Maria Savala-Mahany & Full Circle Ranch

Informed Consent and Request for Mental Health Services

Consumer Rights, Responsibilities, Notice of Privacy Grievance/Appeal Process & Financial Policy

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Information About This Practice

The individual therapist who operates this practice is:

Maria Savala-Mahany, M. Ed	**Marriage and Family**	**MFC 47185**
Name of Therapist	*Therapy License Type*	*State License Number*

Fees and Insurance

The fee for service is $ _____ per individual therapy session.

The fee for service is $ _____ per conjoint (marital /family) therapy session.

The fee for service is $ _____ per group therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples

therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

You may leave a message for your therapist at any time on her confidential voice-mail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within 24 hours.

Your therapist is not available to return phone calls on Sundays.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voice-mail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement carefully and understand its contents. Please ask your therapist to address any questions that you have before you sign!

_____ _____

Name of Patient *Date*

_____ _____

Name of Parent or Guardian *Date*

PATIENT ACKNOWLEDGEMENT of

NOTICE OF PRIVACY PRACTICES

I, _____ have

Patient Name (Please Print)

received or read a copy of my Notice of Privacy Practices rights in blue binder in waiting room.

Notice of Privacy Practices, and understand that Maria Savala-Mahany & Full Circle Ranch has legal duties to safeguard my Protected Health Information. (PHI). regard to my (PHI).

Signature _____Date_____

APPEALS AND GRIEVANCES

Appeals Process

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient visits are denied certification by Maria Savala-Mahany & Full Circle Ranch. I understand that I can request an Appeal through my Therapist and that I risk nothing in exercising this right. I understand that I or my therapist my may initiate the appeal process by submitting a letter and any pertinent documentation within 30 days of the denial to my insurance company.

Signature_____

Grievances

I also understand that I may submit a complaint or Grievance to my insurance or the County of San Bernardino at any time to register a complaint about my care. I am aware that I may contact the Member Service Department DBH Office of Compliance 268 W Hospitality LN Suite 400 San Bernardino,CA 92415 909 382 3137.

I understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California DOC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans.

Name (Printed)

_____

Signature of Patient, Legal Guardian/Legal Representative

Maria Savala-Mahany & Full Circle Ranch

Consent for Non-Secure Communications.

Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security and I am not prepared to watch them closely for important messages from clients.

This form is the short authorization version of the Consent for Non-Secure Communications. It is intended to be supplied to clients after informing them of the confidentiality risks in using email and texting.
CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, AUTHORIZE: (name of client)_____

Maria Savala-Mahany, M.Ed MFT
760 963-1416
TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:
* Information related to the scheduling of meetings or other appointments
* Information related to billing and payment

* Information related to your legal case.

TERMINATION
* This authorization will terminate _____ days after the date listed below. OR

* This authorization will terminate when the following event occurs:

_____.
I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that Maria Savala-Mahany makes available to me the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:
* Method 1 encrypted email
* Method 2 secure texting apps for smartphones.

_____
(Print client Name) Date

_____
(Signature of Client) Date