AUTHORIZATION TO TREAT MINOR CHILDREN

I, _____, give my permission to
(name of parent or guardian)

_____ to see my son/daughter
(counselor)

_____ for treatment or counseling,
(name of minor child)

with and / or without me being present in the same session. I / we understand that we are the holder of confidential privilege - the right to withhold disclosure of private counseling information about my child.

However, in the interest of developing a trust relationship between the counselor and my / our child(ren), I / we give the counselor permission to reveal or withhold information that in his / her clinical judgment is necessary to best help and protect my / our child(ren).

The only exception to this discretion would be in the case of _____
_____
_____
_____
_____

Parent / Guardian Signature_____Date_____

Therapy / Witness_____Date_____

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Sacramento, CA 95827

CHILD INTAKE FORM

The information that you provide in this form is considered strictly confidential and will only be used for the purposes of assessment and to determine the best type and level of intervention in your particular case. Your honesty in providing this information is essential in ensuring that you receive the best level of service possible.

CHILD'S INFORMATION:

Name:_____Date of Birth:_____

Child's Primary
Street
Address:_____

City:_____ State: _____ Zip:_____

Mailing Address
(If different from above):_____
Child's
Ethnicity:_____ Family's
Religious Affiliation:_____

For what reason(s) are you referring your child to counseling?

_____

_____

_____

How willing is your child to participate in counseling?

_____

What concerns, if any, has your child expressed about counseling?

_____

Is the child a foster child or adopted? Y N

Date of Adoption:_____ Age at time of Adoption:____ How many prior Foster placements?____

Emergency
Contact Name:_____ Phone Number: _____

Relationship: _____

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PARENT / FAMILY INFORMATION:

Father's (Legal Guardian) Name: _____ Date of Birth:_____

Father's Employer: _____ Occupation: _____

Work Phone: _____
Father / Legal Guardian Address (if different than child's):

_____

Biological Father
(If different than above): _____ Date of Birth:_____ Living? Y N
If deceased, please indicate date of death: _____ Cause of death: _____

Mother's (Legal Guardian) Name:_____ Date of Birth:_____

Mother's Employer: _____ Occupation: _____

Work Phone: _____
Mother / Legal Guardian Address (if different than child's):

_____

Biological Mother
(If different than above): _____ Date of Birth:_____ Living? Y N
If deceased, please indicate date of death: _____ Cause of death: _____

Are Child's parents currently married to each other? Y N If yes, for how long? _____yrs

If not currently married, have Child's parents ever been married to each other? Y N

Separated? Y N Divorced? Y N Divorced for ____ years, after ____ years of marriage

If divorced or never married, please describe current custody situation and visitation rights:

_____

With whom does the Child primarily live? _____

Please list all members of the household with whom the Child currently lives (use back if necessary):

Name:	Age:	Relationship to Child:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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SCHOOL INFORMATION

Is the child currently enrolled in school? Y N

Name of School: _____

Location (City & State): _____

Grade Level: _____ Teacher's Name: _____

Has child ever been diagnosed with any learning disabilities? Y N

If yes, please explain: _____

In general, how well does child perform in school? _____

In general, how hard does child have to work to sustain this level of performance? _____

Please check all that apply to the child:

[ ] Gifted Learning Abilities	[ ] Above Average Grades	[ ] Average Grades
[ ] Below Average Grades	[ ] Resists Going to School	[ ] Refuses to go to School
[ ] Repeated a Grade	[ ] Fighting	[ ] Suspended
[ ] Expelled	[ ] Home Schooled	[ ] Psychological Testing
[ ] School Counseling	[ ] Frequent Tardies	[ ] Truant
[ ] Expelled	[ ] Suspended # of times in the school year.	[ ] I.E.P.

Please indicate which, if any, of the following learning differences apply to the child:

[ ] Speech Therapy	[ ] Reading Difficulties	[ ] Math Difficulties
[ ] Spelling Difficulties	[ ] Writing Difficulties	[ ] Discipline Issues

Does the child participate in any regularly scheduled, structured activities (such as sports, youth groups, or clubs)? Y N

Kind of Activity:	Where Held:	How Frequent:
_____	_____	_____
_____	_____	_____

SOCIAL / PLAY INFORMATION

Please rate the child on the following scales, placing a mark on the scale where it best represents the child's experience in that category:

Not Talkative Very Talkative
[]----------[]

Has No Close Friends Has Many Close Friends
[]----------[]

Is Not Interested in Friendships / Does Not Make Friends Easily — Enjoys Having Friends / Seems to Make Friends Easily
[]----------[]

Displays Little to No Imagination — Has Active Imagination
[]----------[]

Name the child's favorite hobbies, activities, and areas of interest:

_____

_____

On average, how many hours of 'screen time' (use of smart phone, tablet, computer, or television) does the child get on a:

Daily Basis: _____ Weekly Basis: _____

Does the child possess / have access to their own smart phone?	Y	N
Does the child possess / have access to their own tablet or computer?	Y	N
Does the child have a television in their room?	Y	N
Are there parental controls in place concerning internet access, Which only the parent or guardian controls?	Y	N
Is the child allowed to text or utilize 'chat rooms' on line?	Y	N
Is the child active in social media (Facebook, Twitter, Snapchat, etc.)	Y	N
Does the child access text, phone, or internet without immediate adult supervision?	Y	N

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Child's Medical History

Child's Primary Care Physician: _____

Contact Number for Medical Provider: _____

Is your child currently being treated for a medical condition,
or do they have any chronic medical conditions? Y N

If yes, please explain: _____

Please list all medications your child is currently taking (prescription and non-prescription):

Name of Drug:_____ Why Used / Prescribed: _____

Name of Drug:_____ Why Used / Prescribed: _____

Did the child have any birthing complications? Y N

If yes, please describe: _____

Has the child experienced any developmental anomalies? Y N

Please indicate all that apply:

[ ] Developed quicker in one area than the other [ ] Sat up later than children his/her age

[ ] Spoke sooner or later than others his/her age [ ] Other

Please describe: _____

To your knowledge, has child ever been exposed to,
or used, any controlled substances (tobacco, alcohol, narcotics, etc)? Y N

Substance:	Date of Exposure / Use	Frequency:
_____	_____	_____
_____	_____	_____

Did the child's birth mother use controlled substances during pregnancy? Y N

If yes, please explain: _____

Please explain any concerns or other knowledge that you may have concerning child's exposure or use of controlled substances:

_____

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Child's Mental Health History

Has your child ever been seen by a counselor, psychotherapist, or psychiatrist before? Y N

Name of Therapist:	Dates Seen (from when to when)	Reason
_____	_____	_____

Has your child ever received a diagnosis for a mental health condition? Y N

If yes, please list the diagnosis: _____

Please check all behaviors that apply to the child:

[ ] Alcohol and or Drugs	[ ] Bed Wetting	[ ] Bullying Behavior
[ ] Day Dreams	[ ] Fantasizes	[ ] Does not get along with others
[ ] Does not want caretaker out of sight	[ ] Excessive interest in sex	[ ] Expressing wish to die
[ ] Fears and or avoids things	[ ] Harms animals	[ ] Harms self
[ ] Has rituals, habits or superstitions	[ ] Inability to pay attention	[ ] Inability to sleep alone
[ ] Inability to stay asleep	[ ] Involved in gang activity	[ ] Lies
[ ] Peer abuse	[ ] Nightmares / night terrors	[ ] Over Activity
[ ] Physically Aggressive	[ ] Over Eats	[ ] Physically Aggressive
[ ] Poor Appetite	[ ] Poor relating to adults	[ ] Poor relating to children
[ ] Sadness / Crying	[ ] Self Stimulation Sexually	[ ] Sleepwalking
[ ] Smokes Tobacco and or Drugs	[ ] Steals	[ ] Temper Tantrums
[ ] Tiredness / fatigue	[ ] Twitches / Unusual movements	[ ] Wanting to or has run away

Has the child ever been the victim of, or witnessed, sexual abuse? Y N

Has the child ever been the victim of, or witnessed, domestic violence? Y N

Has the child ever attempted suicide? Y N

Is there a history of mental health problems in the child's biological family? Y N

If yes, please explain:_____

Please provide additional information concerning child's behavior, as indicated above, if needed:

_____

Financial Responsibility

Our standard fee is $100 per counseling session. We do accept several major forms of insurance. If you want to use insurance to pay for therapy, please discuss this with us. If you do not have insurance and / or intend to pay out of pocket, we do offer a sliding fee scale that is based on your household income and the size of your household.

How do you intend to pay for services (Please Circle One): Private Pay Insurance

Insurance Provider:_____ Policy Holder's Name: _____

Relationship to Child: _____ ID Number:_____

Address of Policy Holder:

Street Address:_____ City:_____

State: _____ Zip: _____ Phone Number: _____

Policy Holder Employer: _____

Employer's Phone: _____

Employer's Address: _____

If required for your plan, please provide any authorization number: _____

Number of sessions authorized: _____

If you intend to pay for services out of pocket, and you choose to request a fee consideration, you may be required to bring in a copy of your tax records or proof of income prior to determination.

Household gross annual income
(the amount made before taxes):_____ How many dependents:_____

Additional Information Regarding Consent to Treat Minors

A signed consent form must be obtained from all parties with parental authority / each legal guardian of a minor prior to the beginning of therapy. This form is an intake form, and is used for the purposes of gathering information that is necessary for the intake process. This form *DOES NOT CONSTITUTE A CONSENT FORM*, and accordingly, therapy with the child who is the subject of this form cannot and will not begin until all necessary documentation has been obtained.

In the event that the child is 12 years old or older, the child will also have the therapeutic process explained to them, and will be asked to sign their own consent form prior to the beginning of any therapy.

Lighted Paths Counseling

Policies, Informed Consent, and Fee Agreement

I look forward to providing you with quality treatment. The first step in the treatment plan is to develop a working relationship with you that is free of any misunderstanding. This contract is provided as a clear statement of my policies. It is imperative that you accurately understand each statement below before signing. I will be glad to answer any questions you may have, so please ask. Psychotherapy is an interactive growth process between client and therapist. Because of this, open and honest communication is a vital part of the therapeutic process. Any feedback, questions or concerns are welcome and encouraged.

RISKS AND BENEFITS OF THERAPY:

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell your counselor immediately. We will make every effort to remedy the situation, work with you to make it more tolerable, or provide you with names of therapists or other resources should you prefer a referral. Initially, as a result of the therapeutic process and exploration, it may feel as though "things are getting worse instead of better". Keep in mind that even though this may be uncomfortable, these feelings are usually temporary and reflect a sign of progress. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships. If for any reason your therapist leaves this office (due to a move, accepting a position elsewhere, etc.) we will assign another therapist qualified to meet your counseling needs or provide a referral to someone who can.

Therapy evaluations may last from 2-4 sessions. By the end of the evaluation, I will be able to offer you some first impressions of what our work will collaborate with you on a treatment plan, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your counselor. At the end of the evaluation, we will notify you if we believe that we are not the right therapist for you and, if so, we will give you referrals to other practitioners whom we believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

CONFIDENTIALITY:

Your client records are the property of Lighted Paths Counseling and your individual licensed counselor and shall be treated as confidential. As part of the counseling process, we are bound by ethical responsibilities to keep confidential the information shared during the sessions and we will not release any information without your written permission. However, there are important exceptions to confidentiality in the counseling relationship. We are required by law to reveal certain information under the following circumstances:

a) Disclosure of serious intent to do harm to self or others
b) Disclosure of child abuse or the counselor's suspicion of child abuse/neglect, elder abuse, or dependent adult abuse/neglect
c) If a court of law orders the release of specific information
d) Submitting billing for psychotherapeutic services to your health insurance company or employee assistance program (EAP) entails signing an authorization to release information. Technically, this allows the company the right to inquire about anything that has occurred during treatment in order to ensure quality of services and to make sure that your condition fits within the company's criteria for benefits. Please contact your insurance company or EAP if you have any questions about how your information will be handled.

Records Requests, Security, and Maintenance: Should you request your records, such a request must be made in writing, and you will be required to reimburse any time necessary to complete requested written treatment summaries prorated at the current standard fee per hour. Note, for couples and families, both/all individuals are my client and I will need the signatures from both/all persons in order to provide a summary report. Therapists also reserve the right to refuse to provide a copy under certain legal or emergency circumstances, or when assessed that releasing such information might be harmful in any way. We will securely maintain the records for at least 7 years for adults and 10 years for children after termination of therapy and after they have turned 18 (as required by law). After this time period, records will be destroyed in a manner that preserves confidentiality.

It is important to remember that electronic communications such as e-mail, faxes, text messages and cell phone call are not always secure. In addition, the Patriot Act (2001) requires therapists (and others) in circumstances related to national security to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained these items.

Lighted Paths Counseling uses contracted billing providers/bookkeepers to assist with administrative tasks. These providers will have access to your file in order to maintain

legally required records and payment information. These providers are held to the same standard of confidentiality and are required to maintain HIPAA compliance.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The consultant is also legally bound to keep the information confidential. Ordinarily, we will not tell you about these consultations unless we believe that it is important to our work together.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. However, it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Confidentiality Related to Telehealth
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy or another platform that is HIPAA compliant. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Minors and Confidentiality: Communications between therapists and clients who are minors (under age 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment as clinically appropriate. Consequently, I may discuss the general treatment progress and any safety concerns of a minor client with the parent or caretaker, but not specific details that would negatively impact the therapeutic relationship and trust between the minor and the therapist. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

INTERN/TRAINEES:

A) I am an unlicensed P.C.C. (Professional Clinical Counselor) Intern and am supervised by Julie Grant L.C.S.W. (license # 19517). I have completed a Masters program in _____and am preparing for licensing through weekly supervision by a licensed clinician (listed above). My name and Intern # is _____, #_____.

B) I am an unlicensed A.M.F.T (Associate Marriage and Family Therapist) Intern and am supervised by Julie Grant, L.C.S.W. (license # 19517). I have completed a Masters program in _____ and am preparing for licensing through weekly supervision by a licensed clinician (listed above). My name and Intern # is _____.

If you are seeing an Intern or Trainee for therapy, your case will be discussed in a group or individual supervision format with a licensed supervisor present for quality control, feedback, education, and/or discussion. The primary supervisor is Julie Grant, L.C.S.W; Please call Julie Grant, L.C.S.W. at (916) 600-7887 immediately if you have any concerns regarding the quality of care you are receiving from the Intern or Trainee that you are receiving services from.

APPOINTMENTS:

The length of a usual appointment is 45-60 minutes, except for the initial session, which may take up over an hour. Appointments are usually scheduled weekly to bi-monthly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made. Your therapist attempts to carefully schedule clients in order to begin each session promptly at the appointed time. The session will end at the scheduled time if the client arrives late. If your therapist begins a session late due to his/her own tardiness, the session will be extended to provide the client with the full 45-50 minute

session. Neither the client nor the therapist is expected to wait longer than 15 minutes past the scheduled time for the start of the session unless there has been previous notice.

CANCELLATIONS AND MISSED APPOINTMENTS:

Cancellation of appointments must be made at least 24 hours in advance. You will be charged the full fee for late cancellations and missed appointments. If you have a true emergency or serious illness, you will not be charged (see below for information about insurance client cancellations). The next appointment will not be scheduled until this late cancellation/no show fee is paid.

PRIVATE PRACTICE:

The Interns and Sole Proprietors (licensed mental health providers) at Lighted Paths Counseling are not responsible for the activities of anyone else in the building. Note that the bathrooms and waiting room are shared areas between multiple tenants in the building and/or the other therapists in the office.

FEES:

Our standard fees are $120 per 50 minute session. However, we offer counseling services on a sliding scale basis for those who are under financial hardship and are willing to see an Intern or Trainee to receive services. In order to qualify for reduced fees, you must provide financial documentation (pay stubs or bank statements). Please ask your counselor about this to get more specific information on this program.

You are responsible for payment for all services rendered either by debit card, credit card, check, or cash. This includes any insurance co-pays and balances that the insurance does not cover. You are responsible for verifying and understanding your insurance coverage and the procedures required for any possible reimbursement (including prior authorizations for certain benefits). All checks and credit cards submissions need to be paid to your counselor (or to Julie Grant, LCSW if you are being seen by an Intern). Please ask in advance if you need a receipt or summary of payments received in order to seek insurance reimbursement.

<u>Unpaid Balances:</u> Payment is expected in full at the time services are rendered, unless otherwise agreed upon and documented. Any accounts with a past due balance of 60 days or more will be handed over to a collection agency, incurring a $50 processing fee. If your account has an unpaid balance at any time, it may be necessary to suspend counseling sessions until the account is paid, to avoid a dual relationship as creditor and therapist.

<u>In addition to regular sessions, billing will occur for the following:</u>

1) Missing a scheduled appointment without 24 hour notice for reasons other than serious illness or emergency. You will be billed your normal fee for a session. Also, we cannot bill an insurance company for a missed session. Insurance companies do not allow

providers to collect payments for missed sessions. Therefore, if you miss 3 sessions or more without proper notice as an insurance client, you will be terminated as a client and referred to another provider.

2) Phone conversations lasting more than 15 min. will be prorated based on a $120 per hour fee.
3) If the therapist is subpoenaed or requested by you or your legal representative to appear in court or provide a written report of assessment, the fee will be prorated based on a $120 per hour fee. The fee for written reports (or copying notes) is due prior to the release of the document requested.
4) $25 service charge for all checks returned by the bank.

PHYSICAL EXAMINATION:

We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

CLEAN AND SOBER POLICY:

We ask that you come in to your session at least 24 hours clean and sober. This is to ensure that the best work can be accomplished with a clear mind. If you come to a session under the influence, we reserve the right to end the session and charge for the appointment. I may also call your emergency contact or the police to insure your safe exit from our office.

EMERGENCIES:

We do not have an "on call" service. We will try to return your calls as soon as possible. However, if you need to reach us on an emergency basis in between sessions, please call Julie Grant at (916) 600-7887 or Jamie Jones at (916) 616-7871 and they will try to get back to you as soon as possible. In an urgent crisis situation, please call the Sacramento County Mental Health Crisis Service at (916) 875-1000.

CHILDREN:

It is asked that you do not bring young children to your counseling session (unless they are participating in family treatment) or leave them unsupervised in the waiting area. Their safety is a priority and certain behaviors can be disruptive to other clients or building tenants. I am dedicated to your counseling needs, and appreciate your cooperation in these matters.

TERMINATION OF THERAPY:

We reserve the right to terminate therapy at any time at our discretion. Reasons for such termination might include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, avoiding potential conflicts of interest, failure to participate in therapy, client needs being outside of our scope of practice, or the lack of progress or effectiveness in therapy. You also have the right to terminate therapy. Upon either of our decisions to discontinue treatment, we may do one or possibly more termination sessions as an opportunity to reflect on the work that has been done together and/or support a smooth transition to another therapist or referral. Please note that any lack of therapy attendance (with or without communication from you) for 30 days or longer, unless previously discussed and agreed on, will be considered a formal termination of treatment, and your therapy case record will be officially closed and our therapeutic relationship discontinued.

CONSENT TO TREAT:

If you have any questions about Lighted Paths Counseling policies or about psychotherapy, please ask before signing below. ***Your signature indicates that you have read our policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate therapy if you do not comply with the policies or if we feel you are not benefitting from treatment.***

I hereby authorize Julie Grant, L.C.S.W., Jamie Jones, LPCC, or (name of Intern/Trainee)_____

to render services to me _____

(Name of Client)

_____ _____

(Signature of Client) Date

_____ _____

(Signature of Therapist) Date

"NO SECRETS" POLICY (When Treating a Couple or Family):

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the client (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (i.e. an individual, siblings, parents, etc.) for one or more sessions, for treatment supporting the overall couple/family's goal(s). These sessions should be seen by you as a part of the work that I am doing with the family or couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit -- that is, the family or the couple -- if I am to effectively serve the unit being treated. I will use my best clinical judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk a about matters that you absolutely want to be shared with no one, you might want to consult with a separate individual therapist.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. ***If, at any time, members of the overall treatment unit are potentially no longer working towards mutual goals, I will need to refer out.*** For instance, information learned in the course of an individual session may be relevant or even essential to the proper and effective treatment of the couple or the family (i.e. infidelity, plans to separate, etc.). If I am not free to exercise my clinical judgment regarding the need to bring this to the couple or family during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or family. This policy is intended to prevent the need for such termination. If at any point, one or both members of a couple decide to no longer participate in the couple's treatment, or if there is a lack of communication and/or treatment for 14 days or longer,

unless otherwise arranged, this will indicate a formal termination or our therapeutic relationship for couple's treatment.

We, the members of the _____(couple/family) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with _____(name of counselor) and that we enter couple/family therapy in agreement with this policy.

X_____ _____ _____

Signature Print name Date

X_____ _____ _____

Signature Print name Date

X_____ _____ _____

Signature Print name Date

X_____ _____ _____

Signature Print name Date

JULIE GRANT, LCSW (and affiliated Interns/Trainees)

ACKNOWLEDGMENT OF RECEIPT:

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have read and understand the Notice of Privacy Practices.

_____ _____

Signature of Client or Client's Representative Date

_____ _____

Print name Relationship to Client

Written Acknowledgement Not Obtained:

___ Notice of Privacy Practices Given -- Client unable to sign

___ Notice of Privacy Practices Given -- Client Declined to Sign

___ Notice of Privacy Practices Given -- Awaiting Signature

___ Other Reason Client Did Not Sign.

_____

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of you PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

HOW I MAY USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operation.

Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

To avert a serious threat to health or safety. For example, I may have to use or disclose you PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
You have the following rights with respect to your PHI:

The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You

also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary of explanation of the PHI as long as you agree to that and to the cost in advance.

The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to you PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Nor Cal Medical Billing, Attn: Privacy Officer, P.O. Box 1561, Placerville, CA 95667 (530) 622-1017. You will not be retaliated against or penalized for making a complaint.

Confidential Authorization Release

LIGHTED PATHS COUNSELING

I, _____, Date of Birth_____

Hereby authorize Julie Grant, LCSW to:

OBTAIN INFORMATION FROM:

Business Name		Attention	
Address		City	
State	Zip Code		

RELEASE INFORMATION TO:

Business Name		Attention	
Address		City	
State	Zip Code		

The following information (please check appropriate boxes) for the purpose of treatment planning

- o Entire Record
- o Diagnosis
- o Psychiatric Evaluation
- o Neurological
- o Individual Treatment Plan
- o Medical Information
- o Lab Test Results
- o Legal Information
- o Results of Psychological/Vocational Testing (Including Raw Data)
- o Discharge Summary
- o Telephone Conference
- o Treatment Summary
- x Other Information necessary to utilize insurance benefits

The above information may be exchanged orally or in writing. This authorization is given of my own free will and is in effect for six months from the below date. I understand that I can revoke this authorization in writing at any time.

Signature_____Date_____

Witness/Therapist Signature _____Date _____