INFORMED CONSENT & OFFICE POLICIES

CONFIDENTIAL CLIENT INFORMATION

Name:_____Date:_____
Address: _____
City: State: Zip: _____
Phone: (home)_____ (cell)_____
Email: _____
What is the best way to contact you? email_____cell phone_____home phone_____
Person to notify in the event of an emergency: _____
Emergency contact's relationship to you:_____ Contact's phone: _____
Whom may we thank for referring you? _____
Life Design Centre Therapist Assignment:_____

INSURANCE INFORMATION

Insurance Company's Name_____Group #:_____

Claims Address:_____

Insurance Phone :_____Subcriber ID #_____

Subscriber's Name:_____

Subscriber's Social Security #:_____DOB:_____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EDUCATION & VOCATIONAL INFORMATION

Current Occupation: _____Employer: _____

FAMILY INFORMATION

Present Relationship Status (check all that apply):
__Married/Partnered (yrs:___ mos:___) __ Single (yrs:___ mos:___)
__In a new relationship (6 mos or less) __ Widow/Widower(yrs:___ mos:___)
__Divorced (yrs:___ mos:___) __ Dating (yrs:___ mos:___)

Others living in your household: _____
Name:_____ Relationship_____ Age _____
Name:_____ Relationship_____ Age _____

MEDICAL INFORMATION

Medical Doctor: _____Phone: _____
Medications:_____
How would you rate your physical health? _____
Psychiatrist: _____Phone: _____
Other Specialist:_____Phone:_____
Do you have any current physical problems or concerns?_____
Have you any history of significant physical problems (e.g., broken bones, head injury, surgery):
_____
List any current or past legal issues: _____
List any hospitalizations or inpatient programs:_____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you (client) give permission to the clinical staff at Life Design Centre to provide psychotherapy treatment. This includes but is not limited to all clinical and administrative staff members of the Life Design Centre.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. At Life Design Centre, we have a no secrets policy in couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property or is gravely disabled or when client's family members communicate to the therapist that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know. Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify the client.

Consultation: The clinical team at Life Design Centre takes pride at working together as a treatment team. You authorize the exchange of information between the clinical staff at Life Design Centre to provide you with the best possible care and treatment. We also reserve the right to consult regularly

with other professionals regarding your case; however, in such instances your identity remains completely anonymous, and confidentiality is fully maintained.

Emergencies: You may call or email your therapist at any time. If you need to contact your therapist between sessions, please leave a message on the answering service (877) 361-2551 and your call will be returned as soon as possible. Please note that therapists generally return calls within 24 hours and during their regular office times. **If you have a life-threatening emergency, dial 911 or go to the nearest emergency room.**

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Any claims that are submitted for reimbursement require a diagnostic code. Please be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. At Life Design Centre we are happy to submit claims on your behalf or provide you with a super bill.

Appointments: Sessions are 50 minutes in length for adults and 45 minutes for minors and begin at the scheduled appointment time. At Life Design Centre we enforce a 24 hour cancellation policy. Please cancel your appointments via voicemail or email. **You will be responsible for the full fee of any session canceled with less than 24 hours notice.**

Emails & Text Messages: These are not secure forms of communication and can compromise your privacy and confidentiality. In general, Life Design Centre Therapists will utilize these forms of communication for issues such as scheduling or session cancellations but not for in depth clinical issues.

The Process of Therapy: Therapy can result in a number of benefits to you, including improved quality of life and/or resolution of the specific issues that led you to seek therapy. However, during the course of therapy, recalling or talking about certain events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, traumatic feelings, etc. Your treatment can result in you making decisions about changing behaviors that can affect different aspects of your life. There is no guarantee that psychotherapy will yield positive or intended results. The therapeutic orientations that the therapists at Life Design Centre use but are not limited to include: Interpersonal Neurobiology, Integral Psychotherapy, and Archetypal psychotherapy, Behavioral, Cognitive-Behavioral, Psychodynamic, System Theory, Humanistic, Psycho-educational, Hakomi or Body Centered Psychotherapy.

Records : At Life Design Centre appropriate treatment records are kept confidential and you have the right to review or receive a summary of your records at any time except in limited legal, emergency circumstances or your therapist assesses that releasing such information might be harmful to you in

any way. In such a case, the records will be forwarded to an appropriate and legitimate mental health professional of your choice. All record requests must be made in writing.

Fees, Payments & Insurance Reimbursement: Clients are expected to pay their standard and agreed fee of $_____per hour session. Clients pay for services at the beginning of each session, unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, insurance appeals, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Sliding-scale fees may be established based on ability to pay. Please notify your therapist if any problems arise that affect your ability to make timely payments. All payments for services are to be made payable to **LIFE DESIGN CENTRE**. Payments are not made directly to individual clinicians. In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made;
(2) Clients are responsible for payment at time of service via cash, credit card, and check or PayPal
(3) Super bills can be provided for you to submit for insurance reimbursement;
(4) If payment is not received when services are rendered, the full session fee will be applied to the credit/debit card on file unless other payment arrangements have been made.
(5) If your credit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

Termination: If at any point during psychotherapy, your therapist assesses that they have not been effective in helping you reach reasonable therapeutic goals, the issue will be discussed with you and, if appropriate, they may recommend that you terminate treatment with them. In such a case you will be given a number of referrals that may be of help to you. Termination can take place for a number of reasons including but not limited to: fiduciary breach, counter transference/transference issues, lack of progress, etc. You have the right to terminate therapy at any time.

Body Centered Psychotherapy/Therapeutic Touch: By signing below you are acknowledging that you understand the following: that your therapy operates in a holistic mind-body-spirit model. As part of our body centered psychotherapy approach, a specific type of touch that is administered consciously, non-sexually, and always with your permission and consent is available to you. You further understand that you have the right at any time for whatever reason to modify or stop any methods that are employed during therapy.

Based on these understandings, please indicate if you chose to incorporate the use of therapeutically appropriate touch in your psychotherapy:

YES_____initials_____ NO_____initials_____

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully, I understand them and agree to comply with them:

Client name (print)	Date	Signature

Therapist (print)	Date	Signature

877.361.2551
INFO@LIFEDESIGNCENTRE.COM
WWW.LIFEDESIGNCENTRE.COM

LIFE DESIGN CENTRE - DEL MAR
1337 CAMINO DEL MAR, SUITE B
DEL MAR, CA 92014

LIFE DESIGN CENTRE - WEST LOS ANGELES
2100 SAWTELLE BLVD. SUITE 106

CREDIT CARD PAYMENT AUTHORIZATION

I, _____authorize a representative at LIFE DESIGN CENTRE to maintain and charge the following credit card as my chosen payment option. I understand it is my responsibility to keep a valid credit card on file at Life Design Centre. Charges will appear on your credit card statement as "Argonaut Services" or "Life Design Centre" if you pay via PayPal.

Cardholder Name: _____
Billing Address: _____City:_____ Zip: _____
Credit Card Type: Visa_____ MasterCard_____
Credit Card Number:_____ _____ _____ _____
Credit Card # 3 digit CVV code: _____
Expiration date: Month_____Year_____Phone_____
Email Address: _____
Cardholder:_____

Client Signature:_____ Date: _____

Therapist Name: _____

Please check your payment preference:
1._____Cash/Check
2._____Credit Card
3._____PayPal
4. _____Prepaid Account

Payment Instructions: All payments are made out to Life Design Centre. I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

_____ _____
Signature Date

_____
Printed Name

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of medical information complies with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq; 42 U.S.C. Section 290 dd-2; 42 C.F.R. Section 2.1 et seq.; federal HIPAA regulations, 45 C.F.R. Section 164.508; and the Lanterman-Petris-Short Act, Welfare and Institutions Code Section 5328 et seq., and Health Insurance and Accountability Act of 1996 as applicable.

I hereby authorize:_____at **Life Design Centre** to furnish, receive and/or exchange:

Assessment	Presenting Problems	Testing Report
Dates of Treatment	Prognosis	Entire File
Discharge Plans	Progress to Dates	Other
Diagnosis	Treatment Plans	Recommendations

To designee or representative of (Name):

Name:_____

Address: _____Phone:_____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. I authorize the disclosure of the health information described above for the continuation and follow-through of appropriate treatment.

The specific uses and limitations on the uses of my health information by Recipient are as follows:

_____

_____

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Policy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

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I understand I have the right to:

- Revoke this authorization by sending written notice to my Life Design Centre therapist _____and that revocation will not affect any previous reliance on the uses or disclosure pursuant to this authorization.
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
- Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
- Refuse to sign this authorization.
- Receive a copy of this authorization.
- Restrict what is disclosed with this authorization.

Duration: This authorization shall be effective immediately.

I have carefully read and understand the forgoing. I consent to the release of the above-mentioned Protected Health Information, which may include psychiatric illness and alcohol and/or drug abuse and dependence to those persons or agencies listed above. I further release _____and/or any Life Design Centre Associate from any liability arising from the release of this information or records to such designated persons or entities.

Restrictions: Release or transfer of specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

I understand that Provider cannot condition treatment upon me signing this authorization

Provider is authorized to disclose the protected health information specifically listed above until:

Date Effective: _____ Date Terminated: _____

_____ _____

*Signature of Patient or Patient's Authorized Representative** *Date*

**If signed by other than Patient, please indicate relationship between Patient and Representative:*

_____

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