TERMS AND CONDITIONS OF SERVICE

Center for Mental Wellness
PO Box 1112, Cardiff, CA 92007
858-461-9409
info@socalmentalwellness.com

Please read the consent form below carefully. It is important that you understand the services being offered and the terms and conditions under which these services are offered. If you have any questions, please feel free to ask.

CONSENT FOR EVALUATION/TREATMENT

The undersigned client or responsible adult* consents to and authorizes mental health service by the Center for Mental Wellness. These services may include psychological testing, psychotherapy/counseling, and evaluations.

1. Confidentiality: All information disclosed within these sessions is strictly confidential and may not be revealed to anyone without the written permission of the client, or if applicable, the client's representative. The only exceptions are when disclosure is required or permitted by law. Those situations typically involve substantial risk of physical harm to oneself or to others, or suspected abuse of children or the elderly.
2. Fees/Payment Obligation: Payment is due at the time the services are rendered. The fee must be paid for each appointment made unless the appointment is canceled at least 24 hours prior to the appointment time. Fees are payable to "Center for Mental Wellness." Failure to pay fees for service may result in the termination of treatment and/or the use of an outside collection agency to collect fees. If the client has two or more returned checks, only cash payments will be accepted from that point on. The client is also responsible for paying any additional fees that are incurred as a result of the returned check(s).
3. Insurance: Even if the client has insurance coverage, he/she is responsible for payment of fees at the time of each session. If the client has insurance coverage, a letter will be provided to allow the client to request reimbursement from his/her insurance company. The client authorizes the Center for Mental Wellness to furnish from the client's record necessary information to the insurance company to the extent required to collect insurance benefits to which the client may be entitled.

Accomplishing treatment goals requires the cooperation and active participation of the client. Very rarely, lack of cooperation by a client may substantially interfere with effective rendering of services to the client or to others. Under such circumstances, services to the client may be discontinued.

The client or, if applicable, the client's parent(s), legal guardian(s) or conservator(s), certifies that he/she has read, understood, accepted, and received a copy of this Terms and Conditions of Service for his/her records. This contract covers the length of time the undersigned is a client obtaining services from the Center for Mental Wellness.

If client is a minor:

Child’s name:	
Name of parent or client’s representative (please print):	
Signature of parent or client’s representative:	
Relationship to client:	
Date of signing:	

If client is over 18 years old:

Name (please print):	
Signature of client	
Date of signing:	

*Responsible adult refers to guardian, conservator, or parent of a minor.

For office use only:
Signature of representative/witness obtaining consent:________________________________
Date:________

CENTER FOR MENTAL WELLNESS - NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Information about your mental health treatment and related health care services ("mental health information") is personal and we are committed to protecting the privacy of the personal and mental health information you disclose. We are required by law to maintain the confidentiality of information that identifies you and the care your child receives. When information is disclosed to other people and companies to perform services for us, they will be required to protect your privacy also. We are required to give you this Notice about our privacy practices, your rights, and our legal responsibilities. This Notice also applies to other health care professionals who provide care to you. There are special laws that protect information about HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol services. We will obey these laws.

WITH THE WRITTEN CONSENT OF A PARENT, GUARDIAN, OR MINOR LIVING INDEPENDENTLY, WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For treatment. For example, we may give information about your child's psychological condition to other health care providers to facilitate your treatment, referrals or consultations.
- For payment. For example, your insurer may be contacted to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- To other providers. For example, so they can treat your child, or obtain payment for their services.
- For appointments and services to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.
- To individuals involved in your care, such as parents, if the child is a minor, or a conservator.
- With your written authorization. Your child's mental health information may be used or disclosed for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:

- If it is required or authorized by other laws (e.g., to report child abuse, elder abuse, or dependent adult abuse).
- For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
- In judicial proceedings in response to court/administrative orders, subpoenas, discovery requests or other process.
- To public health authorities to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.
- To law enforcement (e.g., to assist in an involuntary hospitalization process).
- To the state legislature for legislative investigations.
- For research purposes subject to a special review process, and the confidentiality requirements of state and federal law.
- To prevent a serious threat to health or safety of an individual. We can notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
- To protect certain elective officers including the President, by notifying law enforcement officers of the potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

- To receive a copy of this notice when you come for treatment.

- To request restrictions or limit the mental health information that is disclosed about your child for treatment, payment or health care operations. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment. We require that you put such requests in writing.
- To inspect and request a copy of your child's Mental Health Record except in limited circumstances. A fee will be charged to copy your record. If you are denied access to your child's mental health record for certain reasons, you will be informed of the reason and what your rights are to challenge that denial. We require that you put such requests in writing.
- To request an amendment or addendum to your child's Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (an addition to the record) of no longer than 250 words for each inaccuracy. Your request must be in writing and give a reason. Your request may be denied if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or is accurate and complete. Even if your request is accepted, any information already in your records is not deleted.
- To receive an accounting of certain disclosures we have made of your child's mental health information. We require that you put such requests in writing.
- To requested that we contact you by alternate means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and must be honored if it is reasonable.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

CONTACT INFORMATION

If you believe your privacy rights have been violated, you may file a complaint by calling or writing the Privacy Officer, CA Department of Health, Services, P.O. Box 997413, MS 0010, Sacramento, California 95899-7413; (916) 445-4646 or (877) 735-2929 (TTY/TDD). You may also contact the Secretary of the U.S. Department of Health and Human Services by writing or calling the Office for Civil Rights, U.S. Department of Health & Human Services, 90 7th Street, Suite 4-100, San Francisco, CA 94103, (415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX.

Effective date: ___________

CLIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, ____, have received a copy of the Notice of Privacy Practices from Center for Mental Wellness.

____
Name (print)

____
Signature

____
Date

For Office Use Only

I have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

____Patient/Individual refused to sign (Date of refusal):___________________

____Communication barriers prohibited obtaining an acknowledgement.

____An emergency situation prevented us from obtaining an acknowledgement.

____Other ____

Attempt was made by:______________________________Date:_____________

Explain:____
____