# CLIENT CONSENT AND UNDERSTANDING

***Please read carefully, initial where indicated (___), sign and date at the bottom.***

I understand that full participation in mental health services is essential to the success of the treatment and that my participation is voluntary (___).

I understand that fees are to be paid at the beginning of each session and are my responsibility. The standard professional fees are $150 per 60 minute session. Costs vary in cases of third party payers (___).

I understand that if I fail to keep an appointment or do not give 24 hours notice of appointment cancellation, I will be billed at full cost (___).

I understand that no billing services are available. Fees not paid on the date of service are subject to a $10 billing/late fee. Returned checks are subject to a $25 NSF charge (___).

I understand that I am able to request certain professional services that contribute to the care received and must be done outside of the office visit. These services include letter writing, document completion, telephone conversations, email exchanges, and consultations with other treatment professionals. There are additional fees for the above mentioned services should they exceed 10 minutes in duration, as they are beyond professional office time and outside the scope of insurance covered services (___).

Insurance coverage pays for a standard 50-55-minute office appointment. Sessions that extend beyond this covered benefit will be billed at $25 per additional 15 minutes or portion there of (___).

I understand that all services provided are confidential. I understand that there are exceptions to this, however. Disclosures of suicidal and/or homicidal intent, and child or elder abuse must be reported to the proper law enforcement/governing agency in order to prevent possible harm, and in conjunction with current laws (___).

I understand that service fees, co-payments, deductibles and cancellation fees are my responsibility. I further understand that unpaid balances beyond 120 days will be submitted for collection services and my credit rating may be negatively impacted. Further, I understand that I will be responsible for any costs associated with collecting on my unpaid balance. Utilizing collection services means that my personal information will need to be released to a third party, so that they may perform collection activities. Personal information may include but is not limited to, name, address, phone numbers, employer, social security number and payment history with this office (___).

I understand that should my insurance company deny payment on services that I have received through this office, I am ultimately responsible for the balance. Pursuant to said insurance, I understand that I am responsible for informing the office immediately of any coverage and/or benefit changes. My failure to do so holds me liable and responsible for direct payment to the therapist of any and all denied claim amounts (  ).

For Cal Optima clients- I understand I must provide a 24-hour advanced notice of cancellation. If I'm unable to provide a 24 cancellation notice, or do not attend a scheduled session no charge will result for the missed appointment. However, in compliance with Cal Optima standards, after three such missed appointments our sessions together will terminate and I will be offered resources for alternate service providers (  ).

Eye Movement Desensitization and Reprocessing (EMDR) is an evidenced based practice utilized in treatment, as needed, with client's verbalized consent. EMDR is well researched to support decreasing intrusive thoughts that result from past traumas or disturbing events. During the beginning of the EMDR treatment, you may experience increased thoughts regarding those triggering events. (  ).

**Telehealth services:**

I understand all telehealth services provided will maintain the same client rights to confidentiality, privacy, service coordination, and quality of care as in-person services. (  ).

I understand and agree to meet through a HIPPA compliant software/platform even though there potentially could be a breach in confidentiality due to the use of wireless devices (  ).

Additionally, I understand that no part of our sessions are to be recorder and/or posted on any form of social media for personal or public use without prior written consent. Doing so without written consent by either party can lead to legal ramifications(  ).

Your help in keeping the office schedule running timely and efficiently is greatly appreciated.

*I have read, understand and agree to all of the above.*

_____

_____

*Signature* *Date*