Jennifer Whitley, LMFT
MFC# 52329
3017 Douglas Blvd, Suite 300 ❖ Roseville, CA 95661 ❖ 916.346-1848 ❖ www.jenniferwhitley.org

AGREEMENT FOR SERVICE / INFORMED CONSENT

This Agreement is intended to provide [name of patient]_____ (herein "Patient") with important information regarding the practices, policies and procedures of Jennifer Whitley, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist Background

Jennifer Whitley has been practicing as a licensed marriage and family therapist (LMFT) since 2012, working children, adolescents, families and adults.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice.

As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

Jennifer Whitley, LMFT is an **Independent Contractor and has no business ties to the other therapists working in this office.**

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Patient shall pay all fees related to creating and mailing copies. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples' therapy.** This means that if you participate in family, and/or marital/couples' therapy, I am permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family. Please feel free to ask me about the "no secrets" policy and how it may apply to you.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $125.00 plus a $500.00 retainer.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her

mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is $130.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Patients are expected to pay for services at the time services are rendered. Therapist accepts cash and major credit cards.

In the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Therapist can use legal means (court, collection agency, etc.) to obtain payment.

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Co-pays are due at the time of service.

Therapist is a contracted provider with the following companies: HMC, and has agreed to a specified fee. If Patient intends to use benefits of his/her health insurance policy, Patient agrees to inform Therapist in advance.

Should Patient choose to use his/her insurance which the therapist is not contracted with, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Cancellation Policy

Patient is responsible for payment of the agreed upon fee for any missed session(s). This includes the full rate for a session typically covered by insurance including the co-pay or the full fee for the session for non-insurance clients. Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours' notice of cancellation. This fee will be charged to the credit card on file. Cancellation notice should be left on Therapist's voice mail at 916-346-1848.

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 48 hours (or two business days), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, Placer County Behavioral Health at 916.787.8860, or go to the nearest emergency room.

Therapist does not provide any treatment over the phone, text or email. E-mail or texting is an acceptable way to contact me regarding making cancellations or changes to appointment times. Please do not send personal information via e-mail between sessions that may be of a confidential nature, as I cannot ensure the privacy of e-mail or ensure that I will always be able to read/respond to e-mail in a timely fashion.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, I will provide her or him with the essential information needed.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____	_____	_____
Name of Responsible Party (please print)	Signature of Responsible Party or Authorized representative	Date

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New Client Information Packet

Please fill out as thoroughly as possible. If you are uncomfortable about answering any of these questions, please leave blank and we will discuss in session.

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Parent/Guardian (if applicable): _____

Home Address: _____ City: _____ Zip: _____

Home phone: _____ Voicemail OK? ❑ Yes ❑ No

Cell phone: _____ Voicemail OK? ❑ Yes ❑ No Text message OK? ❑ Yes ❑ No

Email Address: _____ Is it OK to Contact You by Email ❑ Yes ❑ No

How did you hear about this office? _____

Emergency Contact/Relationship to You: _____ Phone: _____

Educational/Employment History: _____

_____

Medications: _____

_____

Name of Physician: _____ Date of last physical exam: _____

Is it ok for me to contact your primary physician? (most insurances require this) ❑ Yes ❑ No

Name of Psychiatrist: _____ Date of last psychiatric appointment: _____

Is it ok for me to contact your psychiatrist? (most insurances require this) ❑ Yes ❑ No

Medical History (illnesses, surgeries, injuries, etc.): _____

_____

_____

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Reason for seeking therapy: _____

_____

_____

_____

_____

Drug and Alcohol History: _____

_____

_____

Suicidal thoughts/past and present (please include age, situation, etc.): _____

_____

_____

Are you involved in any current or pending civil or criminal litigation, lawsuits, or divorce/custody issues? (If yes. please explain): _____

_____

_____

History of Counseling Services (when, with whom, what was worked on in treatment, individual, marital, family, etc. and what you felt was helpful or wasn't helpful): _____

_____

_____

Do you have any history of being psychiatrically hospitalized? ❑ Yes ❑ No If yes, please list the hospital where you stayed, reason for your stay, and how long you stayed: _____

_____

_____

What is most enjoyable in life to you? _____

_____

_____

What concerns you or worries you at this time? _____

_____

_____

_____

_____

Spouse/Partner Name: _____ Education: _____ Occupation: _____

Any previous marriages? If yes, please describe the length, reason for dissolution: _____

_____

Children (biological, step-children etc.):

_____

_____

_____

Please write about the relationships you have with the following people as applies:

Father: _____

_____

_____

Mother: _____

_____

_____

Stepparents: _____

_____

_____

Siblings: _____

_____

_____

Family Medical/Mental Health/Addiction History: _____

_____

_____

How would you describe your childhood? (Relationships with parents, siblings, peers, school, physical, emotional, or sexual abuse, etc.):

_____

_____

_____

_____

If your parents were divorced: How old were you at the time of the divorce: _____

Describe how it has impacted you (past and present impacts): _____

_____

_____

Friendships, community, spirituality: _____

_____

_____

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Insurance Information

If you plan on having me bill your insurance as an in-network or out-of-network provider, please fill out this form prior to session. Also, please fill out the Authorization to Release Information on the next page for your insurance company.

Patient's Name: _____

Insured's Name: _____

Patient's Relationship to the insured: _____

Insured's Insurance Carrier: _____ Insured's I.D. Number: _____

Insured's Address: _____

Insured's Phone Number: _____ Insured's Date of Birth: _____

Insured's Policy Group of FECA Number: _____

Insured's Employer: _____

EAP Authorization Number: _____

Contact Member Services via the toll-free number on the back of your Insurance Card, to gather the information below, including your annual individual deductible and your current remaining deductible owed, as well as your co-pay for out-patient Mental Health Services.

Do you have a deductible? ❑ Yes ❑ No Amount of Individual Annual Deductible: $_____

Have you met your deducible for the year? ❑ Yes ❑ No Amount Remaining: $_____

Do you have a Co-Payment? ❑ Yes ❑ No Amount of your Co-Payment: $_____

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Authorization to Exchange Confidential Information

I, [Name of Patient] _____ hereby authorize Jennifer Whitley, LMFT to exchange confidential information regarding my treatment with:

_____

This Authorization permits the exchange of the following information:

- ❑ Any and All Information Necessary

❑ Diagnosis	❑ Treatment Plan	❑ Prognosis
❑ Progress to Date	❑ Clinical Test Results	❑ Dates of Treatment
❑ Patient Records	❑ Summary of Treatment	❑ Other _____

I authorize the exchange of the information described above for the following purpose(s):_____

_____

The recipient may use the information described above solely for the following purpose(s): _____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____

By: _____Date: _____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

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CREDIT CARD AUTHORIZATION

I, _____, am authorizing Jennifer Whitley, LMFT to use my credit card information to charge my credit card for our sessions. I authorize my card to be processed in the event that scheduled appointments are canceled with less than a 24-hour notice or appointments are missed as agreed to in the policies stated in the signed Office Policy/Informed Consent. I authorized my card to be processed for applicable fees not covered by insurance.

Card Type (check one): ❑ Visa ❑ MasterCard

Card #:_____ Expiration Date:_____ Verification/Security Code _____
(3-digit code on back by signature line)

Name as Printed on Card: _____

Billing Address: _____
Street City State Zip

Signature: _____ Date: _____

ALTERNATE PAYER CREDIT CARD AUTHORIZATION

If a third party (parent, spouse, etc.) will be paying for your treatment, please have that person fill out this form

I, _____, am authorizing Jennifer Whitley, LMFT to use my credit card information to charge my credit card for therapy sessions for _____. I authorize my card to be processed in the event that scheduled appointments are canceled with less than a 24-hour notice or missed appointments as agreed to in the policies stated in the signed Office Policy/Informed Consent. I authorized my card to be processed for applicable fees not covered by insurance.

Card Type (check one): ❑ Visa ❑ MasterCard

Card #:_____ Expiration Date:_____ Verification/Security Code _____
(3-digit code on back by signature line)

Name as Printed on Card: _____

Billing Address: _____
Street City State Zip

Signature: _____ Date: _____

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By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you.

My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change.

If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 916-346-1848.

If you have any questions about my Notice of Privacy Practices, please contact me at: 916-346`1848.

I acknowledge receipt of the Notice of Privacy Practices of Jennifer Whitley, LMFT

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including:

However, because of: _____

_____

I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. F**or your treatment.** I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or** disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law, and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**
3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made**. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:

3017 Douglas Blvd., Suite 300, Roseville, CA 95661, 916-346-1848

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on September 20, 2013