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Informed Consent for Psychotherapy

SCHEDULING AND CANCELLATIONS

Sessions can be scheduled several ways, face to face with the practitioner, through text, or through email on a weekly basis. If you are unable to make your scheduled session, please inform me in 24 hours prior to client's session time. Please note that clients will be charged the full session rate if a client does not attend a scheduled appointment without at least 24 hours' notice. If a client does not attend sessions for two weeks and there is no communication regarding absences, then the therapist will close the client's case.

FEES

The fee for service generally covers a 60 minute session and will be agreed upon in the first treatment session and payable at the time service is rendered.

AVAILABILITY

The therapist is available for regularly scheduled appointment times. Dates of vacation and other exceptions will be given out in advance if possible. A message may be left at 562-583-2233 although the call may not be returned until the next business day. If the client faces a psychiatric emergency call College Hospital Costa Mesa at 1-800-773-8000 or dial 911. If the client faces a life threatening emergency, call 911.

BENEFITS AND RISKS

Participating in therapy may result in a number of benefits for the client. Therapy provides an opportunity to more deeply understand oneself as well as any problems or difficulties the client may be experiencing. Psychotherapy is a joint effort between the client and the therapist. There are no guarantees that therapy will yield these benefits. Participating in therapy may also involve some discomfort, including remembering, experiencing, and discussing unpleasant events, feelings, and situations. During the therapeutic process, many clients find that they feel worse before they feel better.

CLIENTS WHO ARE DEPENDENTS

If you are requesting services for a child(ren) as the guardian, the parent, or Possessor Conservator of that child, it will be critical that the child trust the therapist. While CBT therapy often includes parents' involvement throughout the session, there may be times when it is appropriate and beneficial for older children or adolescents to meet with the therapist one on one. With your understanding in advance, the therapist will keep what your child says/does confidential. If I think it would be helpful to share a specific detail with you, I will first ask the child's permission to do so, or I will encourage the child to do so. It is important to the therapy process that he/she does not think the parent and the therapist are conspiring against him/her in any way. You have the right and responsibility to question the therapy process, to understand the nature of activities with the child, and to be informed of the child's progress. I have the right to use my clinical discretion as to what is appropriate disclosure. If I believe that the child is in danger or is a danger to someone else, I will notify parents of my concern. I will review the child's progress in therapy with you, and I want to obtain feedback from you regarding your interactions with the child and observations of the child in various settings. In this way, we will work as a team. I value your consultations and your involvement. I will discuss with you how you can participate effectively in the child's treatment and progress outside of therapy.

RELATIONSHIP WITH THE THERAPIST

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It must be limited to the relationship of therapist and client only. If we were to interact in other ways, we would then have a dual relationship. Therapy professions have rules against such relationships to protect us both. I cannot give legal, medical, financial, or any type of professional advice. I do not accept "friend requests" or contact requests from current or former clients on social networking sites (Facebook, Instagram, etc.) out of concern for your confidentiality and my privacy.

PATIENT LITIGATION

The therapist will not voluntarily participate in any litigation, or custody dispute in which the client or another individual are parties. The therapist has a policy of not communicating with clients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a clients' legal matters.

TERMINATION

The therapist may terminate treatment if payment is not timely, if therapy is contraindicated, or if some problem emerges that is not within the scope of competence of the therapist or if the therapist experiences the interaction as abusive. Clients have the right to terminate at any time but at least one termination session is requested for closure.

Health Insurance Portability Accountability Act (HIPAA) **Client Rights & Therapist Duties**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to

protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the appropriate California Child Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate California Elderly or Dependent Adult Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- **For Treatment** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- **For Payment** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- **For Operations** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- **Right to Treatment** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- **Right to Confidentiality** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of \$1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS INFORMED
CONSENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN
ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM
DESCRIBED ABOVE.

Client/Legal Guardian Signature

Date

Printed Name

Client/Legal Guardian Signature

Date

Printed Name

Dianne Tiberg, LMFT

Date

MINOR CHILD SIGNATURE STATEMENT

1. The minor(s) named below live in my home and I am 18 years of age or older. Yes No

2. Name of Child: _____ Child's Date of Birth: _____
Name of Child: _____ Child's Date of Birth: _____
Name of Child: _____ Child's Date of Birth: _____

3. Your Name (please print): _____

4. Your relationship to child(ren): Parent Stepparent Guardian Grandparent Other

5. I hereby swear that I have the following legal custody (circle appropriate): Joint Sole None

6. I hereby swear that I have a legal right to obtain treatment for the above-named child(ren): Yes
No

7. In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above child(ren). Are you willing to do so? Yes No

If the answer to any of the above questions is "No," counseling services can not be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

Client/Legal Guardian Signature

Date

Printed Name

Client/Legal Guardian Signature

Date

Printed Name