Health Psychology Associates
Deacon Shoenberger, PhD
Natalie Sanchez, LMFT
245 Mt. Rose Street
Reno, NV 89509
775-448-6828 Fax 775-322-2964

Crystal Nejabat, Licensed Clinical Professional Counselor Intern

Informed Consent – Provision of Services by a Master's Level Therapist

I, _____, as a recipient of outpatient mental health services at Health Psychology Associates, understand that:

- My counselor has completed a Master's Degree in Counseling and is currently a Licensed Clinical Professional Counselor Intern, and as such, is providing services under the direct supervision of and Natalie Sanchez, LMFT and Deacon Shoenberger, Ph.D. at this office.

- Information about my case may be presented in an individual/group supervision with Natalie Sanchez, LMFT for the purposes of professional development and/or improved quality of care. Other group members may include: Suzanne Calzada, LMFT, Chris Dietrich, LMFT, Kristina McIntrye, LMFT, Leonard Capozzi LCSW-Intern, and Monique Normand LCSW-Intern.

- In order to protect my privacy, information shared will be done so with the least amount of identifying information possible.

- I have a right to refuse the disclosure of personal information to specific members of the supervision group where a conflicting relationship may exist. If such a relationship exists, it is my responsibility to address this with my counselor.

By signing this authorization for treatment by a supervised intern, I acknowledge that I have read and understand the information above and

_____ I consent to treatment with the supervisory arrangement as specified.

_____ _____
Signature of Client, Parent or Legally Authorized Representative Date

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Consent for Services

1. I understand that the fee for each 50 minute therapy session is my responsibility.

2. I agree to give 24 hour notice if I am unable to make a scheduled appointment. I understand that I will be charged the usual fee for any appointment not cancelled 24 hours in advance. If you miss a session without cancelling, we will assume that you have terminated therapy unless you call within 30 days to reschedule.

3. I understand that every effort will be made to keep the information obtained from each session strictly confidential, as provided by law. Information concerning me will be released to outside this facility only to agencies or individuals specifically designated by me in writing.

4. The exceptions to this policy are: (1) when in the therapist's judgment I am determined to be dangerous to myself or others; (2) when in the therapist's judgment I am suspected of child or elder abuse or neglect; (3) when my client material is ordered to be released by the courts as an essential part of a legal proceeding; and (4) during court ordered treatment.

5. In the event there are two or more clients in therapy at the same time (e.g., couples therapy), I understand that no information about these sessions can be released without the written consent of both parties.

6. I agree to inform my therapist of any pending legal action initiated by me or legal action brought against me.

7. I understand that the purpose of therapy is for my enhanced psychological functioning and specifically not intended to be used in any current or future legal proceedings (e.g., custody, divorce, civil, or criminal proceedings).

8. I understand that no treatment will be provided to me when I am under the influence of alcohol or drugs.

9. I understand that terminating therapy is part of the therapy process. I agree to terminate therapy by way of discussion with my therapist, not by cancelling a therapy session.

10. I understand that my signature below indicates that I have read the information above and that I fully and freely give my consent.

_____
Name of Client (Please Print)

_____ _____
Signature of Client (if over 18 years of age) Date

_____ _____
Signature of Parent or Legally Authorized Representative Date

Client Information Form

Please fill in the information below for each family member attending therapy. All this information is quite personal. Do not provide this information to anyone other than your therapist. Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring your insurance card(s) with you, all charges will be your responsibility and payable at the time of service. All unpaid balances and denied claims are your responsibility. By signing this form you are consenting for you and your insurance to be billed.

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the notice before signing this consent. A copy is available upon request. As provided in the notice, the terms of the notice may change. If there are changes to the notice, you may obtain a revised copy by contacting, Natalie Sanchez, MFT with Health Psychology Associates, at 775-448-6828.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction but if we do, we are bound by our agreement. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent.

(Client) Last Name: _____ First: _____ Middle Initial ____

Parent(s) Name if Client is under 18: _____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: M F

INSURANCE INFORMATION

Primary Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Secondary Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Client or Parent/Legal Representative Signature:_____

Print Name: _____ **Date**:_____

Informed consent regarding use of telehealth

Unforeseen circumstances (e.g., illness, weather related events, academic breaks during the school year, etc.) may prevent your counselor from delivering services via regularly scheduled face-to-face visits. To minimize disruptions to care, telehealth psychological services will be utilized for a *limited period of time* via a HIPPA-compliant electronic communication platform or via telephone. Procedures to safeguard clients' Protected Health Information already in place will be extended to psychological services provided via telehealth.

Consent and Terms of the Plan:

I, _____, have read the above statement and consent to receiving psychological services via (initial below to indicate consent):

___ HIPPA-compliant video conferencing as follows via Zoom

___ telephone (provide number): _____

I agree with the following plan (initial below to indicate consent):

____ My therapist and I will e-meet during our regular time, or any other time as agreed upon

____ My therapist and I will meet:

- ❑ Weekly
- ❑ Every other week
- ❑ Other: _____

____ My therapist and I will meet for:

- ❑ 45-50 minutes
- ❑ Brief phone check-up (5-10 minutes)
- ❑ Other: _____

____ I agree to fill out any necessary for continuity of care (ROI, etc.)

_____
Client name (Print)

_____ _____
Client Signature Date

_____
Therapist Name (Print)

_____ _____
Therapist Signature Date