WAVE Professional Clinical Counselors Inc.

What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. **When you or other persons are in physical danger**, the law requires me to tell others about it. Specifically:

    a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.

    b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.

    c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.

    d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

    Important Disclaimer: Please be aware that child abuse now includes minors sexting (texting revealing pictures of themselves or other minors) and if I hear of this occurring from your child or a third party, I will be mandated to report it.

    In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

    a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.

    b. In cases where your emotional or mental condition is important information for a court's decision.

    c. During a malpractice case or an investigation of me or another therapist by a professional group.

    d. In a civil commitment hearing to decide if you will be admitted to a psychiatric hospital.

    e. When you are seeing me for court-ordered evaluations or treatment. In this case, we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

3. There are a few other things you must know about confidentiality and your treatment:

    a. In order to assure the quality of the services I provide you, I will at times consult with another professional about your treatment. In such situations, I will only provide the information necessary to achieve the goal of the consult. Persons that I consult with are also bound by their professional ethics to keep your information confidential.

    b. I am required to keep records of your treatment. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you. Your records will be kept electronically through an electronic health record system (EHR). WAVE specifically uses www.theranest.com. If you chose to have your records stored in another form, please let us know.

4. Here is what you need to know about confidentiality regarding **insurance and money matters**:

    a. If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or other companies usually want only your diagnosis, my fee, the dates we met, and sometimes a treatment plan. Managed care organizations, however, ask for much more information about you and your symptoms, as well as a detailed treatment plan.

    b. I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this

information at the insurer's office. You cannot be required to release more information just to get payments.

c. If you have been sent to me by your employer or your employer's Employee Assistance Program, either one may require some information. Again, I believe that employers and companies will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.

d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

5. Finally, here are a few other points:

   a. I will not record our therapy sessions on audiotape or videotape without your written permission.

   b. If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies which you can see so you will know what is involved.

   c. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations that are not mentioned here come up only rarely in my practice. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally.

Signature of Parent/Guardian	Date
Parent Printed Name	Parent Date of Birth
Full Name of Minor Client	Minor Date of Birth

Notice of Privacy Practices

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

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

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PH– in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

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

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. **If disclosure is otherwise specifically required by law.**

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

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving yourwritten request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a **summary** or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for

example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom 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 cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also 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. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. 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 me.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice

Signature of Parent/Guardian	Date
Parent Printed Name	Parent Date of Birth
Full Name of Minor Client	Minor Date of Birth

Consent for Treatment

This document is intended to provide you with important information about my professional services and business practices. Please read it carefully and make note of any questions you may have so we can discuss them at our next meeting. Psychotherapy is not easily described in general terms since the form it will take varies with each individual client and therapist. To determine what psychotherapeutic treatment best suits your needs I will evaluate your situation and the problems for which you are seeking treatment. This will occur during the first 2 to 4 sessions. Following this evaluation period, I will present you with my initial impressions and an outline of what your treatment with me will entail. The evaluation period is also intended to give you the opportunity to assess your comfort and confidence in working with me. Given the large commitment of time, money, and energy psychotherapy involves, you must be thoughtful about the therapist you chose. Any questions you might have about the verbal or written information I provide to you, or any matter that occurs between us, should be discussed with me as soon as possible. Should you choose not to pursue therapy with me I will be pleased to help you arrange an appropriate consultation with another therapist.

Psychotherapy has both benefits and risks. Some of the risks include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. While these feelings are a normal part of the therapeutic process, they can be quite intense and overwhelming at times. Though psychotherapy often requires recalling unpleasant aspects or your history, familial background and relationships, it has been shown to have benefits for those who undertake it. Psychotherapy often leads to a significant reduction in one's feelings of distress, an improvement in one's relationships and the resolution of specific problems. There are, however, no guarantees about the outcome.

Sessions

Our sessions will be scheduled to last 45-55 minutes. Your appointment time is reserved for you. Once you have scheduled a session, you will be expected to pay for it unless you provide at least 24 hours advanced notice. In situations where your absence was beyond your control, and where time permits, I will attempt to reschedule your session.

At WAVE, we use an electronic note taking and storage system called Theranest. Client files are protected and safeguarded with multiple daily encrypted backups using the highest, bank-level Secure Sockets Layer (SSL) certificates. However, please be aware that online storage, as well as paper files, can never be 100 percent secure.

Fees & Payment

It is our practice to charge a prorated fee for other professional services you request such as report writing, telephone conversations lasting longer than 15 minutes, consultations with other professionals, preparation of treatment summaries etc. If you require me to participate in a legal proceeding, I will charge $450 per hour due to the complexity and difficulty of such activity. Unless otherwise arranged, you will be expected to pay following each session. To maximize the time spent on your treatment it is suggested that you have your check completed in advance.

Between Session Contact

Please be aware that I am not available immediately by phone. If you need to contact me between sessions, please leave me a message. I check my messages several times a day and will get back to you as soon as I am able. Whenever I am out of town I will leave you with information for contacting a trusted colleague who will be available to deal with any emergency you may have. If you have a psychiatric or medical emergency, I suggest you call 911 or go to the nearest emergency room for assistance.

Client Rights

You have the right to decide not to enter therapy with me. If you wish, I will provide you with the names of other therapists and clinics. You have the right to end therapy at any time. The only thing you will have to do is pay for any treatments you have already had. You have the right to ask any questions about what we do during therapy and receive answers that satisfy you. You have the right not to allow the use of any therapeutic technique.

Privacy

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Acknowledgement of Registered Marriage and Family Therapist Associates at WAVE

WAVE has Marriage and Family Therapist Associates, who are post graduate, BBS approved professionals with training and experience, conducting therapy. They are under the direct supervision of a Licensed Marriage and Family Therapist. It is customary for a supervisor and pre-licensed professional to discuss clients to assure the client is receiving the best possible care. The licensed supervisor is also bound by his professional ethics and will keep your information confidential, with the exception of legal mandated reporting as stated in the form on confidentiality.

Other Acknowledgements

This acknowledges that you have been offered an Advance Directive which can help your family make health choices according to your wishes. This link provides access to a guide and printable Advance Directive, should you require one, www.aarp.org/caregiving/financial-legal/free-printable-advance-directives. This acknowledges that you have been given the Access and Crisis Phone number **(888) 724-7240** and website http://211sandiego.org which can be used for suicide prevention, crisis intervention, community resources, mental health referrals, and alcohol and drug support services. This line is confidential, free of charge, and is immediately answered 7 days a week, 24 hours.

Arbitration Agreement

Article 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

Signature of Parent/Guardian _____ Date _____

Parent Printed Name | Parent Date of Birth

Full Name of Minor Client | Minor Date of Birth

Parent/Guardian Consent for the Treatment of a Minor

I certify that I am the parent or guardian of the child who is seeking therapy services at WAVE Therapy. I give my permission for my child to participate in counseling/therapy at WAVE Therapy with the therapist, social worker, and/or therapist intern.

Because counseling is based on a trusting relationship between therapist and client, the therapist will keep information shared by the minor client confidential except in certain situations in which an ethical responsibility limits confidentiality. You will be notified under the following circumstances:

1. The client reveals information about hurting himself/herself or another person.
2. The client or another person may be in physical danger.

By signing this form, I give my informed consent for my child to participate in counseling/therapy. I understand that anything that my child shares will be kept confidential except in the above-mentioned cases or any other cases agreed upon between you and your therapist.

You may revoke this consent at any time. Please submit your revocation of consent to your therapist in writing.

Signature of Parent/Guardian | Date

Parent Printed Name | Parent Date of Birth

Full Name of Minor Client | Minor Date of Birth

WAVE Professional Clinical Counselors Inc.

Minor Client Information Form

A. Identification

Minor's name: _____ Age: _____Gender:_____Legal Gender:_____

Nicknames or aliases: _____ Date of birth: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

Emergency contact: _____Relationship:_____ Phone: _____

Allergies: _____Email Address:_____

B. Your current/most recent employer/ Insurance Information

Employer: _____What do you do for work:_____

Address: _____Suite: _____

City: _____ State: _____ Zip: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

Please list your Insurance: _____ ID#: _____ Group#_____

Please indicate if you are currently employed or on a leave for any reason _____

C. Chief concern

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

Please briefly describe your significant relationships (spouse, children, family, friends):

_____

_____

D. Treatment

1.Have you ever received psychological counseling services before? • No • Yes If yes, please indicate:

A. Duration of services? B. From whom? C. For what? D. With what results?

_____

_____

2.Have you ever taken medications for psychiatric or emotional problems? • No • Yes If yes, please indicate:

A. Which medication? B. Purpose of medication? C. Duration it was taken? C. Prescribing psychiatrist? D. Was it effective for your symptoms?

_____

_____

3. Current/Previous mental health and medical diagnoses/illnesses? • No • Yes If yes, please indicate:

_____

4. Have you ever been hospitalized for a psychiatric emergency? • No • Yes If yes, please indicate:

_____

E. Legal history

1. Are you presently suing anyone or thinking of suing anyone? • No • Yes If yes, please explain:

_____

_____

2. Is your reason for coming to see me related to an accident or injury? • No • Yes If yes, please explain:

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

• No • Yes If yes, please explain:

_____

_____

4. Are there any other legal involvements I should know about?

_____

_____

Is there anything else you want your therapist to know?

_____

_____

Your signature below indicates that the above information is true and correct to the best of your knowledge.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Parent Printed Name Parent Date of Birth

_____ _____

Full Name of Minor Client Minor Date of Birth

Fees and Payments

Using Insurance

Your appointment time is reserved for you. Once you have scheduled a session, you will be expected to pay for it unless you provide at least 24 hours advanced notice. Even if you have insurance, your insurance is not expected to pay for sessions cancelled with less than 24 hours notice. You will be billed a $65 cancellation fee if you are utilizing insurance that is to be paid prior to the next session.

Paying Cash

If you are NOT utilizing insurance and paying Cash you will be billed the full agreed amount of each session if you do not give 24 hour notice to cancel. Once you have scheduled a session, you will be expected to pay for it unless you provide at least 24 hours advanced notice.

Please Remember: If you do not cancel within 24 hours of your session you will be billed for the full amount of the session even if you have insurance. The insurance companies will not cover cancelled sessions.

Should you be writing checks and a check should bounce, meaning "insufficient funds in the account", you will be charged a $10 processing fee plus the original amount. The original amount plus the $10 fee is due in form of cash/money order before the next session in order to reserve your time. In a situation where your absence was beyond your control, (i.e. a true emergency, NOT a cough/cold or flu) and where time permits, I will attempt to reschedule your session within the same week but you may still be billed for a cancellation if there was less than 24 hours notice. If you are not feeling well and choose to do a Facetime or Phone call in place of our session because it is more convenient for you, that may be an option.

By signing this form, I agree to pay the amount my insurance has requested as a part of my copay or deductible or the agreed upon amount my therapist charges if I am not using insurance or if my insurance lapses.

Signature of Parent/Guardian	Date
Parent Printed Name	Parent Date of Birth
Full Name of Minor Client	Minor Date of Birth

Permission to Text and Email

In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of and agree to them. Most email systems are considered unsecure email; while risk of misdirected or intercepted email is small, it does exist. If you access your email account through your employer or through a work or school network, your messages may be subject to network provider's storage and review. Please let us know if you have any questions about unsecure email and your related privacy rights.

At WAVE Therapy, we use G Suite for most of our email communication which is HIPPA compliant and more secure than a standard Gmail account. We also have locks on our work phones to prevent confidential information from being easily accessed. Even though we take precautions to protect your information, there is still a risk that e-mail messages and SMS messages may be read by others. For this reason we advise not to send sensitive information via e-mail or SMS message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers, credit card information, or insurance identification information.

I hereby give permission for my therapist to send messages via e-mail and text, including any information that he/she deems appropriate, that would otherwise be considered confidential. I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet or text messaging. I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment and use text messaging for the purpose of scheduling and checking in.

I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call my therapist. I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or SMS by notifying my therapist in writing.

- ☐ Yes to Text
- ☐ No to Text
- ☐ Yes to Email
- ☐ No to Email

Signature of Parent/Guardian	Date
Parent Printed Name	Parent Date of Birth
Full Name of Minor Client	Minor Date of Birth

WAVE Professional Clinical Counselors Inc.

Credit Card Authorization Form

Normally we would collect copays or charges at the beginning and end of a therapy session using your preferred payment method. However, in the event of non-payment of fees, whether this is for copays that go unpaid, charges accumulated for not showing to a session, or late cancelations (less than 24 hour notice), we may need to charge a credit card.

By signing this form, you hereby authorize WAVE Therapy and all its associates to charge this credit card in the event of non-payment of fees. You also authorize this information to be saved to your confidential file.

If you do not want this card charged, please speak with your therapist about a payment plan for unpaid balances and we will do our best to accommodate.

Credit Card Information
Card Type: VISA Mastercard Discover Other:
Cardholder Name:
Card Number:
Expiration Date (mm/yy):
CCV (3 numbers found on the back of your card:
Cardholder's ZIP code (credit card billing address):

Signature of Parent/Guardian _____ Date _____

Parent Printed Name _____ Parent Date of Birth _____

Full Name of Minor Client _____ Minor Date of Birth _____

Important Message From Our Billing Department

As a courtesy, we have billed your insurance company. Benefits or coverages quoted are not a guarantee of eligibility or payment. Any charges denied or not paid by your insurance company are transferred to patient responsibility. To avoid late fees, please submit payment within 10 days of being notified of your balance. If you have not paid balance in full within 90 days of charges being applied to your account, your account may be sent to a collections agency.

We will require a credit card on file by the first appointment, even if you have no copay. The card will be charged the copay or a $1 registration fee at the first visit to ensure patient responsibility of any fees (including copays, cancellation fees, and sessions not covered by insurance). The card will be charged automatically unless we are contacted with an alternative form of payment.

If you have any questions as to how your insurance paid or elected not to pay, please call the insurance company directly. For questions regarding your account not related to insurance, please call our office at (760) 500-3325 Monday-Friday 8am to 5pm. Thank you.

Signature of Parent/Guardian	Date
Parent Printed Name	Parent Date of Birth
Full Name of Minor Client	Minor Date of Birth