UNEARTH HEALING & WELLNESS

Carolina A Miranda, LCSW, EMDR Therapist, Sound Healing Practitioner

TELETHERAPY CONSENT FORM

California law has long recognized telehealth as a form of delivery of health care and behavioral health services which many psychotherapists are practicing in the state of CA and the U.S. In California, “Telehealth” is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. This form of service is usually live video conferencing through a personal computer with a webcam. Due to the current Worldwide Pandemic, all sessions are performed on HIPPA compliant video platform.

Definition of Services:
I ____________________________ hereby consent to engaging in telehealth with the following provider: Carolina A. Miranda, LCSW. I understand that “telemedicine or telehealth” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California. I understand that I have the following rights with respect to telehealth: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improve, and in some cases may even get worse.

If you have an emergency, feel suicidal, or homicidal please:

- Call 911
- Go to the nearest Hospital Emergency Room
- Call the Suicide Hotline 1-800-273-8255 available 24 hours a day.

I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. (5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above. I have discussed it with my therapist, and all my questions have been answered to my satisfaction.

Client’s Signature: _______________________________ Date____________

Form updated: 1/2021

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PLEASE READ THOROUHGLY

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES. As a provider, I am committed to providing caring and professional mental health care to you. As part of the delivery of mental health services, we have established a financial policy that provides and clarifies payment policies and options for clients, as determined by the therapeutic relationship we agree upon through forms of consent signed before initiate treatment.

PROFESSIONAL FEES: The hourly fee is $________, per agreement. If additional reports, written content, and consultation are needed**, a separate fee of $50** will be charged and needed to be paid before services are rendered. If legal involvement is needed including Subpoenas, or additional consultation, or written reports another fee will be set by provider to account for professional time spent in preparing for such event.
Emergencies or unexpected events are understandable and will be considered as events in which appointments are canceled or no-shows without providing provider with at least a 24-hour notice.

A fee of $45 will be charged for **No-show/Late cancelation fee** and will be paid before scheduling future appointments. If you have already pre-paid for sessions or purchased packages, this cancelation fee will be a separate charge and your pre-paid sessions will not be affected.

If you are using your health insurance, please note that your insurance does not cover any canceled appointment or No-show/Late cancelation fees.

Frequent cancellations may result in termination of treatment; your compliance in keeping appointments and active participation in the treatment process are vital.

BILLING AND PAYMENTS: If you are using your health insurance coverage, billing department will submit claim upon a session taking place. Please note, by the billing department submitting a claim, it does not guarantee reimbursement/payment to provider. If your account is not paid for more than 60 days and arrangements for payment have not been agreed upon the provider, has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, the costs are included in the claim.] In most collection situations, the only information provider releases regarding patient treatment is the patient's name, that services were provided, and the amount due. As the insurance policy holder, you have every right to contest declined claims with your insurance provider. You are your biggest advantage and I encourage you if ever in this is the circumstance to contact the insurance company yourself. The chances of you getting them to pay claim are better than provider.

Client's Signature: ____ Date: _____________________

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CLIENTS USING INSURANCE AS PAYMENT FOR SERVICES, PLEASE COMPLETE THE FOLLOWING:

Name of insured: ___________________________________ Birthdate:____________ SS#: _____ - _____ - _____

Employer of insured: ______________________________________

Address: ________________________________ City: ________________________ State: ______ Zip: __________

Home phone: (   ) _____ — _________ Work phone: (   ) ______ —__________

Relationship to patient: _______________________ Primary insurance name: ______________________________

Insurance phone: (   ) _____ — ________ Identification #: _______________________ Group #________________

Authorization number: ______________________________________

IF SECONDARY (ADDITIONAL) INSURANCE EXISTS, PLEASE COMPLETE THE FOLLOWING:

(**PLEASE NOTE, IF INFORMATION NOT PROVIDED, IT CAN AFFECT THE REIMBURSEMENT OF CLAIMS AND CLIENT IS RESPONSIBLE FOR UNPAID CLAIMS).**

Name of insured: ___________________________________ Birthdate:____________ SS#: _____ - _____ - _____

Employer of insured: ______________________________________

Address: ________________________________ City: ________________________ State: ______ Zip: __________

Home phone: (   ) _____ — _________ Work phone: (   ) ______ —__________

Relationship to patient: _______________________ Secondary insurance name: ______________________________

Insurance phone: (   ) _____ — ________ Identification #: _______________________ Group #__________________

Authorization number: ______________________________________

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature of Person Responsible for Account: _______________________________________ Date: _______________

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize the provider and company, to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to provider. I (we) understand that access to this information is limited to determining insurance benefits and is accessible only to persons whose employment responsibilities involve the determination of payments and/or insurance benefits.

I (we) understand that I (we) may revoke this consent at any time by providing written notice. Additionally, this consent expires after one year from the date of signing this form. I (we) are informed about the information that is provided, its purpose, and who receives it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: __________________________________ Date: _______________________

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NOTICE OF PRIVACY PRACTICES YOUR INFORMATION & PROVIDERS RESPONSIBILITIES.

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please know that this notice is a summary only, and that applicable law places requirements on providers, and limiters/expanders on the issues discussed in this notice (including our uses/disclosures), that may not be obvious. As a California provider, I also abide by state law and regulations of Board of Behavioral Science where I hold my state licensure. In addition, this provider follows The Administrative Simplification provisions of HIPAA (Title II of the Act).

How provider may share healthcare information:

-The most common and way your information is shared is when we bill a claim for services with your insurance provider.

-Obtaining additional authorizations, re-authorizations, or extensions based on medical necessity.

-Consulting with previous therapist for continuity of care purpose, Release of Information Form will be required.

-Reprocessing a claim and insurance company may need explanation of services and/or justification for medical necessity.

-Submitting an internal referral for additional resources and support for treatment, (i.e., case management service).

-Provider will require signed Release of Information form to complete outside referral for specialty services if needed for treatment.

-As a mandated reported, provider is required to report suspicion of child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

Please note legal proceedings are distinct in the disclosure of client's private information including medical treatment and diagnosis. Provider and client will discuss further in detail potential legal proceedings that may put in jeopardy the confidentiality of the client and medical information and treatment.

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ELECTRONIC COMMUNICATION POLICY FORM

ELECTRONIC COMMUNICATIONS POLICY EMAIL COMMUNICATIONS: The provider will use email communication and text messaging only with your permission and only for administrative purposes unless another agreement was reached. That means that email exchanges and text messages with provider should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email about clinical matters because email is not a secure way of contacting us or an efficient way of communicating complex and information regarding your treatment. If you need to discuss a clinical matter with your provider, please email provider regarding the need for communication for provider to set time before or during follow up scheduled session.

TEXT MESSAGING: Due to the unsecure and impersonal mode of communication text messages can be in therapy, provider will limit text message only to communicate rescheduling, cancelation or confirm appointments.
SOCIAL MEDIA: Provider has public Social Media providing resources to the public and informative content about the services provided. Provider will not communicate or be in contact with existing clients. This is a precaution to maintain legal confidentiality to the client.

CONSENT FOR TREATMENT/ACCEPTANCE OF POLICIES: If you have further questions or concerns, as the provider, I will do my best to answer any further questions you may have during treatment. Your signature represents a statement that you have read and understood the information above (and as outlined by the provider), have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this provider, agree to comply with fees and policies, and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

PROVIDER'S DISCLAIMER: With any modality of treatment I provide, it takes your commitment and readiness for change and of course your wiliness to receive. Deep inner work is hard, challenging and at times, oh so overwhelming, but it is necessary in the transformative and healing journey. In your treatment, the provider will encourage and recommend you implement and practice coping skills, techniques and may even assign homework to help in the treatment progress. We all are given the gift of free will, and thus, it is up to each invidual to decide to take the information provided during treatment and implemented outside therapy sessions. What you put in is what you will get out of it.

Print client name: ____

Signature of client: ______________________________ Date: ________________________