The Center for Stress & Healthy Aging, LLC
3411 Third Ave. San Diego, Ca 92103
www.centerforstressandhealthyaging.com
(619) 722-5797

Informed Consent Agreement

Status of Therapist: Your therapist Dr. Sofie Champassak is a licensed clinical psychologist at The Center for Stress & Healthy Aging (CS&HA).

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.

In Case of Emergencies: Please call your therapist at the number she 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 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 as noted in the CS&HA's no show agreement.

___ 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 & Healthy Aging. I understand that should my check bounce or be returned, I will be charged an additional $15 fee.

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 Date

______________________________ ___PSY30201____ ___________
Signature of Therapist License Number Date