Agoura Hills Counseling
Danielle Ciccone, Licensed Professional Clinical Counselor #4677
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Informed Consent Form for Outpatient Psychotherapy Treatment (Child or Adolescent)

QUALIFICATIONS OF PSYCHOTHERAPIST: Danielle Ciccone is a Licensed Professional Clinical Counselor (#4677) who is licensed by the California Board of Behavioral Sciences (BBS) with requirements as specified in Business and Professional (B&P) Code Section 4999.20. Danielle Ciccone holds both Bachelor of Science and Master of Science degrees in the field of Psychology. You are free to ask questions at any time about your therapist's education, experience and professional orientation.

I have reviewed, understand, and agree to the qualifications of the psychotherapist.

Client Initials _____

Parent/Guardian Initials _____ _____

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

> Information may be released to designated parties by written authorization of client or parents/legal guardians.

> When clients seek reimbursement for psychotherapy from insurance companies or other third parties, information, including psychological diagnoses, must be provided to the third party. In many cases, explanations of symptoms and treatment plans and, in rare cases, entire client records are also included. If health coverage is provided by an employer, the employer may have access to such information. Insurance companies usually claim to keep psychological diagnoses confidential, but may enter this information into national medical information databanks, where it may be accessed by employers, other insurance companies, etc., and may limit future access to disability insurance, life insurance, jobs, etc. Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purpose of treatment and payment. Your therapist has no control or knowledge over what insurance companies do with the information or who has access to this information.

> Psychotherapists are required to release information obtained from clients or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, and spouses) to appropriate authorities to the extent to which such

disclosure may help to avert danger to a psychotherapy client or to others, e.g., imminent risk of suicide, homicide, or destruction of property that could endanger others.
> Psychotherapists are required to report suspected past or present abuse or neglect of children, dependent adults, and elders to authorities, including Department of Children and Family Services or Child Protective Services, and law enforcement, based on information provided by the client or collateral sources.
> Others involved in a client's therapy are not therapy clients and have no therapist-client confidentiality.
> If clients participate in psychotherapy in compliance with a court order, psychotherapists are required to release information to the relevant court, social service, or probation departments.
> Psychotherapists are required to provide information in response to court orders and, in some cases, to subpoenas. In some kinds of proceedings, courts order the entire psychotherapy record to be provided.
> Psychotherapists often consult with other professionals on cases and teach or write about the psychotherapy process, but disguise identifying information when doing so. Please indicate to your therapist if you wish to place restrictions on consultation, teaching, or writing related to your case.
> Clients being seen in family work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment, therefore clients under 18 cannot be assured of unconditional confidentially from their parents.
> Cell phone text message communications can be intercepted by third parties. This form of communication is reserved for urgent or time-sensitive matters and scheduling concerns, mostly. Please do not send any personal or confidential information via text message as I cannot guarantee the confidentiality of these communications, though I do my best to protect the information in my cell phone using a passcode.
> Because of the nature of the Internet, confidentiality cannot be assured in un-encrypted e-mail messages; therefore your use of such forms of communication constitutes implied consent for reciprocal use of electronic mail.
> Telemental health therapy sessions are available when necessary and your therapist utilizes a HIPAA compliant web platform to conduct these sessions in order to protect confidentiality.

I have reviewed, understand, and agree to the stated policies regarding confidentiality.

Client Initials _____

Parent/Guardian Initials _____ _____

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Please refer to the HIPAA Notice of Privacy Practices with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about

your case to your health plan for certification, claims, and case management for the purposes of payment and treatment. Danielle Ciccone has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. Please be aware that submitting a mental health invoice for reimbursement carries a risk to privacy, confidentiality or to future capacity to obtain life or health insurance.

I have reviewed, understand, and agree to the stated policies regarding health insurance and confidentiality of records.

Client Initials _____

Parent/Guardian Initials _____ _____

EMERGENCIES: You may telephone your therapist in an emergency. Your therapist is not always immediately available by phone and may not be available in the late evening. If unavailable, your call will be returned as soon as possible. If your therapist is unavailable and you have an emergency, you should call 911; telephone a crisis line; or proceed to a psychiatric emergency facility. **For emergency/crisis team services call: Los Angeles County - (800) 854-7771, Ventura County - (800) 671-0887**.

I have reviewed, understand, and agree to the stated policies regarding emergencies.

Client Initials _____

Parent/Guardian Initials _____ _____

TREATMENT FEES: Payment for service is made at the start of each therapy session at the agreed upon fee determined by therapist and client, which is ***$125 per 55 minute session***. If necessary, any other services requested from therapist that are initiated by you or others relating to your case are billed at **$125 per hour**, including written letters, reports, written testimony, other written documents, meetings, and phone consultations.

I have reviewed, understand, and agree to the stated policies regarding psychotherapy and related services fees.

Client Initials _____

Parent/Guardian Initials _____ _____

SUBPOENA/COURT APPEARANCE: The client is responsible for all fees (*$1,500.00 a day*) incurred if Danielle Ciccone, LPCC is called to court for a legal case related to the client. This includes, but is not limited to, subpoenas by council representing client, mother, father, legal guardian, Department of Children and Family Services or Child Protective Services, minor's council, or other specified person/agency. Fees will be paid in full before court appearance.

I have reviewed, understand, and agree to the stated policies regarding subpoenas/court appearance.

Client Initials _____

Parent/Guardian Initials _____ _____

ARBITRATION/MEDIATATION AGREEMENT: Please address any grievances that you may have directly with your therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. *By signing this contract you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.* It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently rendered, will be determined by submission to arbitration as provided by California law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures.

I have reviewed, understand, and agree to the stated policies regarding arbitration/mediation.

Client Initials _____

Parent/Guardian Initials _____ _____

CONSULTATION: Your therapist consults regularly with other professionals regarding clients; however, client's name and other identifying information are never mentioned. Your therapist is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the laws of the state of California governing the practice of psychotherapy and she is liable for infractions of those standards.

I have reviewed, understand, and agree to the stated policies regarding consultation.

Client Initials _____

Parent/Guardian Initials _____ _____

PSYCHOTHERAPY AND EVALUATION: Psychotherapy is both a way of understanding human behavior and of helping people with their emotional difficulties and personal problems. Psychotherapy typically starts with an assessment of problematic symptoms and maladaptive behaviors that often intrude into a person's social life, personal relationships, school or work activities, and physical health. Specific psychotherapeutic strategies may be employed to alleviate specific problems causing distress such as depression, anxiety or relationship problems. Self-knowledge is seen as an important key to changing attitudes and behavior. Psychotherapy may involve the development of insight as to how our physical health may be compromised in many ways by emotional and relationship issues. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to one self and to others. Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. These feelings are important because elements of one's history of important affections and hostilities toward parents and siblings or significant others are often shifted onto the therapist and the process of therapy. Psychotherapy can be relatively short-term (8-16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities.

I have reviewed, understand, and agree to the stated policies regarding psychotherapy and evaluation.

Client Initials _____

Parent/Guardian Initials _____ _____

SOCIAL MEDIA: Your therapist does not directly communicate with current or former clients on any social networking sites (Facebook, Instagram, LinkedIn, etc) because doing so can compromise confidentiality and privacy. Your therapist does, however, utilize some social networking sites as platforms to provide mental health resources to the general public and clients are welcome to view these resources.

I have reviewed, understand, and agree to the stated policies regarding social media.

Client Initials _____

Parent/Guardian Initials _____ _____

MISSED APPOINTMENTS/CANCELLATIONS: Please understand that your psychotherapist reserves an appointment time for your. ***By signing this contract, you agree to call 24 hours in advance if you must cancel a session in order to allow your therapist to reschedule her time. If you provide less than 24 hours notice of a cancellation, unless a sudden medical emergency has occurred, you will pay the agreed upon regular session fee of $125. If you miss an appointment without contacting your therapist at all, you will pay the agreed upon regular session fee of $125.***

I have reviewed, understand, and agree to the stated policies regarding missed appointments/cancellations.

Client Initials _____

Parent/Guardian Initials _____ _____

TERMINATION: The decision to terminate therapy belongs to the client, although one may evaluate this with one's therapist. It is critical that you have a final psychotherapy session before terminating therapy. If at any point during psychotherapy your therapist assesses that she is not effective in helping you reach the therapeutic goals, course of treatment and the possible need for termination will be discussed with you. In such a case, you will be given a number of referrals that may be of help. If at any time you want another professional's opinion or wish to consult with another therapist, you will be assisted in finding someone qualified, and if your consent has been given, your therapist will provide the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will offer to provide you with names of other qualified professionals whose services you might prefer.

I have reviewed, understand, and agree to the stated policies regarding termination.

Client Initials _____

Parent/Guardian Initials _____ _____

I have read this informed consent form completely and have raised any questions I might have about it with the therapist. I have received full and satisfactory response and agree to comply with all items freely and without reservations.

_____

Client Printed Name **Client Signature** **Date**

Address: _____ **City, State, Zip**:_____

Phone: _____ **Email**: _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

Address: _____ **City, State, Zip**:_____

Phone: _____ **Email**: _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

Address: _____ **City, State, Zip**:_____

Phone: _____ **Email**: _____