Christine Zacha, LMFT

PSYCHOTHERAPIST

INFORMED CONSENT FOR THERAPY

Welcome, I have a commitment to providing quality individualized services. Before starting your therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be as transparent with you as I can about the therapy process, so you are fully informed prior to starting your journey.

Psychotherapy is a cooperative effort between the therapist and the client. Research has indicated that therapy can stimulate significant changes in the participants' lives. In order to have the most success, you will have to be an active participant during sessions and work on areas discussed when you are outside of sessions. The process of therapy may arouse some uncomfortable feelings and emotions. Participation in therapy does not guarantee problem resolution.

You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment.

MY CREDENTIALS

I am a licensed marriage and family therapist, fully licensed in the state of California (Credential #48069), to provide teletherapy (FTP9).

CONFIDENTIALITY

My practice is committed to following the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. All information, discussions, and documents are confidential and privileged information for all patients. Under federal law, disclosure of information regarding services provided and information about a patient requires written consent of release to alternate or third parties. I cannot reveal to third parties whether or not you are a past or current client of mine and cannot disclose any of the information you discuss during our sessions without first obtaining your written consent to do so. In the following instances, however, I may be mandated or allowed to share information without your written consent:

- If during your therapy, you are deemed to pose a threat of harm to someone else or to yourself, I am allowed to collaborate with the police or a hospital to take necessary measures to prevent harm from happening.

- If you talk about events that lead me to believe that a child under the age of 18 or an elderly or disabled person is at risk for emotional, physical orsexual abuse, neglect, or exploitation, I am required by state law to make a report to Children and Family Protective Services with or without your consent.

- If you disclose sexual misconduct by a previous therapist I am required to make a report to the licensing board governing the license of the therapist.

- If a judge in a court of law orders me to release information or if I need to respond to a lawfully issued subpoena.

- If I need to cooperate with legal actions against a mental health professional by a licensing board.

My practice utilizes health information technology. Health IT involves the storage and exchange of health information in an electronic environment. I am committed to upholding privacy and security standards for the protection of electronic health information standardized by HIPAA.

The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic protected health information (e-PHI). This includes protecting client information from potential security threats, maintaining privacy disclosure statements, and using only authorized technical devices that have security systems.

I am required to keep appropriate records of the psychological services that I provide. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

RISKS WITH TECHNOLOGY

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

EMAIL NOTIFICATIONS

When appointments are scheduled, automatic email reminders of your appointment will be sent to the email you used when scheduling your first appointment. By signing this consent form, I agree to receive these notifications, and understand that email is not a confidential medium for transmitting health information. Please note, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.

PATIENT RIGHTS

You have the right to considerate, safe, and respectful care, in the absence of discrimination regarding race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy, therapist training, and therapist experience. You have the right to communicate your therapeutic needs if you feel dissatisfied or feel like any of your rights under this agreement have been violated in any manner. You have the right to request a change in service providers. In this case, your current service provider will assist in providing the needed information to the new service provider with written consent from the patient.

You understand that telemedicine based services and care may not yield the same results as complete as face-to-face service. You understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite our best efforts, your condition may not improve and in some cases may even get worse.

You understand that you may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

CLINIC HOURS

I do not keep regular clinic hours. My practice is by appointment only. I respond to messages within 24 hours. If you are experiencing a mental health emergency do not wait to call me, go to your nearest emergency services or call 911. I do not provide emergency services, but will attempt to fit you in the next available appointment if requested for non-emergency but pressing issues.

EMERGENCY PROTOCOL

You have been provided with a list of local support services in case of an emergency. You are aware that I may contact the proper authorities and/or your designated, local contact person in case of an emergency.

TERMINATION OF TREATMENT

Your participation in therapy is voluntary and may discontinue at any time. Generally, you will be the one who decides when therapy will end. When possible, I encourage you to make this decision in collaboration with me. Additionally, the therapist has the right to terminate treatment at any time due to lack of payment, verbal/physical abuse from the patient, refusal of the patient to comply with the treatment plan, the termination of medication by the patient without a medical doctor’s consent, or a development that occurs outside my scope of competence. In the case of termination, the therapist will support the transition to a service provider for continued care.

INVESTMENT AND PAYMENT

Individual therapy is billed at the rate of $125.00 for a 50 min session. I accept payment through Ivy Pay, a card processing program designed for therapists. It provides added privacy protection, is HIPAA-compliant, and works with all credit cards, HSA and FSA cards. After making your first payment, your card information will be securely stored in Ivy Pay. If you are not able to make a session, please give me at least 24 hours advance notice. If you give me less than 24 hours you will be charged the full cost of the session.

THE SCOPE OF MY SERVICES

If you are having current hallucinations/delusions, severe thoughts of suicide or self harm, or extreme mood swings you may need more support than I can offer you through teletherapy, and I reserve the right to refer you to a different or more intensive treatment if I believe you exceed the level of care I can offer.

I, the client, consent to the above terms and agree to initiate treatment with Christine Zacha, LMFT

Print name

Date of birth

Signature

Date