Informed Consent for Psychological or Psychiatric Services (Minors)

Welcome to The Rosetta Center for Counseling and Wellness. This document contains important information about our services and business policies. This is a legal document; it is very important that you read it carefully. It is equally important that you ask any questions that you may have about the procedures.

Staff: The Rosetta Center is staffed by Licensed Psychologists, Licensed Marriage and Family Therapists, Psychiatrists, Pre- and Post-Doctoral Psychology Interns, and Master's level counseling trainees and interns. Interns and trainees are supervised by licensed professionals and will inform of you their current supervisor's name and license number at your first meeting.

Benefits and Risks: Psychotherapy is a collaborative effort. Progress depends on many factors including motivation, effort, and other life circumstances. Since therapy often involves discussing unpleasant aspects of your life experiences, you may at times notice uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have significant benefits such as more fulfilling relationships, improved coping skills, solutions to specific problems, reduction in feelings of distress, and personal growth. Open and honest communication is essential to a positive outcome in counseling and you are encouraged to voice any concerns or questions about the effectiveness of treatment.

Confidentiality: Therapy includes talking about very private things. So that you feel free to talk openly about your concerns, and so that your right to privacy is protected, the law makes it our duty to keep client information confidential. As a general rule, your case will not be discussed nor will any information about you be sent outside of the Rosetta Center without your permission. If you would like us to share information with someone else, you will be asked to sign a release of information form allowing me to exchange information with that person or organization.

There are some situations that require you to provide written, advance consent for the release of information. Your signature on this document provides consent for the following activities:

- In order to provide you the best treatment we can, staff may consult with other health or mental health professionals. In these consultations, every effort is made to avoid revealing your identity. These consultants are also legally bound to keep the information discussed confidential.
- The Rosetta Center employs administrative staff. Protected information is shared with these individuals for administrative purposes such as scheduling, billing, and quality assurance. All staff members have been trained in protecting your privacy and have agreed not to release any information without appropriate releases in place.
- Disclosures required by insurance companies are discussed in the relevant section below.

There are other situations where staff are permitted or required to disclose information **without** either your consent or authorization. They are as follows:

- If there is any reason to suspect that a child has been, or is at risk of, being abused (sexual, physical, emotional, witness to domestic violence) or neglected, the law requires that we report the suspicion to Child Protective Services or Law Enforcement.
- If we have knowledge of, or reasonable cause to suspect that, an elderly person or an adult with developmental disabilities or mental illness is abused, neglected, or exploited, we are required by law to report the abuse to Adult Protective Services.
- If you threaten to seriously harm yourself or someone else, we are permitted to take action to prevent any harm from occurring.
- If a court of law, or other government agency, orders me to release information, we are required to provide that information to the court.
- If you are or become involved in any kind of lawsuit or administrative procedure (Ex. worker's compensation), you may not be able to keep your records or therapy private.

Attendance Policy: A minimum of 24 hours notice is required for rescheduling or canceling an appointment. You will be charged a $25 fee for the 1st session for no shows or late cancellations. Second and subsequent no shows or cancellations are subject to the full session fee. There are few exceptions to this policy such as a last minute illness or emergency. Insurance companies will not cover no shows or cancellations.

Payment: Payment should be made by cash, check, debit or credit card at the time services are rendered. Services provided outside of regularly scheduled appointments are prorated based on the session fee. Examples of such services include, but are not limited to, report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals at your request, and preparation of records or treatment summaries. If you become involved in legal proceedings that require my participation, you will be expected to pay for all service time, including preparation and transportation costs, even we are called to testify by another party. If you think you will have trouble paying any fees, please discuss this with your therapist.

Insurance: If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with assistance to help you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of fees. If claims are denied by your insurance company, for any reason, you are responsible for payment of that service. You should also be aware that most insurance companies require that the Rosetta Center to provide them with a clinical diagnosis and possibly additional clinical information (e.g., treatment plans or summaries) in order to process claims.

Authorized Consent: Therapy generally requires consent of both parents prior to providing services to a minor child. If there are any questions regarding the authority of the representative providing consent for treatment, we will require that you submit supporting legal documentation, such as a custody order, prior to beginning treatment.

I certify that I have read and understand the above conditions of therapy and disclosures. I accept these conditions and give my consent to be treated at The Rosetta Center for Counseling and Wellness.

_____ _____

Client Signature (Minor) Date

_____ _____

Guardian Signature and Relationship Date

_____ _____

Guardian Signature and Relationship Date

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act, HIPAA, requires The Rosetta Center to give you the following information. This notice describes how psychotherapy and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

We are legally required to protect the privacy of your protected health information (PHI), or information that can be used to identify you that relates to your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for the provision of health care to you. We may use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization; for others, however, we do not.

II. USES AND DISCLOSURES THAT DO NOT REQUIRE AUTHORIZATION

- **a. For treatment.** We 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.
- **b. To obtain payment for treatment.** We can use or disclose your PHI to bill and collect payment for the treatment and services provided to you by the Rosetta Center.
- **c. Child abuse.** Whenever any of our staff, in their professional capacity, observe, have knowledge of or reasonably suspect a child has been the victim of child abuse or neglect, s/he must immediately report the incident(s) to the proper authorities.
- **d. Elder/dependent adult abuse.** If a member of our staff has knowledge of, has observed, or reasonably suspects physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if a member of our staff is told by an elder or dependent adult that s/he has been abused, we must report the abuse immediately to the proper authorities.
- **e. Serious threat to health or safety.** If you communicate to a member of our staff that you are in such condition as to be a danger to yourself or others, we may release relevant information as necessary to prevent harm or danger.
- **f. Other.** Other situations that may require disclosure of your PHI include situations required by federal, state, or local law; judicial, board, or administrative proceedings.

III. USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

- **a.** In order to use or disclose your PHI in situations other than those noted above, The Rosetta Center must obtain your written authorization. This authorization must be received prior to releasing the information.
- **b.** You may revoke or modify all such authorizations at any time.

IV. **PATIENT'S RIGHTS**

- **a. Right to request restrictions.** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, the Rosetta Center is not required to agree to the requested restriction.
- **b. Right to receive confidential communication by alternative means and at alternative location.**
- **c. Right to inspect and copy.** You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **d. Right to amend.** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **e. Right to an accounting.** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.
- **f. Right to a paper copy.** You have the right to obtain a paper copy of this notice from me upon request.

V. **PSYCHOTHERAPIST'S DUTIES**

- **a.** We are required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI.
- **b.** We reserve the right to change the privacy policies and practices described in this notice and to make the new notice provision effective for all PHI that we maintain. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- **c.** If we substantially revise these policies and procedures, we will notify you at your next meeting and provide you with a paper copy of the revised notice upon your request.

VI. COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Tiffany Mimms, Ph.D. at (916) 424-3700. You may also send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Ave S.W., Washington, D.C. 20201.

I acknowledge receipt of this notice.

_____ _____

Print Client (or Parent/Guardian) Name Date

_____

Signature

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I acknowledge receipt of this notice.

_____ _____

Print Client (or Parent/Guardian) Name Date

_____

Signature

The Rosetta Center for Counseling and Wellness, Inc.

A Place for Health, Healing, and Hope

A Professional Psychology Corporation

A. Client Information Date:_____

Name:_____ SS:_____

Address: _____

Street City State Zip Code

Phone: (Home)_____ May we leave a message on this phone? Y N

(Cell) _____ May we leave a message on this phone? Y N

(Work) _____ May we leave a message on this phone? Y N

Email: _____May we email you? Y N

What is your preferred way that we contact you? _____

Date of Birth:_____ Age:_____

Relationship Status:_____ Ethnic Identity: _____

Sexual Orientation: _____ Religious/Spiritual Affiliation:_____

Employer/School: _____

Occupation/Major: _____

Referred by:_____

B. Insurance

Primary Insurance Company: _____

Subscriber's Name: _____

ID#: _____ Group #:_____

C. Emergency Contact

Name: _____ Relationship:_____

1531 Corporate Way
Sacramento, CA 95831

(916) 424-3700
Info@TheRosettaCenter.com

Address: _____

Phone: (Home) _____ (Other)_____

D. Family/Social

List all person's currently living in household:

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. Current Concerns

Please mark all of the following concerns that pertain to you. Circle the 2-3 that you would like the most help with.

- ☐ Addiction
- ☐ Abuse
- ☐ Aggression
- ☐ Alcohol use
- ☐ Anger
- ☐ Appetite
- ☐ Anxiety, nervousness
- ☐ Career/School
- ☐ Childhood issues
- ☐ Confusion
- ☐ Compulsions
- ☐ Crying
- ☐ Delusions
- ☐ Dependence
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Discrimination
- ☐ Disorganized thoughts
- ☐ Divorce/Separation
- ☐ Drug use
- ☐ Eating
- ☐ Emptiness
- ☐ Fatigue
- ☐ Fears, phobias
- ☐ Financial trouble
- ☐ Forgetfulness
- ☐ Gender identity
- ☐ Grief/mourning
- ☐ Guilt
- ☐ Harassment
- ☐ Headaches
- ☐ Heterosexism/homophobia
- ☐ Illness/physical health
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Impulsivity
- ☐ Infertility
- ☐ Irritability
- ☐ Irresponsibility
- ☐ Lack of motivation
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Menstrual problems
- ☐ Mood swings
- ☐ Obsessions
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination
- ☐ Problems in judgment
- ☐ Racism
- ☐ Relationship problems
- ☐ Sadness
- ☐ Self esteem
- ☐ Self-harm
- ☐ Sex

- ☐ Sexism
- ☐ Shyness
- ☐ Sleep
- ☐ Smoking, tobacco use
- ☐ Spirituality/religion
- ☐ Stress
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Tension
- ☐ Violence
- ☐ Weight
- ☐ Withdrawal, isolating
- ☐ Work problems
- ☐ _____
- ☐ _____

F. Mental/Physical Health History

Do you currently have any physical health problems? _____

_____

Have you had any health problems in the past? _____

_____

Have you been in counseling or psychotherapy before? If yes, with whom and for how long?

_____

Are you currently receiving psychiatric services, counseling, or therapy elsewhere? If yes, with whom and for what?

_____

_____

List all medications (dosage, purpose, length of time) you are currently taking:_____

_____

Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe.

_____

Have you ever had thoughts, made statements, or attempted to harm another person? If yes, please describe.

_____

Have you been hospitalized for psychiatric reasons? If yes, please describe. _____

_____

G. Substance Abuse

Do you regularly use alcohol, drugs, or medications not prescribed by your doctor? If yes, how much and how often? _____

_____