation or similar programs, to the minimum extent necessary.

The County will not disclose your health information for marketing fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, the County will no longer use or disclose health information about you for the reasons you permitted. You understand the County is unable to retract disclosures already made with your permission, and must retain records of care already provided.

E. Rights and Responsibilities

With regard to health information, the County recognizes and commits to safeguard your:

1. **Right to request restrictions on certain use and disclosure.** You have the right to request restriction or limitation on the health information the County uses or discloses for treatment, payment or health care operations, though the law does not require the County to agree to your request. If the County agrees, it will comply except to provide emergency treatment. Requests must be in writing and state: the information you want to limit; whether to limit use, disclosure, or both; and, to whom limits apply. For instance, you may ask not to disclose to your spouse.
2. **Right to confidential communications.** You have the right to ask the County to communicate with you in a certain way, or at a certain location.
3. **Right to request to inspect and copy records.** You have the right to request to inspect and obtain copies of your health information. Requests may be required in writing, and the County may charge you a fee for the costs of fulfilling your request. The County may

deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another health care professional chosen by the County. The County will comply with the results of that review.

4. **Right to amend health records.** If information the County has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. The County may deny your request if it is not in writing, or does not include a reason supporting it. The County may deny requests if the information:
   - Was not created by the County;
   - Is not health information kept by or for the County;
   - Is not information you are permitted to inspect and copy; or,
   - Is accurate and complete.

5. **Right to an accounting of certain disclosures.** You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. The County may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.

6. **Right to obtain a paper copy of the notice of privacy practices upon request.**

7. **Right to file complaints without fear of retaliation.** Under law, the County cannot penalize you for filing a complaint. If you believe the County violated your privacy rights, you may file a complaint with the department privacy officer, County privacy office, or with the U.S. Secretary of Health and Human Services.

PRIVACY COMPLAINT CONTACTS

Riverside County Regional Medical Center
Privacy Officer
26520 Cactus Avenue
Moreno Valley, CA 92555
(951) 486-4659

Community Health Agency
Privacy Officer
4065 County Circle Drive
Riverside, CA 92503
(951) 358-5000

Mental Health
Privacy Officer
4095 County Circle Drive
Riverside, CA 92503
(951) 358-4500

Office on Aging
6296 Rivercrest Drive, Suite K
Riverside, CA 92507
(800) 510-2020

Public Social Services
Privacy Officer
10281 Kidd Street
Riverside, CA 92503
(951) 358-3030

Veterans Services
1153A Spruce Street
Riverside, CA 92507
(951) 955-6050

Employee Assistance Program
3600 Lime Street, Suite 111
Riverside, CA 92501
(951) 778-3970

★ County Privacy Office ★
P.O. Box 1569
Riverside, CA 92502
(951) 955-1000

Exclusive Care Plan
P.O. Box 1508
Riverside, CA 92502
(800) 962-1133

U.S Department of Health & Human Services
Region IX Office of Civil Rights
50 United Nations Plaza, Room 322
San Francisco, CA 94102
TEL: (415) 437-8310 ♦ TDD: (415) 437-8311 ♦ FAX: (415) 437-8329

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

PERSONAL INFORMATION

_____ _____
FIRST NAME MIDDLE NAME LAST NAME DATE OF BIRTH

44 ☐ ☐ _____ _____
AGE F M SOCIAL SECURITY NO. DRIVERS LICENSE NO.

_____ _____ _____ _____
HOME ADDRESS CITY STATE ZIP

WORK PHONE: _____ CELL PHONE: _____ HOME PHONE:_____
MAY WE CALL YOU AND LEAVE A MESSAGE HOME:☐ WORK:☐ CELL:☐
EMPLOYER: _____ OCCUPATION:_____
WORK ADDRESS:_____
STREET NO. CITY ST ZIP CODE

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐SEPARATED ☐DIVORCED ☐WIDOWED

FAMILY INFORMATION

SPOUSE'S NAME:_____ SPOUSE'S EMPLOYER:_____
SPOUSE'S WK. ADD.:_____
STREET NO. CITY ST ZIP
SPOUSE'S WK PHONE: _____

NAMES OF CHILDREN & AGE

1)_____( ) 5)_____( )
2)_____( ) 6)_____( )
3)_____( ) 7)_____( )
4)_____( ) 8)_____( )

Client Name:_____
Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

INSURANCE INFORMATION

INSURED NAME:_____ DATE OF BIRTH:_____
INS. CO.NAME:_____ INS. CO. PHONE#: _____ GROUP ID #: _____
POLICY #: _____ EFFECTIVE DATE OF POLICY: _____
INS. CO.ADDRESS:_____
STREET NO. CITY ST ZIP CODE

INS. CO. #2: _____ INS. CO. PHONE#:_____ GROUP ID #:_____
POLICY 2 #: _____ EFFECTIVE DATE OF POLICY#2:_____
INS. CO. #2 ADDRESS:_____
STREET NO. CITY ST ZIP CODE
INSURED INDER: _____
PRIME (MEMBER#)_____
SECONDARY (MEMBER #)_____

IN CASE OF AN EMERGENCY NOTIFY
Name_____ Phone:_____

Emergency Address:__ _____

Street no. City St Zip Code

*GENERAL CONSENT TO THERAPY & *24 HOUR NOTICE POLICY*

I apply for and consent to counseling, psychotherapy and diagnostic test as prescribed by the therapist. I agree to be responsible for payment of $ _____per hour which is payable at time of session unless prior arrangements have been made with the office. This does include phone consultations. I UNDERSTAND THAT APPOINTMENTS NOT KEPT OR CANCELED 24 HOURS IN ADVANCE WILL BE CHARGED FOR AND IT WILL BY MY RESPONSIBILITY TO PAY FOR MISSED SESSIONS.

I do ☐ do not ☐ Authorize New Hope to contact my insurance company to (1) verify insurance benefits and (2) to bill my insurance for payment of services rendered.

REFERRED TO NEW HOPE BY : DOCTOR_____OTHER_____

MAY WE THANK THE PERSON WHO REFERRED YOU TO NEW HOPE: ☐ YES ☐ NO

Client Name :_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

AGREEMENTS, AUTHORIZATIONS & CONSENT TO TREATMENT

PRIVACY POLICY: I acknowledge having been offered New Hope Christian Counseling Center's "Notice of Privacy Policy." My rights including the right to see and have a copy of my record, to limit disclosure of my health information, and to request an amendment to my record is explained in the Policy. My right to make a complaint and fi le a grievance has also been explained. I understand that I may revoke in writing my consent for release of my health care information except to the extent that New Hope has already made disclosure with my prior consent.

TREATMENT: The undersigned client, or the parent/legal guardian if the client is a minor, requests, consents to, and authorizes New Hope and its mental health practitioners, to perform all counseling and psychological services which may be deemed advisable or necessary. This agreement may be revoked at any time. Service provided through this program is optional.

INFORMATION RELEASE: I understand that any records kept regarding me and my treatment are the property of New Hope. Such records can be made available, upon my written release, to other qualified mental health professionals. Or public welfare agencies.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION*:* I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of New Hope. I authorize New Hope to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that New Hope may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

Client Name:_____

Client Signature:_____ Date:_____

AGREEMENTS, AUTHORIZATIONS & CONSENT TO TREATMENT (CONT)

4. AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of New Hope. I authorize New Hope to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that New Hope may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

5. EXCEPTION TO CONFIDENTIALITY: Although New Hope adheres to confidentiality standards and thus will not release any information to others without signed consent, there are exceptions which arise from certain California legal mandates. These exceptions are:

A) The necessity of reporting to authorities, with or without the client's consent, any information which may indicate the presence of child or elder abuse or neglect.

B) The necessity of reporting to authorities and the potential victim, with or without the client's consent, should it appear that the client or a person known to the client intends to seriously hurt another person, destroy another's property.

C) The necessity to take appropriate steps to prevent a suicide attempt, with or without the client's consent, should a suicide attempt appear imminent. In all cases an effort will be made to inform the client and/or the legal guardian that a report will be made to the appropriate authorities, before such a report is actually made.

6. MAILINGS: I agree to have my names placed on a mailing list to receive follow-up contact from New Hope including but not limited to a New Hope Newsletter, Seminar information, and/or education information, etc. (_____) initial Each of the undersigned acknowledges that he/she has read and understand the foregoing provisions and that the person signing as parent, or legally responsible party certifies that he/she is lawfully entitled to act on behalf of the client.

Client Name:_____

Client Signature:_____ Date:_____

RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH
Informed Consent Guidelines

CLIENT NAME: _____ **CLIENT NUMBER:**_____

ISSUES AND LIMITATIONS Of CLIENT-THERAPIST CONFIDENTIALITY:
All Mental Health staff are mandated reporters of suspected child abuse and will report such suspicions to the appropriate authorities in accordance with applicable laws. Your records will be held in strict confidence except where disclosure is required by law and/or as noted in this section. You may give your written permission to release all or part of your confidential file to a specified agency or person(s) at any time and at your discretion.
Examples in which confidentiality and the client/therapist privilege is waived include but are not limited to;

-Client has treated the information as if it were not confidential. Examples: a client verbally disclosed the information to a third party outside the therapy setting; Client has signed a written release covering specific disclosures such as to a doctor, school staff, associated therapist, or other agency.

-Court or Legally Mandated Disclosure: Reporting child, dependent adult, or elder abuse; and duty to protect about serious threat of bodily harm to a reasonably identifiable other.

-Client is dangerous to himself or others due to a mental disorder and the therapist has reasonable cause to believe this is the case.

-Where the client is under 16 and has been a victim of a crime specified in Penal Code section 111.60 (i.e., injuries by deadly weapon, assault or abusive conduct)

-Where the client has waived or tendered his/her emotional condition pursuant to any legal proceeding. A legal proceeding to establish client's mental competence

-Where the services of the therapist are sought or obtained to enable or aid anyone to commit or plan to commit a crime or tort.

Initials (_____)

APPOINTMENTS:
Clients/Parents/Guardians are responsible for attending all scheduled appointments. If an appointment cannot be kept, you must contact the clinic to cancel at least 24 hours in advance. Appointments not kept or previously cancelled will be viewed as a "no-show", and ***two "no-shows" or* repeated absences *may jeopardize continued treatment at the clinic.*** Punctual attendance to all scheduled appointments is necessary. If you are more than 15, minutes late to an appointment, your appointment will be rescheduled, and no services will be rendered that day. Repeated tardiness will jeopardize continued treatment at the clinic.
Initials (_____)

PSYCHIATRIC APPOINTMENTS:
The above appointment punctuality and attendance guidelines also apply to appointments with the clinic's psychiatrist. If you miss an appointment and need refills. you may be required to wait on a "first come first served" basis when the doctor is next in the office. Telephoned requests for refills are generally not accepted.
Initials (_____)

My initial above and my signature below indicate that the above clinic policies and information were reviewed with me, and I understand them. I understand a copy of this form will be given to me.

Parent / Legal Guardian Signature: _____ Date: _____

Client Signature: _____ Date: _____

Clinician Name: _____ Date: _____

Clinician Signature: _____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

POLICY INFORMATION

Dear Client,

As we begin this therapy process we want to be sure that you understand our polices and something about the way we view therapy.

THERAPY: Because we will be dealing with issues which are personal and of great importance to you, your therapist is committed to providing you with the best professional service possible. In order for this to be truly effective, it will be necessary for you to make our sessions one of your highest priorities during this time.

SESSIONS: Generally, sessions will last for 45-55 minutes, unless you and your therapist agree on a different arrangement. Your therapist will do his/her best to start and stop on time, although there may be times when this will be difficult for various reasons.

TERMINATING THERAPY: Bringing therapy to a close is often one of the most important parts of this process and should be done in a planned and deliberate way rather than as a sudden decision. This allows you are your therapist time to work through key issues.

TRANSFER OF CASE UPON DEATH/INCAPACITATION: In the event of my death or incapacitation I appoint the directors at New Hope Christian Center Inc. New Hope Christian Counseling Foundation, Inc. whose main office is located at 1175 E. Garvey Street, Ste 102, Covina, CA 91724, phone 626-967-6421, to properly care for your case in regard to proper care and transfer of your clinical file and transfer case to another therapist.

We have found that the standards described here enhance the work we will do together and will help to ensure that you get the most out of this experience. Your therapist welcomes any questions you may have about this so please feel free to discuss it with them.

Sincerely, **Clinical Directors of New Hope**

I have read, understand and agree to the policies stated above.

Client Name:_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

Appointment Policy

We understand that life can be busy and full of unexpected changes. However, our mission is to help those that are suffering and in need of counseling so regular counseling is necessary to get the results you are looking for.

Our Staff set aside time specifically for you so it is important to make the regular appointments as scheduled.

As mentioned previously we have a 24-hour notice policy if you are going to cancel appointments otherwise you will be charged for the time missed. The advance notice. allows our therapists to open up the time for someone else that may need to come in.

For County referred clients, after 2 missed sessions (this includes cancellations and no-show appointments) the County will be contacted regarding the missed sessions. ACT/CAST clients are required to have regular weekly counseling in most cases and CARES at least every other week. Cases will be terminated after a pattern of missed sessions as per our contract with the County.

I understand New Hope's appointment policy and agree to abide by the policy.

Client Name:_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

Telemedicine Informed Consent Form

I _____hereby consent to engaging in telemedicine with New Hope Christian Counseling as part of my psychotherapy. I 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. I 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. I understand that I have the following rights with respect to telemedicine:

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

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

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Name:_____

Client Signature:_____ Date:_____

Telemedicine Informed Consent Form (Cont.)

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my 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, I understand that telemedicine based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases, may even get worse.

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

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

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Name:_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

Financial Information Policies

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from clients for the cost incurred in their care, and financial responsibility on the part of each client must be determined before treatment or during the initial session. *This office cannot render services on the assumption that our chargers will be paid by an insurance company. You are responsible for the full amount of the fee if for some reason your insurance fails to pay.

Clients who carry health insurance understand that all services furnished are charged directly to the client, and that he or she is personally responsible for payment of all counseling services unless arrangements to bill your insurance is made. In some cases our office will prepare the clients insurance forms or assist in making collections from insurance companies and will credit any such collections to the client accounts. Alternately, your therapist can give you a superbill to send to your insurance company for reimbursement. However, .this office cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for the full amount of the fee if for some reason your insurance elects not to pay.

In consideration for the professional services rendered to me or at my request, by the therapist, I agree to pay therefore the reasonable value of said services to the therapist at the time of said services are rendered, or within five (5) days of billing if credit shall be extended. There will be a $35.00 service charge for all NSF checks returned to our office. I further agree that a ·waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney's fee's if suit be instituted hereunder. I grant my permission to New Hope and assigned staff, to telephone me at home and/or work to discuss matters related to this form.

*I have read the above conditions of treatment and understand the policies stated above. I further agree to their content and agree to the fee amount of $ per hour which includes therapy sessions and phone consultations.

Preference of payment

*IF COUNTY IS PAYING Check Here ☐
Cash on day of treatment:☐ Master card:☐ Visa:☐ Discover Card:☐
Credit Card Number:_____ Expiration date: MO____ YR_____
CCV 3 digit code_____
Name on Credit Card:_____
Insurance Co-payment of:$_____ * Insurance will pay:$_____
Other:_____

Client Name:_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

CLIENT INFORMATION QUESTIONNAIRE

When were you last examined by a physician?

Physicians name:

List any major health problems from which you currently receive treatment:

List any medications (prescription and nonprescription) you are now taking:

Have you ever been hospitalized? If yes, please give approximate dates and reasons:

Have you ever received counseling before? if yes, with who and for what?

Please give approximate dates To: From:

Are you presently receiving counseling? ☐ Yes ☐ No
If yes, with who and for what?

In your own words, please describe the problems that brought you to counseling:

What are the clients strengths?

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU

- ☐ Nervousness
- ☐ Bowel Troubles
- ☐ Appetite
- ☐ Children
- ☐ Legal Matters
- ☐ Memory
- ☐ Ambition
- ☐ Drug Use
- ☐ Divorce
- ☐ Fears
- ☐ Friends
- ☐ Sleep
- ☐ Alcohol Use
- ☐ Sexual problems
- ☐ Stomach Issues
- ☐ Education
- ☐ Career Choices
- ☐ Health Issues
- ☐ Anger
- ☐ Stress
- ☐ Work
- ☐ Relaxation
- ☐ Headaches
- ☐ Tiredness
- ☐ Shyness
- ☐ Finances
- ☐ Being a parent
- ☐ My thoughts
- ☐ Energy
- ☐ Insomnia
- ☐ Marriage
- ☐ Loneliness
- ☐ Inferiority
- ☐ Concentration
- ☐ Separation
- ☐ Self Control
- ☐ Unhappiness
- ☐ Depression
- ☐ Temper
- ☐ Nightmares
- ☐ Relationships
- ☐ Making Decisions

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

AUDIO/VIDEO RELEASE

I authorize New Hope Christian Counseling Center to make an audio/video recording of my counseling session(s) for the purpose of supervision, with the therapist's supervisor. It is my understanding that the tape will be erased at my request or when supervision is completed. I understand that all audio/video recordings are available for my listening/viewing.

*This release must be signed by all family members 18 years of age or older, or those who are emancipated minors.

Client Name:_____

Client Signature:_____ Date:_____

Riverside University Health System – Behavioral Health

Adult Consent for Treatment

I, _____, consent and agree voluntarily to receive psychological services from New Hope Christian Counseling, on behalf of Riverside University Health System – Behavioral Health. These services may include, but are not limited to, diagnostic assessments; psychological testing; crisis intervention; individual, group, and/or family therapy; and consultations and referrals to other behavioral health professionals.

I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

_____ _____

Consumer or Legal Representative's Signature Date

Riverside University Health System – Behavioral Health
Assessment and Consultation Team (ACT)
Authorization Requesting Release/Receipt of Information and/or Records

(Confidential Patient Information – W & I Code Sec. 5328)

Patient's Name: _____ **Date of Birth:** _____

The Department of Public Social Services has arranged and is partially funding treatment services for you as a part of a service plan through the Juvenile Court. As a part of this process, there is a need to share information between your clinician/provider, Riverside University Health System – Behavioral Health and the Riverside County Department of Public Social Services. This release of information allows for this exchange of information. If you do not wish to sign this authorization, you may still receive confidential services through your own resources. If desired, discuss possible treatment resources with your clinician and, if you wish, with your DPSS social worker.

I, the undersigned, hereby authorize the following to release and exchange information. Please be advised that this authorization allows disclosure as described above and Riverside University Health System – Behavioral Health cannot be held liable for how this information is used by the person/agency to whom the disclosure is made to and their safeguard practices.

Provider: New Hope Christian Counseling Phone Number: 951-247-6542

Riverside University Health System – Behavioral Health Assessment & Consultation Team
Riverside County Department of Public Social Services

Information may be released with the knowledge that such contact discloses the fact that mental health and/or chemical dependency services have been/are being provided.

This disclosure may include any of the following:
Assessment & Diagnosis
Consumer Care Plan and Discharge Summary
Psychological Testing
Medical, Neurological, Lab Tests, Medications
Progress Reports

This authorization becomes effective _____/_____/_____. This authorization may be revoked by the undersigned at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization. You have the right to have a copy of this Authorization upon request.

Date: _____ Consumer Signature: _____

☐ Authorization Revoked: _____/_____/_____ Consumer Signature: _____

☐ I refuse all release of information.

Date: _____ Consumer Signature: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient or Subscriber Name:_____
(Please print patient or subscriber name)

I,_____**,**
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which the County may use or disclose personal health information to provide service, provided by the County of Riverside:

New Hope Christian Counseling.
(Name of facility, provider or program)

Signed:_____ **Date:**_____

If not signed by patient, indicate relationship:_____

NOTE: Parents must have legal custody. Legal guardians and conservators must show proof.

****

THIS SECTION TO BE FILLED OUT ONLY BY THE COUNTY OF RIVERSIDE

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:

☐ **Patient left office before Acknowledgment could be signed.**
☐ **Patient does not wish to sign this form.**
☐ **Patient cannot sign this form because:**_____

Patient did not receive the Notice of Privacy Practices because:

☐ **Patient required emergency treatment.**
☐ **Patient declined the Notice and signing this Acknowledgment.**
☐ **Other:**_____

Name: New Hope Christian Counseling
(Print name of provider or provider's representative)

Signed:_____ **Date:**_____
(Signature of provider or provider's representative)

Riverside University Health System – Behavioral Health

CSI DATA COLLECTION

(MH Admission / Admission Screen)

Last Name	First Name	Middle Name	SFX, i.e., Jr., Sr., etc.

(Enter in CSI Admission Screen)

Birth Name (if different from above)	Social Security Number
Mother's First Name:	

Living arrangement:

- ☐ Adult Res. Facility, Social Rehab Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
- ☐ Board and Care
- ☐ Community Treatment Facility
- ☐ Foster Family Home
- ☐ Group Home (includes Levels 1-12 for children)
- ☐ Homeless, No identifiable residence
- ☐ House or apartment (Includes trailers, hotels, dorms, barracks, etc.)
- ☐ House or apartment and requiring daily support & supervision (applies to adults only)
- ☐ House or apartment and requiring some support with daily living activities (applies to adults only)
- ☐ Inpatient psychiatric hospital, Psychiatric Health Facility (PHF), or Veteran's Affairs (VA) Hospital
- ☐ Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- ☐ Mental Health Rehabilitation Center (24 hour)
- ☐ Other
- ☐ Residential Treatment Center (Includes Levels 13-14 for children)
- ☐ Skilled Nursing Facility (SNF)/Intermediate Care Facility/Institute of Mental Disease (IMD)
- ☐ State Hospital
- ☐ Supported Housing (applies to adults only)
- ☐ Unknown/Not Reported

Marital Status: ☐ Single/Never married ☐ Separated ☐ Divorced/Annulled ☐ Married ☐ Widowed ☐ Unknown ☐ Remarried

(MH Admission / Demographics Screen)

Employment Status:

- ☐ Full Time 32+ Hours A Week (Not including Armed Forces)
- ☐ Full Time – 35 Hr or more per wk – Non-Comp
- ☐ In the Armed Forces
- ☐ Not in Labor Force - Homemaker
- ☐ Not in Labor Force – Other Not Seeking Employment in Past 30 Days
- ☐ Not in Labor Force – Resident/Inmate of Institution
- ☐ Not in Labor Force - Retired
- ☐ Not in Labor Force - Student
- ☐ Not in Labor Force – Unable to Work Due to MH, Developmental Disability, or A+D
- ☐ Not in Labor Force – Due to Other Disorder or Disability
- ☐ Part Time (1-15 Hours A Week (Not including Armed Forces)
- ☐ Part Time (16-32 Hours A Week Not Including Armed Forces
- ☐ Part Time, less than _____
- ☐ Part time, less than 35 Hrs Week Non-Comp
- ☐ Unemployed – On Layoff From Job
- ☐ Unemployed Seeking Employment
- ☐ Unknown
- ☐ Volunteer

Occupation:

- ☐ Administrative Support Including clerical
- ☐ Construction Trade
- ☐ Executive, Administrative, and Managerial
- ☐ Extractive Occupations
- ☐ Fabrication, Assemblers, and Hand-working
- ☐ Farming, Forestry, Fishing
- ☐ Handlers, Equipment Cleaners, Helpers and Laborers
- ☐ Machine Operators and tenders, except Precision
- ☐ Mechanics and repairs
- ☐ Military Occupations
- ☐ Never Employed
- ☐ Precision Production
- ☐ Preschooler or Student
- ☐ Private household
- ☐ Production Inspectors, Testers, Samplers, and Weighers
- ☐ Professional Specialty
- ☐ Protective Service Occupation
- ☐ Sales Occupation
- ☐ Svc Occupation except Protective and Household
- ☐ Technicians & Related Support
- ☐ Transportation and Material Moving
- ☐ Unknown

Submit this form to ACT / CARES along with the Initial Assessment / Care Plan, Extension Request, or Quarterly Report

ACT Fax: 951 687-5819 or CARES Fax: 951 358-5352

Riverside University Health System – Behavioral Health

CSI DATA COLLECTION

Name: SSN:

What is the consumer's education level? _____ _____ 98=other _____ 99=Unknown
(State numeric years i.e., 14= High School Grad + 2 additional years)
Smoker/Tobacco: ☐ Current every day ☐ Current some days ☐ Former Smoker ☐ Never ☐ Unknown

(Supplemental Screen)

Sexual Orientation: ☐ Heterosexual ☐ Bi-Sexual ☐ Gay ☐ Lesbian ☐ Questioning ☐ Unreported

Does client self –identify as Transgendered: ☐ Yes ☐ No

(CSI Admission Screen)

Consumer's Place of Birth (County only in CA)
County _____ State _____ Country _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Unknown /Not reported ☐ Hispanic or Latino

Special Population:
☐ Assisted Outpatient Treatment Service(s) (AB 1421)
☐ (AB 3632) Individual Education Plan (IEP)
☐ Governor's Homeless Initiative (GHI) Service(s)
☐ No Special Population Services
☐ Welfare-to-work Plan Specified Service(s)

Is Substance Use Affecting Mental Health?	☐ Yes	☐ No	☐ Unknown
Are Developmental Disabilities Affecting Mental Health?	☐ Yes	☐ No	☐ Unknown
Are Physical Health Disorders Affecting Mental Health?	☐ Yes	☐ No	☐ Unknown

Conservator court status:

☐ Temporary conservatorship (W&I Code, Section 5353)
☐ Lanterman-Petris-Short (W&I Code, Section 5358)
☐ Murphy (W&I Code, Section 5008)
☐ Probate (Probate Code, Division 4, Section 1400)
☐ PC 2974 (Penal Code, Section 2974)
☐ Representative payee without conservatorship (W&I Code, Section 5686)
☐ Juvenile Court, Dependent of the Court (W&I Code, Section 300)
☐ Juvenile Court, Ward- Status Offender (W&I Code, Section 601)
☐ Juvenile Court, Ward- Juvenile Offender (W&I Code, Section 602)
☐ Not applicable
☐ Unknown, not reported

Number of children less than 18 yrs of age that the client cares for/ is responsible for at least 50% of the time:

Number of dependent adult 18 yrs of age and above that the client cares for/ is responsible for at least 50% of the time:

Preferred Language:

Race (select up to five from the choices listed below):

☐American Indian ☐Asian Indian ☐Black or African American ☐Cambodian ☐Chinese ☐Filipino ☐Guamanian
☐Hmong ☐Japanese ☐Korean
☐Laotian ☐Mien ☐Native Hawaiian ☐Other Asian ☐Other Pacific Islander ☐Other ☐Samoan
☐Unknown/Not Reported ☐Vietnamese ☐White

Is consumer an IRC consumer? ☐ Yes ☐ No
If so, IRC case worker's name: _____ Phone: _____

Provider Name: _____ Phone: _____

Agency Name: New Hope Christian Counseling

Submit this form to ACT / CARES along with the Initial Assessment / Care Plan, Extension Request, or Quarterly Report
ACT Fax: 951 687-5819 or CARES Fax: 951 358-5352

Riverside University Health System – Behavioral Health
ADULT MEDICAL HISTORY SUMMARY

Part I – TO BE COMPLETED BY PATIENT OR PATIENT INFORMANT (Please Print)

Patient's Name: _____
(First) (Middle) (Last) (Maiden)

Name of Informant if other than Patient/Relationship: _____

Current Physician: _____
(Name) (Address/City)

Date of Last Physical: _____ **Do you have allergies?** ☐Yes ☐No

PLEASE CHECK ALL OF THE FOLLOWING WHICH YOU HAVE HAD IN THE PAST:

☐Heart Problems	☐Drug Use	☐Liver Problems
☐Shortness of Breath	☐Cancer/Immune Disease	☐Hepatitis/Jaundice
☐Pain/Pressure in Chest	☐Frequent/Severe Headache	☐Diabetes
☐High Blood Pressure	☐Head Injury	☐Tuberculosis (TB)
☐Stomach Problems	☐Stroke	☐Sexually Transmitted Disease
☐Alcohol Use	☐Epilepsy/Convulsions	☐Asthma/Hay Fever/Hives/Rash
☐Dizziness/Fainting	☐Kidney Problems	☐Bedwetting/Soiling
☐Seizures	☐Thyroid Problems	☐Unusual Bleeding
☐PMS/Hormone	☐Therapy	☐Pregnancy

OTHER SERIOUS ILLNESS AND/OR MEDICAL TESTS: _____

_____

SUBSTANCES YOU ARE ALLERGIC TO: _____

_____

DESCRIPTION OF ALLERGIC RESPONSE/NATURE OF REACTION: _____

_____

WITHIN THE PAST YEAR HAVE YOU TAKEN PRESCRIBED OR OTHER MEDICATIONS FOR:

Sleep Disturbance? Name: _____ Currently Using? ☐Yes ☐No

Nutrition/Weight Problem? Name: _____ Currently Using? ☐Yes ☐No

Nerves/Anxiety/Depression? Name: _____ Currently Using? ☐Yes ☐No

Pain? Name: _____ Currently Using? ☐Yes ☐No

Recreation/Relaxation? Name: _____ Currently Using? ☐Yes ☐No

Are you taking, or have you taken Antabuse? ☐Yes ☐No

Consumer Signature: _____ **Date:** _____

Consumer Name:_____

Part II – HISTORY TAKING FOR STAFF USE ONLY (Use Additional Sheets if Necessary)

1. SIGNIFICANT PAST ILLNESS, ACCIDENTS, HOSPITILIZATION, and MEDICAL PROBLEMS: _____

2. SIGNIFICANT FAMILY HEALTH HISTORY AND PROBLEMS: _____

3. SIGNIFICANT CURRENT MEDICAL PROBLEMS: _____

4. CURRENT PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use

5. PAST PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use	Adverse Reachtions? (Yes/No)
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

6. OTHER CURRENT MEDICATIONS (Includes Prescription and Non-Prescriptive Drugs):

Name	Strength /Dose	Indication

7. CURRENT USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

8. PAST USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

IF ENTRIES ARE MADE TO EITHER QUESTION 7 OR QUESTION 8, PLEASE COMPLETE DRUG/ALCOHOL ASSESSMENT.

COMMENTS: _____

_____ _____
Clinician Signature Date

_____ _____
Reviewing Physician Signature Date

_____ _____
Reviewing Physician Signature Date

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

NOTICE TO PROSPECTIVE CLIENTS:

This notice will inform you that the counselor with whom you are conferring does not yet have a license as either a Marriage, Family or Child Counselor, or a Clinical Psychologist, from the State of California.

However, this does not mean that your counselor is not competent. Indeed, she/he has been professionally trained to become a counselor, and will be happy to discuss with you her/his training and educational degrees received. What this notice means is that either your counselor has not amassed the number of counseling hours (3,000) required to apply to take the qualifying examinations, he/she is awaiting the results of such examinations, or in the case of a trainee, is finishing his/her masters degree in counseling.

Please be assured that not only is your counselor professionally educated and trained, she/he is also supervised by either a licensed Marriage, Family and Child Counselor or a Clinical Psychologist.

Our intent with this notice is not only to comply with state regulations, but to avoid any implications of licensure when there is only registration.

Please feel free to ask any questions you might have concerning this notice, or about our counseling facilities.

INTERN: _____

REGISTRATION#: AMFT #_____

SUPERVISOR: **Max J Kayes, LMFT**

LICENSE #: **MFC 22998**

Yes, I have read and understand the above information.

Client Name:_____

Client Signature:_____ Date:_____

New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
Serving Southern California since 1985

CLIENT E-MAIL/TEXTING INFORMED CONSENT FORM

Although electronic media is very useful in communicating with your therapist, we wanted you to be informed and aware of the potential risks in communicating with your therapist using Email or Texting.

1. Risk of using email/texting the transmission of client information by email' and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

d. Employers and on-line services have a right to inspect emails sent through their company systems.

e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email and texts can be used as evidence in court.

g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/ Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

Client Name:_____

Client Signature:_____ Date:_____

c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

☐ Yes, I have read the above and consent to unencrypted, but confidential email/text correspondence.

☐ No, I am not interested in email/text correspondence.

E Mail Address: _____
Client name: _____
Client signature: _____Date:_____
Provider name: _____
Provider signature: _____Date:_____