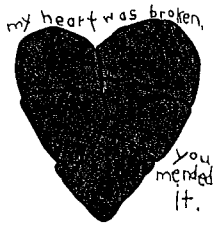


Teletherapy Informed Consent Form

I consent to participate in teletherapy with my assigned therapist (name and title) _____, supervised by (name and title)_____.

1. "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.

2. Teletherapy occurs in the state of CA (USA), and is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist in their CA office, where we meet to do our work. 3. The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.

4. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

5. In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

6. I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above.

_____

Client's Name

_____ _____

Signature of Client (or Legal Guardian if under age 18) Date

CONSENT FOR SERVICES

I, undersigned, am requesting to receive an assessment, counseling and/or home visitation services from the Richstone Family Center's team of service providers. I have received a copy of Richstone Family Center's Client Bill of Rights.

I understand that my counselor may be in training to become a therapist or may be in process of obtaining his/her license as a therapist. If this is the case, he/she will be closely supervised by State-licensed therapist, _____. Name of registered associate/intern/trainee: _____.

CONFIDENTIALITY AND ITS LEGAL LIMITATIONS

I understand that details of what is said during therapy and/or home visits are kept confidential and not released to anyone without my written permission. I understand that in some cases, the State law requires that the service provider make a formal report to the police and/or county authorities. The following are situations, which require such a report:

A. When the service provider has a suspicion or evidence of a child who may be physically or sexually abused, or neglected;

B. When the service provider has reason to believe that a client will harm or injure themselves or others;

C. When a service provider has reason to believe that a dependent adult (age 18-64) or an older person (age 65 or older) may be abused (physically/sexually/financially) or neglected.

The following are other situations, which may result in a release of information:

D. When the client authorizes the service provider in writing to release information to a specific agency or person.

E. When the service provider receives a court-order to release information about your case.

F. When the client is a minor child and a legal parent is requesting information about the child.

I understand that Richstone uses a team approach to providing services, which may require the sharing of information among those providing direct services to my family and me. I understand the team will share only that which is essential to providing the best possible services to my family and me.

NAME OF CLIENT: _____ **Case ID #** _____

SIGNATURE OF CLIENT: _____ **Date:** _____
(or parent/legal guardian if client is a minor)

SIGNATURE OF SERVICE PROVIDER: _____ **Date:** _____
(person who reviewed this form with client)

DATE REVIEWED WITH CLIENT: _____ **CLIENT INITIAL:** _____

SIGNATURE OF ASSIGNED THERAPIST:

_____

RICHSTONE FAMILY CENTER

CLIENT BILL OF RIGHTS

As a client at the Richstone Family Center you have the right to:

- Request and receive full information about the therapist's professional capabilities, including, licensure, education, training, experience, professional membership, specialization and limitations
- Have written information about fees, method of payment, number of sessions, substitutions (in case of vacation or emergency), and cancellation policies before beginning therapy
- Receive respectful treatment that will be helpful to you
- A safe environment, free from sexual, physical and emotional abuse
- Ask questions about your therapy
- Refuse to answer any question or disclose any information you choose not to reveal
- Request and receive information from the therapist about your progress
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case
- Refuse a particular type of treatment, or end treatment without obligation or harassment
- Refuse electronic recording
- Request and in most cases receive a summary of your file, including the diagnosis, your progress and the type of treatment
- Report unethical and illegal behavior by a therapist
- Receive a second opinion at any time about your therapy or therapist's methods
- Have a copy of your file transferred to any therapist or agency you choose

*Note: Entering therapy has many benefits and some risks. One of the benefits is that the problems you are experiencing may be alleviated by your increased coping skills and the changes you are making in your behavior and thinking. Please be aware that one of the risks of therapy is that while you are changing, the important people in your life may not understand the changes. You may wish to further discuss this issue with your therapist.

_____ _____

Client Signature Date

Revised 1/10/02

RICHSTONE FAMILY CENTER

Grievance/Complaint Procedure

A participant(s) of Richstone Family Center (RFC) may disclose their complaint or grievance directly to their service provider. If this approach is not effective and the complaint or grievance left unresolved, the RFC participant(s) should report the facts of the grievance to the service provider's immediate supervisor or to the Clinical Director. A grievance or complaint will be promptly investigated. The investigation will be conducted with sensitivity to the privacy and confidentiality interests of the involved persons. Information will be kept confidential consistent with RFC's need to investigate and arrive at decisions. The participant(s) will be notified within seven business days upon completion of the investigation.

If you have any questions, please contact the Clinical Director, Juliette Stidd, MFT, in writing at 13634 Cordary Avenue, Hawthorne, CA 90250.

.....

Participant's Name

....

Participant's Signature Date

....

Therapist Signature Date

THE RICHSTONE FAMILY CENTER

Financial Information Form

SECTION A

Client/Family:_____

Responsibly Party:_____

Do you have any family members currently receiving counseling and/or parenting classes at the Richstone Family Center? YES NO

SECTION B

The following information should reflect the monthly household income for the party responsible for the payment of services.

____ Earned Income: Wages, Salary, Tips $_____ a month

____ Child Support $_____ a month

____ Spousal Support $_____ a month

____ Workers' Compensation/SDI $_____ a month

____ Veterans' GI/Military Benefits $_____ a month

____ Social Security/SSI $_____ a month

____ Pensions, Retirement Income $_____ a month

____ Welfare, Public Assistance $_____ a month

____ Other $_____ a month
specify:_____

_____ TOTAL: $_____ a month

TOTAL: $_____ a year (= month x12)

SECTION C

I verify that the financial information I have provided is correct and valid. I understand that financial information will be reviewed and updated at least once a year and adjusted accordingly. I understand that this information is used to calculate fees for service.

_____ _____

Responsible Party Date

- Attach a copy (ies) of the responsible party's most recent pay stub or tax return.
- Provide verification of any reported unearned income (check voucher, bank statement, benefit notification letters, etc).

Revised 3/5/02

Payment and Participation Contract

I understand that my fee, as agreed upon will be $_____ per session and that I shall pay this each time I come in. I understand that if I fall four payments behind, a payment plan will be created. If I decline to create a payment plan or do not adhere to it, a four week termination process will be initiated and at the end of that time referrals will be provided to me in the event that I feel further services are warranted.

I, _____ agree to attend all scheduled therapy sessions unless a vital need or emergency prevents my attending. I understand that if I am unable to attend a session, I will call my therapist and cancel at least **24 hours prior to the scheduled appointment**.

I understand that if my financial situation changes, my fee may be adjusted accordingly. If a problem arises in my ability to pay my agreed upon fee, I will notify my therapist immediately.

_____
Responsible Party (Print)

_____ _____
Responsible Party (Signature) Date

_____ _____
Clinical Supervisor Date

Updated September 2016

NOTICE OF PRIVACY PRACTICES

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

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law, and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I 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.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. 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 from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with the Clinical Director, Juliette Stidd, as the Privacy Officer for the agency, and her address and phone number are: 13634 Cordary Ave, Hawthorne, CA 90250; (310) 970-1921 x140.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect in 2019.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that Richstone Family Center has provided to you. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

The Notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a copy of the revised notice from Richstone Family Center by contacting the Clinical Director, Juliette Stidd at (310) 970-1921 x140.

If you have any questions about the Notice of Privacy Practices, please contact the Clinical Director at: (310) 970-1921 x140 or 13634 Cordary Avenue, Hawthorne, CA 90250.

I acknowledge receipt of the Notice of Privacy Practices of Richstone Family Center.

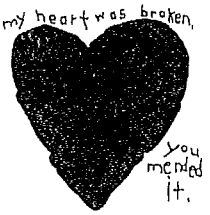
Signature:_____ Date: _____

(patient/parent/conservator/guardian)

Signature:_____ Date: _____

(therapist)

THE RICHSTONE FAMILY CENTER



CONSENT FOR RELEASE OF INFORMATION OR RECORDS

I hereby authorize _____

to disclose records and/or information regarding _____

obtained in the course of his/her diagnosis and treatment to:

_____ _____

NAME OF REQUESTOR AGENCY/ADDRESS

_____

The disclosure of records authorized herein is required for the following purposes:

_____

These records are protected by the California Welfare and Institution Code Section 5328. Disclosure shall be limited to the information indicate below:

- ☐ Diagnosis
- ☐ Diagnostic Evaluation
- ☐ Progress Report
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Other: _____

An additional consent must be obtained for any other transfer or disclosure of information.

This information shall become effective _____ and is subject to revocation
MO/DATE/YEAR

by the undersigned at any time except to the extent that action has already been taken. If not earlier revoked, this consent shall terminate on _____.
MO/DATE/YEAR

The termination date shall not exceed six months from the effective date. I may revoke this authorization in writing at any time, except with respect to information released prior to such revocation.

This authorization gives permission to have information released between the individual (s)/ agencies listed above. I understand that this consent to release information waives any of my rights, currently or in the future, to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information.

_____ _____

Client Signature Date

_____ _____

Witness Date

13634 CORDARY AVENUE / HAWTHORNE, CA 90250 / (310) 970-1921 / FAX (310) 970-1330