Mission Valley:
2878 Camino del Rio South, Suite 200, San Diego, CA 92108

Carlsbad:
1265 Carlsbad Village Drive, Suite 210-C, Carlsbad, CA 92008

Rancho Bernardo:
16959 Bernardo Center Drive, Suite 200, San Diego, CA 92128

INFORMED CONSENT AGREEMENT

Status of Therapist: Your therapist ___________________________ is a __________________________ at The Center for Stress and Anxiety Management. S/he is supervised by ___________________________.

During your first session, your therapist will discuss several important issues with you. This form will help acquaint you with the nature of our services. Please ask for clarification of any issue that may concern you. ***Please initial each blank space if you understand and agree with what is stated.***

CONFIDENTIALITY: In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require relevant information is given to others: (1) danger to self, (2) danger to others, (3) when a child, disabled person, dependent adult, or elderly person is physically abused, sexually abused, or neglected, (4) when a court of law issues a legitimate subpoena, and (5) when a collection service is required for unpaid bills.___________

____ I acknowledge that I have received a copy of the Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices, which informs me of my rights regarding Protected Health Information (PHI).

____ I understand that my therapist may discuss my case in a confidential manner for the purposes of clinical consultation.

____ I understand that my therapist may disclose protected health information to CSAM owner and director, Dr. Jill Stoddard, insofar as this is necessary for conducting CSAM business.

____I understand that deidentified information about me may be published in scientific journals or be presented at professional meetings as long as I am not identified and cannot be reasonably identified from it.

In Case of Emergencies: Please call your therapist at the number s/he provides. If you are unable to reach your therapist directly, please call 911 or the San Diego Access and Crisis line at 1-888-724-7240 or go to your nearest emergency department. **Be aware that Center staff are available during business hours only (M-F 8:30a-5p).**

PAYMENT OF SERVICES: Please read and initial each of the following:

___ I agree to pay in full at the time of service for services rendered by my therapist.

___ I understand that cancellations of therapy appointments must be made at least 24 hours in advance and that I will be charged **100%** of the session fee for missed appointments or cancellations less than 24 hours in advance.

___ I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SSN, and address to a collection agency or small claims court. I also understand that I am responsible for any bills that my insurance does not reimburse.

___ I understand that credit cards are accepted for payment but I will be charged an additional $5 fee. Payments made by check should be made out to The Center for Stress and Anxiety Management or

CSAM. I understand that should my check bounce or be returned, I will be charged an additional $15 fee.

___ I understand that there may be additional charges for time spent outside of session (including but not limited to the therapist driving to a distant exposure location, having a meeting at a child's school, completing lengthy paperwork or reports, etc.). Additional charges will be prorated according to the therapist's hourly session rate.

Treatment Outcome: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based upon your motivation for and commitment to treatment, complexity of the symptom profile, and other factors.

I (WE) HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE AND HAVE RECEIVED A COPY OF THE HIPAA NOTICE. I (CLIENT) WILL REQUEST A COPY OF THIS ADVISEMENT FORM IF SO DESIRED.

_______________________________________ _______________
Signature of Client (or parent of a minor) Date

_________________________ ___________________ _______________
Signature of Therapist Therapist License Number Date