Heather Luevano MFT
Coastal Family Therapy
License #MFC42278
PO BOX 2284 Carlsbad, CA 92018
P: 760-978-9718 E: heatherluevanomft@gmail.com

CONSENT FOR TREATMENT

Welcome! This document contains important information regarding my professional services. **Please take some time to carefully review this form and initial all areas highlighted to initial.** Please feel free to ask me questions about these services at any time.

CONFIDENTIALITY AND MANDATED REPORTING: It is my goal to provide a safe and supportive environment for my clients as they participate in therapeutic services. Your privacy is respected by keeping sessions confidential. Information about you is generally held in confidence by law. My policy is never to release information outside of sessions without your consent. However, as your therapist, I am compelled by law and/or ethics to release information in one or more of the following circumstances:

- *Suspected abuse, past or present, of a child under 18*
- *Suspected abuse of elders or dependent adults*
- *Intention of serious and dangerous harm to self or others*
- *When you waive your confidentiality (Confidentiality is waived when using your insurance company because they require information for payment or reimbursement of a claim)*
- *When you voluntarily use your mental or emotional state in legal proceedings*
- *Following a court order*
- *As requested by a court appointed attorney for a child involved in legal proceedings*

Additionally, if you have recently been under psychiatric and/or medical care, it may be necessary for me to consult with the treating physician for the purposes of diagnosis, treatment and continuity of care. **This informed consent agreement includes your consent for me to consult with other health care professionals as needed.** An additional authorization form will be signed prior to any disclosure of information. _____**(Initial)**

COUPLES THERAPY AND CONFIDENTIALITY: The confidentiality exceptions listed above also apply to couples therapy. My policy is to not hold secrets between partners. If one tells a secret between sessions or during an individual session, the assumption is that you are discussing it in order to get help disclosing it to your partner. **The only exception is if there is an immediate or ongoing safety issue.** _____ **(Initial)**

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CONSENT FOR TREATMENT (cont.)

ADOLESCENTS AND CHILDREN: The confidentiality exceptions listed above also apply to child and adolescent therapy. Because a safe and supportive environment is imperative for all clients, sessions between minors and the therapist are confidential. Parents will be provided with general progress information only. Additional information may be provided if it is determined to be in the child's best interest. _____**(Initial)**

GENERAL CONSENT TO TREATMENT: By initialing below, I authorize and request that Heather Luevano, MFT carry out psychological examinations, treatment and/or diagnostic procedures that now or during the course of my treatment are advisable. I understand that the purpose of these procedures will be explained to me upon request and are subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable and that the therapist can make no guarantees regarding treatment progress or outcomes.

Further, **if I am consenting on behalf of a minor child, dependent or beneficiary**, I authorize Heather Luevano, MFT to deliver mental health services to the patient. I understand that all policies stated in this paperwork apply to the patient. I further accept that although my participation may be required as part of the patient's treatment, the patient's records are confidential, and by law I cannot access these records if Heather Luevano, MFT believes such access would be detrimental to the patient. _____**(Initial)**

FINANCIAL TERMS: **Payment for service is DUE prior to services rendered.** Periodically, special circumstances allow for a sliding fee scale. My standard fee is $150 per 50 minute session unless a modification has been arranged. The best results occur when appointments are regularly scheduled and consistently attended. The standard fee will be charged on a prorated basis for a report or letter writing plus a $50 administration fee, attending meetings, telephone conversations longer than five minutes, or time required to perform requested services. I accept full financial responsibility for this account._____**(Initial)**

RETURNED CHECK POLICY: There will be an additional $35 processing fee for any check returned for non-sufficient funds in addition to the regular service fee. _____**(Initial)**

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CONSENT FOR TREATMENT (cont.)

CANCELLATIONS: Your appointment time has been reserved for you. If you need to change your scheduled appointment, please provide a full 24-hour notice by calling (760) 978-9718. Missing your appointment or failure to give a full 24-hour notice of cancellation will result in a $75 nonrefundable fee. Please note that insurance companies do not pay for missed appointment fees. Your appointment will automatically be cancelled if you fail to arrive within 20 minutes of your scheduled appointment. A $75 missed appointment fee will be assessed. _____**(Initial)**

LITIGATION LIMTIATIONS: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regards to many matters which may be of a confidential nature, it is agreed that should there be a legal proceeding (such as, but not limited to, divorce and custody disputes, injuries, law suits, etc.) neither you, your attorney or anyone else acting on your behalf will call Heather Luevano to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested. _____**(Initial)**

INSURANCE: It is recommended that you contact your insurance carrier to find out how much they will pay for outpatient psychotherapy treatment. The amount of payments will depend on your policy. Many medical health insurance policies do cover at least a part of the cost of outpatient behavioral therapy. Keep in mind that if you are utilizing insurance funds, third parties may review your medical record to obtain information about diagnosis, treatment process and prognosis for the purpose of treatment authorization, quality care management and payment services. As a courtesy service, depending on your particular insurance provider, your insurance may be billed. Payment is required at the time of service. You will be required to pay all fees not covered or denied by your insurance. **(Please initial one choice below only)**

- *I understand my insurance will not be billed by my therapist and payment is due when services are rendered in full (out of pocket/cash patient).____(Initial)*
- *I understand that payment is due when services are rendered and that I can request a superbill to file with my insurance company for possible reimbursement.____(Initial)*
- *I understand that my insurance will be billed. However, co-payment is required at the time of service.____(Initial)*

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CONSENT FOR TREATMENT (cont.)

CONTACTING THERAPIST: My voicemail is confidential. Please leave a message with your name and number, even if you think I already have it. I will return calls within 24 hours but, I usually cannot provide emergency services or treatment. **In case of an emergency, call 911 or go to your nearest emergency room. If you cannot reach me and you need to speak to somebody immediately, please call the San Diego Access Crisis Hotline at 1-888-724-7240.** If an emergency occurs during our work together (or in the future after termination) where Heather Luevano becomes concerned about your personal safety, possibility of you injuring someone else or about you receiving psychiatric care, steps will be taken within the limits of the law to insure that you receive the proper medical treatment. Your emergency contact maybe notified.

_____**(Initial)**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that Heather Luevano, MFT has provided me with a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). _____**(Initial)**

CONTACTING CLIENT: Occasionally there may be times I will need to contact you directly. To ensure that confidentiality is kept, please initial the mode of communication and contact numbers you prefer below:

_____(Initial) Home Phone_____

_____(Initial) Cell Phone_____

_____(Initial) Work Phone_____

_____(Initial) Email_____

_____(Initial) US Mail_____

Signature Page Continued

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CONSENT FOR TREATMENT (cont.)

By signing below, I understand, acknowledge and agree to all the above treatment guidelines, policies and procedures. I am giving my full consent to enter into treatment with Heather Luevano, MFT.

Client Signature:_____ **Date:**_____

Print Client Name:_____

Provider Signature:_____ **Date:**_____

Provider Name: Heather Luevano, MFT #42278

Consent to Treatment of a Minor:

Legal Guardian Signature:_____ **Date:**_____

Relationship to Minor:_____

Legal Guardian Signature:_____ **Date:**_____

Relationship to Minor:_____

If required, additional Client:

Print Client Name:_____

Client Signature:_____ **Date:**_____

A separate consent form for the treatment of a minor is required if a child's biological parents are divorced and share joint legal custody. Consent for treatment must then be provided by both parents. If one parent has full legal custody, court documentation must then be provided.

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