Growing Connections

15155 Springdale St., Huntington Beach, CA 92649

Growing Connections is a psychotherapy practice serving the local community. We are counselors with a variety of training and experience. We want to assure you of the utmost confidentiality in matters you discuss with your counselor. No information will be released concerning your identity or personal life without your express written consent, unless otherwise mandated by law (see "Confidentiality Statement" agreement.)

Therapeutic Contract

The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in you experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. The therapeutic process incorporates several techniques including, insight, interpretation, focusing on emotions, cognitive/behavioral restructuring, teaching and modeling communication skills, drawing, sand tray, parts work, experiential exercises, reframing, dream analysis, educating about individual and family patterns, games, relaxation techniques, and various pencil and paper tests.

Client's Rights

1. You have the right to a confidential relationship with your counselor. (See exceptions to confidentiality under "Confidentiality Statement" on page 3.)

2. You have the right to know the content of your records. Upon your written request your counselor may provide you either with a copy of your complete record or a summary of their content.

3. Upon the written request of involved clients your counselor may release any part of your records, to the person you specify. Your counselor will tell you when you make your request whether or not he/she thinks releasing that information to the specified agency or person would be in your best interest.

4. You have the right to ask questions about any of the procedures used in your course of therapy.

5. You, or your counselor, have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you have already incurred. The following conditions may be reasons for termination:
    - When therapy is no longer beneficial to you.
    - When another professional would better serve you. Your counselor will provide you with other professional referrals.
    - When you have not paid for the last two sessions, unless special arrangements have been made between you and your counselor.
    - When you have failed to show up for your last two therapy sessions.

Consent for Treatment

I authorize my counselor to administer psychotherapeutic examinations, diagnostic procedures, and/or treatment during the course of my care.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment.

I have read and understand the above statements about "The Therapy Process," "Client's Rights," and "Consent for Treatment."

_____	_____	_____
Name of Client (Print)	Signature of Client	Date
_____	_____	_____
Name of Client (Print)	Signature of Client	Date
_____	_____	_____
Name of Parent/Guardian (Print)	Signature of Parent/Guardian	Date

Confidentiality Statement

All information revealed by a client during the course of therapy will be kept confidential and will not be revealed to any agency or other person without the client's written permission. Exceptions to this are legally defined situations your therapist is required by law to reveal the information you tell him/her during the course of your therapy without your written consent.

Confidentiality of client information **will not** be maintained under the following conditions:

1. The therapist has a reasonable suspicion of child abuse. Child abuse is defined as:
    - Physical
    - Sexual
    - Neglect
    - Endangerment – (recent laws)
        1. In California child endangerment includes any incidents of Domestic Violence (DV) occurring when children are anywhere in the home or within the vicinity of the DV. The law considers exposing a child to DV "endangers the person or health of a child" and produces "mental suffering" for the child.
        2. A person who knowingly downloads, streams, or accesses through any electronic or digital media, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct.

    Initial _____ Initial _____ Initial _____

    All suspected abuse will be reported to the appropriate authorities.
2. The therapist has knowledge of elder abuse or dependent adult abuse. All knowledge of abuse will be reported to the appropriate authorities.

    Initial _____ Initial_____ Initial _____
3. The client threatens suicide, physical harm to self, or appears to be gravely disabled. The therapist will inform client's support system or report to appropriate authorities to provide safety for the client. (See "Duty to Warn" below.)

    Initial _____ Initial_____ Initial _____

4. The therapist has information that his/her client is/has threatened homicide or other physical harm to another person. The therapist is required by law to warn the intended victim and notify the appropriate law enforcement agencies.

Initial_____ Initial_____ Initial_____

If you are being seen in couples/family therapy, your therapist may have a "no secrets policy". Please ask your therapist if this applicable in your situation.

Duty to Warn

Confidentiality and privileged communication remain rights of all clients according to state law. However, courts have held that if an individual intends to harm him/herself or is gravely disabled, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of individuals and is up to the counselor's discretion. Such individuals may include the following:
Family members, caregivers, and/or friends of the client
Law enforcement officials
Local psychiatric emergency team members
Before breaching confidentiality the counselor will take all possible steps to first share that intention with the client. Every effort will be made to prevent any such breach of confidentiality.

I have read the above "Confidentiality Statement" and "Duty to Warn" and I understand my counselor's legal and ethical responsibility to make such decisions where necessary.

_____	_____	_____
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_____	_____	_____
Name of Client (Print)	Signature of Client	Date
_____	_____	_____
Name of Parent/Guardian (Print)	Signature of Parent/Guardian	Date

Office Policies

Cancellation: Since an appointment reserves time specifically for you, a minimum of 24 hours notice is required for cancellation of a scheduled appointment. The full fee will be charged for missed sessions without such notification regardless of situation. Insurance companies do not reimburse for sessions missed.

Administrative Office Hours: Office hours are from 9 a.m. to 6 p.m. Monday to Friday. If you need to contact your counselor between sessions, please leave a message on your therapist's phone/voice mail. In the event of an emergency please see "Emergency Procedure" below.

Emergency/Crisis Procedure: In the event of an emergency please call 911 or go to your nearest emergency room for care. In the event of a crisis please call your therapist's confidential phone/voice mail and he/she will call you back as soon as possible.

Telephone Time: After 10 minutes of telephone time, you will be charged your regular fee on a prorated basis.

Sessions Greater Than 50 Minutes: Sessions that go beyond fifty minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with your counselor.

Waiting Room Policy: Children under 12 years of age are not to be left unattended in the waiting room.

Financial Agreement

You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your counselor if any problem arises regarding your ability to make timely payment.

Client's Name _____ Birth Date _____

I agree to enter a therapeutic relationship with _____.
Counselor's Name/Title

The agreed upon fee per session is $ _____.

I understand that I will make payment in cash or by check, made out to Growing Connections, at the time of the therapy appointment, unless other arrangements have been made with my counselor. Ivy Pay (HIPAA compliant) is also a option for electronic transfer of payment.
I understand that I can leave therapy at any time and that I have no financial, legal or moral obligation to complete the treatment. I agree to pay for completed therapy sessions, sessions I miss without providing a 24-hour notice, and/or telephone time as outlined in the above "Office Policies."

Upon entering a therapeutic relationship with a Growing Connections counselor, I understand that my financial information will become privy to the accountant for Growing Connections. The accountant will hold all financial information in strictest confidence. This may include information that I carry on my personal check such as; name, address, phone number, fee/payment amount, and financial institution.

Insurance Reimbursement
Electronic Communication

Clients who carry insurance benefits that reimburse for mental health treatment should remember that therapeutic services are rendered and charged to the client and not to the insurance company. If you plan to use insurance reimbursements, upon your request, your therapist will provide you with a super bill for you to file with your insurance company.

I understand that by using insurance benefits I authorize my counselor, if necessary, to disclose required information to my insurance company to assist in processing the claim. Required information may be as follows: assessment, diagnosis, treatment plan, treatment costs, dates of service, type of therapy, etc.

If the need arises for a phone session or telemedicine (other than the "telephone time" listed above), you will be required to sign a Telemedicine Informed Consent form.

Please check with your therapist on what forms of electronic communication (email, text, face time, phone call) will be acceptable in making or canceling your therapy appointments.

Acknowledgment of Receipt of Privacy Practices

Feel free to download, read, or print copies of the Privacy Practices for yourself. Printed copies are available in the office upon request or on the website Growing-Connections.com. Your signature below signifies that I have received access to or a copy of Growing Connections "Notice of Privacy Practices" with an effective date of September 01, 2018. (National Provider Identifier Number 251S00000.)

I have read, understand, and agree to the above "Office Policies", "Financial Agreement", "Insurance Reimbursement", "Electronic Communication", and "Acknowledgment of Receipt of Privacy Practices".

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