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| **Welcome, to Humano Family Counseling, Inc.** |
| We look forward to working with you, but first we recommend you carefully read this document. What is covered here is important information regarding our professional and business policies and how they may affect you as our client. Please, as you read this, make notes about any questions you have so we can discuss them at the first session (intake). Transparency is important to us because it is what makes people feel safe and a vital aspect to facilitating rapport, we want you to have with our agency and your therapist. Once you sign this consent it becomes a binding agreement between us and signifies you accept to begin a therapeutic relationship with us.  Your therapeutic relationship with ***H***umano ***F***amily ***C***ounseling, Inc. (***HFC***) is entirely voluntary, which means you agree to receive mental health assessment, treatment, or services as are considered necessary and advisable by your therapist. A variety of issues, events, experiences and memories will be looked at for the purpose of creating positive change and an opportunity to better and more deeply understand yourself, in addition to, any concerns you may be experiencing. Presenting problem(s) and client’s motivation(s) impact progress, so, it is vital you understand this document and actively participate in the therapeutic process. |
| **Limits of Services & Assumption of Risks** |
| Therapy carries both benefits and risks. Some benefits from therapy are it can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect the therapeutic process. This includes honesty, and a willingness to change feelings, thoughts and behaviors. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions. The process of therapy will at times challenge your perceptions, traditions and offer different perspectives. Additionally, it may result in unintended consequences, including changes in personal relationships. The success of the therapeutic process is dependent on the effort, you and your assigned therapist put forth, and the realization that you are responsible for the lifestyle choices and/or changes that may result from therapy, in other words decisions you make in therapy are always your own. |
| **Treatment Planning** |
| Our therapists make every effort to conduct a thorough assessment within the first few sessions. An overall treatment plan will be developed based on your goals for therapy. Our therapists strive to understand both your short- and long-term goals for therapy and develop a comprehensive treatment plan for you. However, this is your treatment plan and at any point in the therapeutic process, we invite you to let your therapist know of any questions and/or concerns you are having, so the adjustments you need are implemented. |
| **Number, Fees, & Length of Sessions** |
| The number of sessions depends on many elements, which your therapist will be discussing with you.However, psychotherapy works best when sessions are weekly, with no less than 3 sessions a month. Therapy sessions are approximately 45-50 minutes in length and the psychotherapy fees **$125.00** for individual sessions.    Unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans. When co-payments are applicable, they cannot be waived as provided by law. ***Payment, co-payment, co-insurance, deductibles are all payable at the time of services.***  If you pay by check and it is returned, you will be charged a **$35.00** fee for any **returned check**.  A debt on which payments have not been made by a client for over 60 days will be turned to collection agency as provided by *California Law, Evidence Code Section 1020 regarding breach of duty*. |
| **Administrative Fee** |
| We do charge an ***Administrative Fee*** for our time ($60/hr., pro-rated) when filling out paperwork (not for insurance) or producing documentation and/or letters. Additionally, a copying fee ($.05 per sheet), and costs of postage if you want the copies mailed to you. |
| **Cancelation & Rescheduling Policy** |
| Psychotherapy works best when sessions are weekly, with no less than 3 sessions a month. Your therapist may suggest a different frequency which they will take into consideration the nature and severity of your concern(s). Regular attendance has an impact on the outcome of therapy. In order to cancel or reschedule an appointment, you are expected to notify your therapist 24 hours prior to the appointment.  ***HFC*** dedicated therapists who will do their best to work with your scheduling needs and reserve a weekly session time. Please, be aware of our No-Show/Late Cancellation & Attendance Policies.   |  | | --- | | **No-Show/Late Cancellation Policy** | | If a client does not inform their therapist 24 hours prior to their sessions, is 15 minutes late, or does not show up, a **No-Show/Late Cancellation of $75.00** will be charged on the credit card we have on file for you. If you have insurance, please be advised that insurance companies do not pay for missed or cancelled sessions and we cannot bill for a full session if it is less than 45 minutes. | | **Attendance Policy** | | If a client does not show-up for 3 Consecutive Scheduled Appointments, treatment will be terminated and the client will be financially responsible for the No-Show/Late Cancellation Fee.  Client will be allowed ***6 Cancellations* (including no-shows/late & advance notice cancellation)** per calendar year, at which point a 6+ Cancellation Fee (our *Regular Fee*) will be charged on your credit card. |   Please, be mindful your appointment time is specifically reserved for your needs and if our therapists are not informed in a timely manner and/or there are too many cancellations, our therapists are not available to see other clients. We will do our best to reschedule you for the same week, but this is may not be possible. It is important you understand this and work closely with your therapist regarding scheduling appointments.  Sometimes, our therapist may need to cancel or reschedule, on those rare situations; we will not charge any fee for sessions cancelled. |
| **Records & Recording Keeping** |
| ***HFC*** therapists may take notes during sessions. These notes constitute HFC clinical and business records, which by law, we are required to maintain. Such records are ***HFC*** sole property. We will not alter our normal record keeping process. Should you request a copy of our records, such request MUST be made in writing. We reserve the right, under California law, to provide you with a Treatment Summary in lieu of actual records. |
| **Exception to Confidentiality** |
| During the course of treatment, all communications between you, your therapist and any of our staff will be held in strict confidence unless you provide written permission to release such information. Exceptions to confidentiality, include, but are not limited to ***Exceptions to Confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, if you make a serious threat of violence towards a reasonably identifiable victim, or if you are dangerous to yourself or the person or property of another*.** |
| **Other Exceptions to Confidentiality** |
| These other rare circumstances in which a psychotherapist breaks confidentiality these are court order, investigation by a board, commission, or administrative agency, subpoena from the court (Judge), legal request from an arbitrator or arbitration panel, search warrant, coroner’s investigation of a deceased client.    There are times when it may be appropriate to consult, collaborate with other mental health and/or medical providers. We may even have to refer you to a physician, other healthcare professional, and/or other community resources in order to improve and protect the health & welfare of our clients. In these cases, your personal information is never be revealed, unless you give us written consent. |
| **Referrals** |
| If you are referred to a physician, other healthcare professional, and/or other community resources, or you have been referred to ***HFC,*** be advised that we do not accept or offer payment for referrals, whether in the form of money or otherwise. It is up to you, if you choice to accept or decline a referral made by your therapist and/or our staff. |
| **Psychotherapist-Client Privilege** |
| Typically, the client is the holder of the psychotherapist-client privilege. If ***HFC*** receives a subpoena for records, deposition testimony, or testimony in a court of law, we will assert the psychotherapist-client privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. |
| **Client Litigation** |
| ***HFC***psychotherapists do not willingly participate in any litigation, or custody dispute in which you, your representative and another individual, or entity, are parties. ***HFC*** has a strict policy of **not communicating** with client’s attorney and we will generally not write or sign letters, reports, declarations, or affidavits to be used in in regard to client legal matter.  Should ***HFC*** or our psychotherapists be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse us for any time spent for preparation (***Administrative Fee***), travel, or other time in which has made to be available for such an appearance at the usual and customary hourly rates will apply. |
| **Mediation & Arbitration** |
| All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator should be a neutral third party chosen by agreement between ***HFC*** and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, CA, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand is filed. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum for attorney’s fees. In the case of arbitrations, the arbitrator will determine that sum. |
| **Telephone & Emergencies** |
| There may be times when we or your therapist may need to communicate with you by telephone, especially on the rare occasion we need to cancel or reschedule an appointment. Receiving telephone calls are offered as a professional courtesy and will be answered by ***HFC*** within 48 hours (Monday-Friday, between 9am -5pm), but this service does not constitute a mental health emergency service. ***HFC*** is not responsible for any behaviors occurring outside the consultation room at any given time, whether before or after a telephone call or consultation. Please, be advised if our conversation goes beyond 5 minutes, you may be charged for our time and customarily insurances do not pay for this service.  If you are experiencing a crisis and need to contact us between sessions, please leave a message on our voicemail: **626-722-2143**, however, keep in mind we answer calls as stated above. Occasionally, we can schedule additional sessions in a week, if needed. **If you experience a mental health emergency and require immediate assistance, please call 911 or go to the nearest emergency room.** Please, note most insurance plans cover weekly psychotherapy sessions, only. Clients who need regular support with crisis services and/or sessions more than once per week may need to be referred to a higher level of care.  You should also be aware of the following resources that are available to assist individuals who are in crisis:  National Hope-Line Network 1-800-442-HOPE (4673) Suicide & Crisis Hotline 1-800-999-9999  National Suicide Prevention Lifeline 1-800-273-TALK (8255) Mental Health Help 24/7 1-800-854-7771  Domestic Violence 1-626-967-0658 |
| **Electronic Communication** |
| ***HFC*** cannot guarantee the security of online, email or other electronic forms of communications. Potential risks of using electronic communication may include but are not limited to; inadvertent sending of an email or text having confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device, storing confidential information and interception by an unauthorized third party through an unsecured network. Emails may contain viruses or other defects and it is your responsibility to ensure it is virus-free. In addition, emails or texts may become part of the clinical record. Therefore, we limit emails and texting with clients to matters pertaining to scheduling. From time to time we may email you forms we need updated or psychoeducational information, especially if this information was deemed helpful during session. We do respond to emails within 48 hours. Be advised an ***Administrative Fee*** may be charged for the time spent reading and responding to emails. |
| **Testimonials** |
| You may find ***H***umano ***F***amily ***C***ounseling, Inc***. (HFC)*** on websites such as ***Health Grades, Yahoo Local, Yelp***, or other places that list businesses. Some of these websites may include forums in which users rate their providers and add reviews. Many of these sites explore search engines for business listings and automatically add listings regardless of our policies. If you find ***HFC*** on these sites, please be aware ***HFC*** does NOT request testimonial, rating, or endorsement from our clients.    According to the American Counseling Association’s Ethical & Professional Standards states*,* ***“It is unethical for mental health professionals to solicit testimonials of any kind from their clients.”***  If you chose to write a review on these websites, whether it be positive or negative, we will NOT respond as we are committed to keeping your identity confidential and upholding the ethical standards of our profession.  If any of our psychotherapists have done anything making you feel uncomfortable, we urge you to discuss this with them directly. If for whatever reason, you do not feel comfortable directing your concerns with your therapist, or have expressed your concerns and are still dissatisfied; please call our office and the Clinical Director or Program Coordinator will call you in hopes to resolve your concerns. You also can contact the ***Board of Behavioral Sciences***, which is the agency overseeing the licensing for Marriage Family Therapists, Social Workers, and Professional Clinical Counselors. |
| **Dual Relationships** |
| Therapy never involves sexual or business relationships and/or any other dual relationship which may impair the therapist’s objectivity, clinical judgment, or therapeutic effectiveness. Thus, our therapists are encouraged not to have contact with current or former clients via personal social media (*i.e.,* Facebook, LinkedIn, etc.). However, we do invite you to friend us on our ***HFC*** Facebook, to stay current to new and exciting things we are doing to help the community or to get some psychoeducational information. You may encounter your therapist or our staff outside of the office; your confidentiality is a serious matter to ***HFC***, this means, your therapist or our staff may not even acknowledge you. If this is a concern, we encourage you to discuss this with the therapist working with you. |
| **Medication & Physical Health Issues** |
| None of the therapists working for ***HFC*** are medical doctors, therefore are not able to prescribe medication, as this is outside of our scope of practice. However, with your written consent, our therapists may consult with your physician or healthcare provider regarding your mental health conditions and/or treatment. It is advisable for all potential new clients who have not had a full medical exam within the last year, to make an appointment with their physician or healthcare provider, as many health conditions, may seem to be mental health issues. |
| **Teletherapy** |
| *In California, “Teletherapy” (Telehealth/Telemedicine) is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites*. This form of service is usually live videoconferencing through a personal computer with a webcam. Teletherapy also involves the communication of medical/mental information, both orally and visually, to health care practitioners located in California.  This form of therapeutic intervention is relatively new, therefore not a lot of research indicating its effectiveness has been established. An important part of being in therapy is sitting face-to-face with an individual, where non-verbal communication (body language) is readily accessible to both therapist and client. Consequently, without this information, teletherapy may result in slower progress and/or be less effective. Therefore, if your psychotherapist believes you would be better served by another form of psychotherapeutic services (e.g. face-to-face services) you will be referred to a psychotherapist who can provide such services in your area.  At the start of each Teletherapy sessions, your therapist will ask for your physical location at that moment. If you are located outside the State of California, your therapist will not be able to provide services, you will be responsible for the full cost of the session and it will be included as one of your 6 Cancellation Sessions. Our therapists are licensed in the state of California, which means *both client and therapist must be in California* at the time of service. |
| **Termination of Therapy** |
| ***HFC*** reserves the right to terminate therapy at our discretion***.*** *Reasons for termination are untimely payment, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy on a regular basis, client is not making adequate progress in therapy, and client’s needs are outside of therapist’s**scope of competence or practice.*  *Conditions such as substance addiction may require other types of treatment and/or referrals. Clients also have the right to terminate therapy at their discretion. Customarily, the length of your treatment and the timing of the eventual termination of treatment depend on the specifics of the treatment plan and progress. As the time of completion approaches collaboration on termination of therapy will be discussed. You may discontinue therapy at any time and either of us may elect to initiate a discussion of treatment alternatives including referral, changing your treatment plan or termination. We recommend clients participate in at least one, or more, termination sessions. These sessions are to facilitate a positive termination experience and give both parties an opportunity to reflect. Our therapist will also attempt to ensure a smooth transition to another therapist or related professional service, if this is needed.* |
| **Insurance** |
| If you are planning to use your health insurance to pay for services, please let us know prior to your first session. Insurances have specific reimbursement amounts, co-payments, co-insurances, and deductibles which depend on your plan. Please, be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. It is your responsibility to verify and understand the limits of your insurance coverage. Our team will be happy to assist your efforts to seek insurance reimbursement. However, ***HFC*** cannot guarantee whether your insurance will provide payment for the services provided to you. Please, inform your assigned therapist about any questions and/or concerns related to your insurance so that we can try to get our staff to help you figure these issues out. Also inform your therapist if you are unable to continue to pay for your sessions so we may help you consider any options available to you. Additionally, insurance or other third-party payers are given information that they request regarding services to the clients. (The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.), which is an exception to confidentiality. |
| **Assignment of Benefits** |
| We will communicate with and work with your health/medical insurance for you. HFC will be assigned all medical and psychological benefits from insurance. ***HFC***, Inc. will release information necessary for payment to the paying agency. Your insurance carrier(s), will issue payment directly to ***HFC*** for services. If your care is not covered by insurance and, at any time during treatment, you become ineligible for coverage as deemed by your insurance company, you will be responsible for 100% of the bill. It is thus important you are aware of, and notify us of any changes that may occur in your insurance plan while in treatment. Additionally, if within 60 days of services rendered, insurance has not reimbursed ***HFC***, the balance will be due, and you may seek reimbursement from your insurance. |

This page only needs to be signed and brought or sent prior to your 1st sessions (intake) via email to [info@humanofamilycounseling.com](mailto:info@humanofamilycounseling.com). The rest of this document is for you to keep for your records.

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| **Client’s Name** | **Date of Birth** |

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| **Teletherapy Clients Only** |
| By signing you acknowledge understand the risks and consequences from teletherapy (telehealth/telemedicine), including, but not limited to, the possibility, despite reasonable efforts on the part of your psychotherapist, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons.  🖌   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Signature** |  | **Date** |  | **Print Parent’s Name** |  | **Date of Birth** | |

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| **Type of Therapy:** | **Individual** **Child**  **Dependent Adult** | | | | | | |
| **Acknowledgement** | | | | | | | |
| By signing, you acknowledge you have reviewed and fully understand the terms and conditions of this ***Consent to Treatment & Limits of Liability form***. You have discussed such terms and conditions with your psychotherapist or ***HFC*** staff and have had any questions answered satisfactorily. You agree to abide by the terms and conditions of this consent to participate in psychotherapy. Moreover, you, as the Client or Representative agree to hold HUMANO ***Family Counseling, Inc***. free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.  🖌   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Signature** |  | **Date** |  | **Print Parent’s Name** |  | **Date of Birth** | | | | | | | | |
| **Office Use ONLY:** | |  |  |  |  |  |  |
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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Form/Information** | **Given** | **Declined** | **Date** | **Initial** | | **Consent to Treatment & Limits of Liability Form** | **🗸** |  |  | *Sent via email/online* | | **Notice of Private Practice** | **🗸** |  |  | *Sent via email/online* |   **Witnessed by:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | M. Lourdes Tapia, MA, LMFT |  | 🖌  ***MLTapia*** |  |  | | **Print Witness/Therapist’s Name** |  | **Witness/Therapist’s Signature** |  | **Date** | | | | | | | | |
| **Inability to obtain ACKNOWLEDGEMENT**  To be completed only if signature is **not** obtained. Please check box which applies:  Client /Parent have refused to sign  Describe the ***Good Faith*** effort to obtain client’s acknowledgement, and the reason(s) why it was not obtained   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | | | | | | |  | | | | | | |  |  | 🖌 |  |  | | **Print Witness/Therapist’s Name** |  | **Witness/Therapist’s Signature** |  | **Date** | | | | | | | | |

*Confidential Information | California W&I Code 5328*