Shibley Psychology

2333 1ST Avenue, Suite 107
San Diego, CA 92101

619.307.9346
admin@shibleypsychology.com

PARENT/GUARDIAN DATA

PARENT/GUARDIAN 1:

First, Middle, Last Name: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Address: _____
Number Street City Zip Code

Home Phone:_____ Work Phone: _____

Cell phone: _____ E-mail: _____

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____ Job/Position: _____

Who referred you to me? _____

May I have your permission to thank this person for the referral? ___ yes ___ no

PARENT/GUARDIAN 2:

First, Middle, Last Name: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Address: _____
Number Street City Zip Code

Home Phone:_____ Work Phone: _____

Cell phone: _____ E-mail: _____

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____ Job/Position: _____

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Consent for Treatment & Business Policies

Welcome!

This document contains important information related to my professional services and business policies. Please read it carefully. Questions related to this agreement can be discussed at any time. When you sign this document, it will represent an agreement between us. The information provided herein regarding my policies for protecting the privacy of confidential medical information is provided as required by law.

Psychological Services

Child and adolescent therapy will begin with a family consultation to more thoroughly understand the nature of the concern and gather relevant background information. Depending on the child's age and nature of the concern, this session will either include the child or will involve a private conversation between the parent/guardian and your therapist. At this session, consent for treatment will be required from all parent(s)/legal guardian(s). Therapy will not begin without applicable consents. If any question exists regarding the authority of the representative to give consent for therapy, your therapist will request supporting legal documentation, such as a custody order, prior to the commencement of services. Following this initial session, children are invited to meet with the therapist on a one-to-one basis. However, parental involvement is a crucial component to therapy. Parents provide information concerning their child's behavior, and are relied upon when outlining goals for therapy. Throughout the course of therapy, parents frequently receive consultation from the therapist regarding positive parenting techniques, as well as ways to manage disruptive behaviors. In such cases, time devoted to family sessions, either in person or over the phone is charged at the full session fee.

Privilege

In order for therapy to be effective for children and adolescents, a safe and confidential environment must be created. As a result, it is crucial to the therapy process that parent/guardian consent and child agreement supports a confidential therapist and client relationship. Thus, the dialogue and the content of the sessions between child and therapist will remain private.

Limitations include any instances of safety concerns, which will be determined by the therapist. If such situations arise, both the therapist and the child will discuss these issues with the child's parent or legal guardian. Feedback is provided to parents and legal guardians regarding the progress of therapy for the child. This information is typically delivered in family meetings or parent/guardian consultations. Information shared in these sessions will be first discussed with the child.

Pickup and drop-off policies

We are not able to accommodate children outside of a scheduled appointment time. Unattended children in the waiting room can represent a safety issue, as no supervision is available during this time. Parents and guardians are asked to arrive no earlier than five minutes before their child's appointment.

Parents and guardians are encouraged to wait for their child in the office for the first one or two sessions in case the therapist has a question or if your child would benefit from your presence. After the first one or two sessions most parents/guardians feel comfortable leaving the office. In such cases, we ask for a timely pickup and that during this time parents/guardians are available via cell phone.

Professional Fees

My fee for a 45-minute psychotherapy session is $125. For couples and families, each session is 1-hour long, and the fee is $150. The fee for evaluations is $150 per hour. In addition to regular appointments, I charge these amounts for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, extended telephone conversations, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time at my hourly rate ($200). I will always try to let you know of any charges before you incur them.

Billing and Payment for Services

Unless otherwise agreed upon, payment is expected at the time of service. We accept payment in cash, check, or major credit cards. If making payments by check, please pay to the order of Shibley Psychology.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed on, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or attorney or going to small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is the name, the nature of services provided, and amount due. (If such legal action is necessary, its costs will be included in the claim).

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If you plan on billing an insurance company for your sessions, you will need to complete the "Insurance Reimbursement" form listed on our website. If we are not in network with your insurance plan, we can provide services and bill your insurance as an Out of Network Provider. We can fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. We encourage you to call your plan administrator and find out what your plan covers and the extent of your benefits. Keep in mind that you are ultimately responsible for any fees not covered by your insurance provider.

You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. We will provide your insurance company with only the information required in order to meet their administrative needs. It is important to remember that you always have the right to pay for our services yourself to avoid the issues described above. Any insurance payments will be processed under the name Shibley Psychology and any co-pays will be collected at the time of service.

Cancellation Policy

Once an appointment hour is scheduled, you will be expected to pay for it unless you notify us of your need to cancel **24 hours** prior to your scheduled appointment (e.g. for a 9am Wednesday appointment, you must cancel before 9am on Tuesday. For Monday appointments, you must notify us by Friday). It is important to note that insurance companies do not provide reimbursement for "no shows" or cancelled sessions. In the event that you incur a "no show" or "late cancellation" fee, you are responsible for the total amount of the billed charges (up to the allowed amount contracted with your insurance plan, if applicable).

Professional Records and Confidentiality

How the information in your record is utilized

The laws of California and the standards of my profession require that we keep treatment records. The information in your medical record is utilized in a number of ways. Your therapist uses it to plan your treatment and keep a record of the significant issues addressed in treatment. We also use the information to coordinate your treatment with other professionals or to provide information to significant others or family members; information is only provided to those that you have given permission in writing to communicate with regarding your treatment.

Information in your medical record may also be required by your insurance company or health plan so that the treatment you receive from us can be paid for by the insurance company or health plan. For example, we may need to provide information about a service you received, or we may be required to provide information prior to treatment so that your plan will cover the treatment. In these cases, only information required for payment is provided to the insurance company or health plan. By signing this Consent, you authorize us to provide information to your insurance company as needed for payment for services.

In general, the law protects the privacy of all communications between a patient and a psychologist, and we can only release information about our work to others with your written permission.

Exceptions to your Confidentiality

There are some situations where your therapist is permitted or required to disclose information without either your consent or Authorization, and in general, we will provide information from your record when required to do so by local, state, or federal law.

- If your insurance coverage pays for any of the costs of your therapy, you are giving your consent for information such as your diagnosis and appointment dates to be shared with your insurance company. We will provide your insurance company with the minimal amount of information required.

- If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is protected by psychologist-client privilege law. We cannot provide any information without both of your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and we do not have grounds for objecting under state law (or you have instructed us not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If an agency of the government requires the information for supervision of health activities, we may have to provide it.
- If you file a complaint or lawsuit against your therapist, your therapist may disclose relevant information regarding your treatment in order to defend herself.
- If you file a worker's compensation claim, we must, upon appropriate request, disclose information relevant to the claimant's condition to the worker's compensation insurer.

There are also some situations in which your therapist is legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment.

- If your therapist believes that a patient poses a serious risk to someone, he or she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the patient threatens to harm him or herself, the therapist may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.
- If a patient reveals information related to the abuse or neglect of a child, dependent adult, or elderly person, the therapist is required by law to report this to the appropriate authorities. This includes instances when material has been accessed, streamed, or downloaded where a child is engaged in an obscene sexual act.

If a situation occurs that requires that we share information without your written permission, we will make every effort to fully discuss it with you before taking any action. In order to release any information to another party, we will ask that you sign an *Authorization to Release Information*. You may revoke your *Authorization* at any time.

Contacting Me

In addition to my office number, I have a direct line, which I answer during business hours while I am not with a patient. That number is (619) 752-0262. If I am not immediately available by telephone, you can leave a confidential voicemail. I will make every effort to return your call as soon as possible, and typically on the same day you make it, with the exception of weekends and after hours. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

If you feel that you can't wait for a return call or if it is an emergency, you can contact the San Diego Access and Crisis Line (1-800-479-3339) or go to the nearest emergency room and ask for the psychologist or therapist on call. If you are in a medical emergency, call 911.

> **Important Note:** Though email, voicemail, and text messages are frequently used modes of communication and may be used to contact me, they are NOT considered confidential. I cannot assure or guarantee your privacy when these forms of communication are used. If you have questions or concerns about this, please make sure to bring them to my attention so that we can discuss a sufficient plan for communicating.

Your signature below indicates that we have reviewed the information contained in the Consent for Treatment & Business Policies document, that you have received a copy of the document, and that you agree to abide by its terms during our professional relationship.

I understand that no specific promises have been made to me by this therapist about the results of treatment. I have read and discussed the points addressed in the Consent for Treatment and have had all of my questions fully answered. I hereby agree to enter into therapy with Dr. Jacqueline Jimenez, and to cooperate to the best of my ability, as shown by my signature here.

Today's Date: _____

Signature: _____ Printed name: _____

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Fees and Financial Agreement

Standard Fees: **Individual Psychotherapy, per session: $150**
Couples/Family Psychotherapy, per session: $200
Psychological Testing/Evaluation, per hour: $250

By signing below, I agree to pay a fee of $_____ per hour to Shibley Psychology for services provided. I understand that this fee is subject to change, and that any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as frequently as mutually agreed upon. If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Shibley Psychology.

I agree to be responsible for any charges not covered by my health insurance. I understand that my health insurance cannot be billed for missed appointments and that I am solely responsible for the full session amount for appointments missed or those cancelled without providing **24 hours notice**, emergencies excepted.

Initials: _____

I request an appointment reminder to be sent 48hs prior to my scheduled appointment via **text** to this number: _____

Credit Card Information
A current credit card number must be on file at all times (provided below). Your credit card will only be used to pay for missed appointments, late cancellations, and unpaid balances. Payment by cash or check is due at the time of your appointment. All paid invoices are emailed to the cardholder at the time of charge.

The credit card to remain on file is:

Please check one: ☐ MasterCard ☐ Visa ☐ American Express

Card Number: _____ _____ _____ _____ Expiration Date: _____ _____ Security Code: _____

Name as it appears on the card: _____

Billing address: _____ _____
Number, Street City, State, Zip Code

I authorize Shibley Psychology to charge my credit/debit card for any missed appointment fees, late cancellation fees, and/or unpaid balances. I understand that I am responsible for all charges.

Signature of cardholder: _____

Printed Name: _____

CALIFORNIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I. **Disclosures for Treatment, Payment, and Health Care Operations:** I may use or disclose your protected health information (PHI), for certain treatment, payment, and health care purposes without your authorization. In certain circumstances, I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI.

To help clarify these terms, here are some definitions:
"PHI" refers to information in your health record that could identify you.
"Treatment and Payment Operations"

"Treatment" is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.

"Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

"Health Care Operations" is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.

"Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
"Authorization" means written permission for specific uses or disclosures.

II. **Uses and Disclosures Requiring Authorization**: I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it in writing.

III. **Uses and Disclosures with Neither Consent nor Authorization:** I may use or disclose PHI without your consent or authorization in the following circumstances:

a. **Child Abuse**: Whenever I, in my professional capacity, have knowledge of or reasonably suspect that a child has been the victim of child abuse or neglect, I must immediately report such to Children Protection Services (CPS). Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, I may report such to CPS as well.

b. **Elder or Dependent Adult Abuse**: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to Adult Protective Services (APS) or the local law enforcement agency.

I do not have to report such an incident if:

i. I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

ii. I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;

iii. the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and

iv. in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

c. **Health Oversight**: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.
d. **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
e. **Serious Threat to Health or Safety**: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
f. **Workers' Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. **Patient's Rights and Psychologist's Duties**:

a. Patient's Rights:

i. **Right to Inspect and Copy**: You are entitled to receive a copy of your medical record unless I believe that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, I require written notice to that effect, and I would expect to discuss your request with you in person. If I deny you access to your records, you can request to speak with an independent colleague of mine about your request. Your request for independent review of your request should also be made in writing. If you are provided with a copy of your medical record information, I may charge a fee for any costs associated with that request.
ii. **Right to Amend**: If you believe that the information I have about you is incorrect or incomplete, you may ask me to amend that information. It is my practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to me in written form.
iii. **Right to an Accounting of Disclosures**: You have the right to request an "Accounting Of Disclosures." This is a list of the disclosures I have made of medical record information. That information is listed on the Authorization To Release Information, and will be provided to you at your written request.
iv. **Right to Request Restrictions**: You have the right to privacy, and to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. As noted above, I will not release your confidential information without your written permission. Any restrictions to your Authorization To Release Information should be specified on the Authorization.
v. **Right to Request Confidential Communications:** You have the right to request that I communicate with you only in certain ways. For example, you can ask that I not leave a telephone message for you, or that I only contact you at work or by mail.
vi. **Complaints Regarding Privacy Rights**: If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent colleague of mine, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

You have the right to a paper copy of this document, and you will be offered one when you sign the original for your medical record. I reserve the right to change my policies as outlined herein. If they change, you will be informed of that change and will provided with a copy of the current document if desired.

b. Psychologist's Duties:

i. I am required by law to maintain the privacy of your PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
ii. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

iii. If I revise my policies and procedures, I will provide you with a revised notice either in person or by mail.

V. **Agreement to Arbitrate**: It is understood that any dispute as to psychological malpractice, that is as to whether any psychological services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the psychologist and the psychologist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including claims for loss of consortium, emotional distress or punitive damages.

A demand for arbitration must be communicated in writing to all parties. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I do hereby acknowledge receipt of this office's Notice of Psychologists' Policies and Privacy Practices.

_____ _____
Signature Date

_____
Name