# *Lorraine Weiner, LMFT*

## Informed Consent:

## General Information & Services Agreement

Welcome to my practice. This document contains information about my services and policies, and summary information about the Health Portability and Accountability Act (HIPPA). This federal law protects client rights regarding use and disclosure of Protected Health Information (PHI). HIPPA requires that I explain my privacy practices and limits, and that I obtain your signature acknowledging that I have provided you with this explanation and have your consent to use your PHI as specified.

CONFIDENTIALITY AND ITS LIMITS:

The law protects privacy of communication between a client and a therapist. In most situations, I will not release any information about your treatment to others unless you sign a written Authorization for Release of Information. However, at times I am permitted or required by law to disclose information without consent or authorization:

- The client presents a danger to self.
- If a client communicates a serious threat of physical danger to others.
- Where child/elder/dependent adult abuse is suspected.
- I may release information, upon request to the non-custodial parent of children under the age of 18.
- I may release information to parents, if the client is a minor under the age of 14.
- Where the client has filed a lawsuit in which a claim is made of mental or emotional damages.

In couples therapy I have a "no secrets" policy which means that I will not agree to hold secrets on any one partner's behalf. If you feel something should not be shared with your partner, please do not discuss it with me.

Disclosures may be required to health insurers or collection agencies to collect agreed upon or overdue fees. In instances where insurance does not pay any benefits, you will need to pay for the service. If payment is not received within 90-days from the date the claim was submitted, you will become responsible for the full amount of the balance of the account. If you choose to break the financial agreement, I may release your name for collection purposes. If legal action is necessary, the costs will be included in the claim.

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Prior Authorization: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s). Initial here _____

Missed Appointments: Your appointment time has been reserved exclusively for you. **Insurance does not cover late cancelled or missed appointments**. If you fail to cancel your appointment with at least 24 hours advance notice, you will be charged the session fee. Initial here _____

Contacting Me: I typically respond on business days and not weekends, unless your situation requires my immediate attention. Please keep in mind that the most confidential way for us to communicate is during our sessions and in my office. If I will be unavailable for an extended time, I will provide you with the information of a colleague to contact in case of emergency. Initial here _____

Emergencies: For cases of suicide, or other life and death emergencies when you are unable to reach me and feel that you can't wait for me to return your call, please call 911. You also can call the San Diego County 24-hour Crisis Team at 1-888-724-7240. Initial here _____

Phone Calls: If I am not immediately available by telephone, you may leave a confidential message for me at (619) 417-7176. My voicemail will take your call 24 hours a day/7 days a week. I retrieve and return messages Monday through Friday. Messages left after 5 P.M. will be returned as soon as possible, and most likely, by the end of the following business day. Initial here _____

Text Messages: The response time for texts is the same as phone calls. Text messaging's intended use is for responding to a quick question (for example: "May I move my appointment time?" or "I need to cancel my appointment"). It is for general questions but NOT for sensitive clinical information. Initial here _____

Emails: Using email may be used at your request but please know that the maintenance of your confidentiality cannot be guaranteed through email and sending messages containing confidential information is not advised. If you have more than a brief question, I suggest that we talk about it when we meet rather than use email. Initial here _____

Professional Fees: The fee for paying for services by cash is $130 per 50 minute session. A sliding fee scale may be available and is adjusted to your income throughout the course of therapy. We will begin at a rate to be determined prior to your first session. Payment is due at the time of service. Services involving additional fees include: report writing, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **Phone calls and letters/records are not billable to insurance**. You will be given an hour free for consultations with others involved in treatment (i.e., school teachers and counselors, other therapists, doctors). After the hour is

used, you will be charged for my time at a rate of $40/30 minut. Please note that I will charge a $25 service fee for all returned checks. Initial here _____

Insurance Reimbursement: I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, however, **you (not your insurance company) are responsible for full payment of my fees. It is your responsibility to understand your coverage plan and request authorization prior to services, if deemed necessary by your insurance company**. Initial here _____

Client Rights: HIPPA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your record; requesting an accounting of most disclosures or protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your record; and the right to a paper copy of this agreement along with the attached form. Initial here _____

**Legal/Court Involvement**: **If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings.** This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues. If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. Initial here_____

Termination: Termination of therapy is inevitable. Sometimes this is because the issues that you initially sought help from me for are resolved to your satisfaction. Other times, you or I may decide that your needs might be better served if you were to work with another provider. You will always retain the right to request changes in treatment or to refuse treatment at any time. Initial here_____

Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in relationships or temporary worsening of their symptoms. You may find it unpleasant to talk about negative experiences during the course of therapy. These are common feelings shared by many people and should subside as the work progresses. Please feel free to share these experiences so that we may better work together, as I am open to receiving both negative and positive feedback from you.

# *Lorraine Weiner, LMFT*

In signing below, I agree to be treated by Lorraine Weiner, LMFT. I understand that I am financially responsible to Lorraine Weiner, LMFT for all services whether or not covered by insurance. I authorize the release of medical information necessary to process claims for services rendered by Lorraine Weiner, LMFT. I authorize payment of medical benefits directly to Lorraine Weiner, LMFT. These authorizations shall remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

Thank you for taking the time to review this information. I look forward to working with you.

_____ _____

Client or Representative Signature Date

_____

Printed Name of Client or Representative

If you are an adult who is signing on behalf of a minor or dependent, please indicate the name of the child or dependent and his/her age.

_____ _____

Child's Name/Age Date

*777 S. Highway 101 Suite 123 Solana Beach, CA 92075*
*(619) 417-7176 lorraineweinerlmft@gmail.com*
*Licensed Marriage and Family Therapist MT20598*

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