

Informed Consent for Treatment

A. **Informed Consent for Treatment and Health Care Operations**

- a. I give my consent to Leanne Hart, MFT to provide me, my child (ward) and/or my family outpatient counseling and psychotherapeutic care. If my child is being treated, I understand that treatment is contingent upon parental/guardian participation if such is considered necessary.
- b. If I need to contact you regarding appointment scheduling or emergency cancellations, a phone message or text message will be left on the phone number(s) that you provided.
- c. If you owe money, statements or invoices will be mailed to the address that you provided. This mailing will include my name, title and business address on the envelope.
- d. There may be circumstances in which I will consult with other licensed professionals regarding your treatment. Efforts will be made to keep any identifying information confidential.

B. **Confidentiality**

- a. All information shared in this treatment is confidential except in circumstances governed by law such as:
 - a. Upon receipt of a court order
 - b. In the event of a valid emergency
 - c. If there is suspected child abuse or dependent adult or elder abuse
 - d. When danger to public or self (such as threats of homicide or suicide)
 - e. To the non-custodial parent in the case where there is joint legal custody
 - f. If under 18, your parents are the holder of confidentiality and they have the right to be informed of your needs and progress
- b. If you would like me to confer with another healthcare professional, you will need to sign a release of information form. This permission may be revoked by you at any time by notifying me.

C. **Appointments**

- a. Your session has been reserved for you. 24 hours notice is required for cancellation or you will be charged for the late cancellation or no show at my per session rate. Please understand that your insurance company will not pay for missed or cancelled sessions.

D. **Contacting Me and Emergencies**

- a. You may leave a message or text me at any time on my confidential voicemail at (714)514-3779. If you would like a return call, please leave your name and phone number along with a brief message concerning the nature of your call. Phone calls are returned on my next business day.
- b. You may also email me at LeanneHart@mac.com. However, potential risks of using electronic communication may include, but not limited to; inadvertent sending of an email or text containing confidential information to the wrong recipient, theft or loss of the computer or mobile device and interception by an unauthorized third party through an unsecured network.
- c. If you have a true medical emergency or life-threatening situation, call the police and/or paramedics by dialing 911 or go to your nearest emergency room.

E. **Financial Agreement**

- a. Fees are payable at the time of service. My fee per 50 minute session is \$175.

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- b. Due to the volume of phone messages and requests, phone conversations lasting more than 10 minutes will be charged at my session rate prorated in 15 minute intervals.
- c. I accept cash, checks, Visa, MasterCard, American Express and Debit cards. If you would like to use credit card or checks you will be asked to sign the “Electronic Payment Authorization”. All fees including ‘no show’ or ‘late cancellation’ fees will be deducted from the account designated on this form.
- d. A fee will be charged for any additional professional services rendered at your request such as consults with other professionals, preparation of special forms, reports, court time, etc. will be billed at the rate of \$200 per hour.

F. Financial Policy

- a. If you would like a superbill for your session, please let me know and the superbill will be available to you at your next scheduled session. If you have insurance which provides coverage for services out of your network you may be able to submit your superbill to them for reimbursement. You are responsible for submitting it to your insurance company and tracking your reimbursement. You are responsible for full fee regardless of your insurance company’s reimbursement policies.
- b. It is your responsibility to know your insurance benefits.
- c. I do not accept assignment of benefits, nor do I participate in your managed care insurance plan (HMO or PPO). However, I am on Cigna’s panel and will bill them for your services directly and collect your copay each session.
- d. I will gladly discuss your proposed treatment with your insurance company if they call me and you provide me with a release. Loss of confidentiality can occur with insurance companies. Please refer to my leaflet.

G. Telehealth

- a. You may choose at any time to have your session via teletherapy.
- b. Your teletherapy will be furnished in the state of California and the services I provide are governed by the laws of that state.
- c. All teletherapy will be provided via a HIPPA compliant website which is strictly confidential.
- d. You understand that teletherapy does not provide emergency services. If you have a true emergency please see D(c) of this document.

H. Social Media

- a. I do use Social Media as part of my marketing. I will not request you as a “friend” or seek your connections.
- b. I do not share or sell any email addresses or other client contact information.

I. Statement of understanding

- a. **I have read and understand this information sheet and informed consent.**

Patient/Guardian	Date

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