Spring to Autumn
Family Counseling

Consents and Policies for Treatment

CLIENT IDENTIFYING INFORMATION

CLIENT'S NAME: DOB:

ADDRESS: CITY: ZIP:

HOME #: _____ CELL #: _____

MAY WE LEAVE A VOICE OR TEXT MESSAGE: _____

EMAIL ADDRESS: _____ Social Security #: _____

STATUS:
SINGLE _____ MARRIED _____ DOM. PART. _____ DIVORCED _____ WIDOW/ER _____ SEPARATED: _____ OTHER _____

JOB STATUS:
EMPLOYED _____ UN-EMPLOYED _____ STUDENT _____ OTHER _____

SCHOOL NAME: _____ GRADE LEVEL:_____

IF MEDI-CAL, LIST YOUR #: _____

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT: _____ RELATIONSHIP TO CLIENT: _____

ADDRESS:

HOME #: _____ CELL #: _____

PARENT/GUARDIAN INFORMATION (if applicable)

NAME OF PARENT/GUARDIAN 1: _____ DATE OF BIRTH: _____

ADDRESS:

HOME #: _____ CELL #: _____

MAY WE LEAVE A VOICE OR TEXT MESSAGE: _____

NAME OF PARENT/GUARDIAN 2: _____ DATE OF BIRTH: _____

ADDRESS:

HOME #: _____ CELL #: _____

MAY WE LEAVE A VOICE OR TEXT MESSAGE: _____

1740 Plum Lane, Suite B ~ Redlands, CA ~ 92374
Office Line: (909) 557-6574 ~ Text Line: (909) 375-8696 ~ Fax Line: (909) 363-9202
wethey@springtoautumn.com

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INITIALS
_____ Initial here to **authorize the release of Private Health Information** to the insurance company for billing purposes and referrals for authorization. _____ Initial here to **accept responsibility for payment** of $_____. _____ Initial here to **accept responsibility for any services not covered or denied** by insurance company. _____ Initial here to accept the risks of using T**ele-Mental Health** (phone or online therapy) for treatment as needed. _____ Initial here if you understand the **confidentiality and communication policy**. _____ Initial here if you understand the **Cancellation Policy**. _____ Initial here if you understand the **Privacy Practices Policy**.
SIGNATURES OF CONSENT
By signing below I am requesting enrollment of myself OR my child in Mental Health Counseling through Spring to Autumn Family Counseling**. I understand the policies and information listed above.** **For Minors: I have at least 50% legal custody of the minor** named above and have the right to make medical decisions.
CLIENT'S SIGN: _____ DATE: _____ PARENT SIGN: _____ DATE: _____

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WHAT IS THERAPY?

Therapy is a form of treatment to help reduce the frequency, intensity and duration of mental health symptoms. Your therapist will create an individualized treatment plan to help guide you on reducing symptoms and meeting whatever goals you create in the session. There are no guarantees and you have the right to end your counseling at any time, with the exception of payment of fees for services already provided. Spring to Autumn reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or re-evaluation of your therapeutic needs, and our ability to address those needs, or other circumstances that lead us to conclude that your counseling needs would be better served at another counseling facility. Under such circumstances, we will suggest an appropriate alternative counselor or counseling agency.

CONFIDENTIALITY AND COMMUNICATION POLICY

Communication between you and your counselor is **confidential**. This means that your counselor will not discuss your case verbally or in writing without your expressed written permission. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:

1) If there is a reason to suspect there is or was an occurrence of child, elder, or dependent adult abuse or neglect.
2) If there is reason to believe that you have serious intent to harm yourself, someone else, or property.
3) If you introduce your emotional condition into a legal proceeding.
4) If a court of law subpoenas your records.

In regards to communications with parents/guardians of minor clients: Your therapist will keep the specifics of what you share private. Therapists can share general treatment information and progress or lack thereof. There may be a few exceptions to what stays private. If your child is involved in high risk behavior that becomes dangerous, then the therapist will use professional judgment to decide whether to inform the parent/guardian.

COURT ORDERS AND CUSTODY FOR MINORS

For Minors: Parent signing must have at least 50% legal custody and be able to make decisions about mental health for their child. **If a court order** is in place for mental health counseling, please provide a copy or show a copy to the therapist for our records and to ensure that we are following any court orders. If the order states that both guardians must agree on a therapist for therapy, then treatment can only begin after both guardians have signed this form. **We encourage both parents having legal custody to participate** in their child's therapy, however it is not the responsibility of our therapists to seek out the other parent. Please provide the other parent with our contact information so that they may ask questions and/or set up time separately to meet with our therapist.

FEES

Your fees will be explained before treatment begins and collected upon check in, prior to your therapy session. **You are responsible for the entire dollar amount if Insurance does not cover services rendered**. We may suspend therapy if services are rendered and not paid for after two sessions.

TELE-MENTAL HEALTH AND VIDEO CONFERENCING

If you are unable to physically attend session, it is up to your therapist's discretion whether to offer tele-mental health therapy instead. This 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 I have the following rights: (1) To withhold or withdraw consent at any time without affecting my right to future care or treatment. (2) The same laws of confidentiality for therapy apply to telemedicine. 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 therapist, that: the transmission 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.

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PRIVACY PRACTICES, GRIEVANCE POLICY AND REQUESTS

During the course of treatment **it is often necessary to use and disclose your private health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office**. The use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. **When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment.** You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but we are not obligated to agree to these suggested restrictions.

If you have any **grievances** with therapists during the course of treatment please contact your Insurance Provider, member services or ask your therapist for a grievance form and one will be provided within 3 business days. If you request a copy of records, a labor and printing charge will apply (.25 cents per page). If a progress report is requested, one can be provided at the discretion of the therapist for an additional fee of $25.00. Documents will be ready within 5 business days of receipt of written request.

APPOINTMENTS AND CANCELLATIONS

Appointments are **approximately 45 minutes in length depending on insurance benefits**, and typically take place on a weekly basis. If you have **not arrived for your appointment after 15 minutes, your therapist may reserve the right to cancel the appointment**. The appointment begins at the agreed upon time, and your session will end on time whether or not you began session late. Any appointments **cancelled within 24 hours of the appointment may be assessed a cancellation fee of $60,** per occurrence or the max co-pay if insurance based client.

A**fter 2 last minute cancellations within a 60 day period**, your therapist may give your weekly time slot away. After 3 last minute cancellation you may be discharged from services. If you are unable to keep an appointment, please cancel as soon as possible. IF there is no contact between you and this office after 60 days you may be discharged unless you have an arrangement with your therapist.

EMERGENCIES

Spring to Autumn **does not provide childcare** and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. Children under the age of 12 may not be left without supervision in the waiting room. If you or your child has **had fever or vomiting within 24 hours** of the appointment, please reschedule for a different day.

We do not offer Urgent/Emergency Services. If you call the office to speak with your therapist, you may not get a response until the next business day. Our staff are generally available between the hours of 9am and 7pm mon-fri. **If you are having an Emergency, call 911, go to the nearest emergency room, call Suicide Prevention Hotline: 1-800-273-8255 or Mobile Crisis Unit: 909-421-9233.**