Cognitive Behavioral Therapy Services
Tel. (760) 730-0521 Leanna Aubel, LMFT (44619) 2111 S. El Camino Real Suite 302
Fax. (760) 730-0581 Oceanside, CA 92054

CLIENT ADVISEMENT FORM
(Child)

The following information clarifies issues relevant to our professional contract and relationship. I will go over these issues with you again when we meet. Please let me know if any of these points are unclear to you or if you have any other questions about treatment. ***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 and your child 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 that relevant information is given to others: 1) danger to self, or risk of suicide; 2) danger to others; 3) indications of current/recent child or elder abuse, and sometimes indications of past abuse when someone may be at risk of such abuse presently. In other rare situations (such as a court order from a judge, or as indicated below) confidentiality may be limited.

___ Your child's treatment may require may both parents to sign the advisement form before therapy begins or continues.

___Confidentiality within child therapy is unique. In order for children to feel comfortable discussing a range of issues, they need to know the information will not be shared without their permission. Therefore, I ask that you, as your child's parent/guardian, to agree that what your child discusses with me in session is confidential. I will not provide details of what your child has disclosed to me without your child's consent. I will, however, provide information about the interventions I use, skills being taught, assignments to be completed at home, and basic treatment progress.

___It is possible that some children/adolescents will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal experimentation, but at other times they may require parental intervention. If I ever believe that your child is clearly at serious risk of harming him/herself or another, I will inform you.

____ 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 information regarding appointments, payments, diagnosis, treatment, address, telephone, and other information required by your insurance company for payments or reimbursements will be released.

____ I understand that information regarding appointments, payments, diagnosis, treatment, address, telephone, and other information required for billing statements and managing your account may be viewed by a technician of Theramanager in the process of fixing billing software.

___ I understand that my name may be released to the receptionist in order to check-in for each appointment.

PAYMENT FOR SERVICES

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___ I understand that my fee will be **$140.00** for each (45-50 minute) session, or **$60** for each group session, and that extended sessions or non-emergency phone therapy will incur an additional prorated fee. Consultations with other professionals (e.g. teachers, MD's), and preparation of letters or reports regarding your child, will also be billed at a prorated fee. I agree to pay in full for services rendered by Ms. Aubel. Any checks that are returned due to insufficient funds will incur a **$25.00** return check fee.

____ I understand that I must make changes/cancellations for therapy appointments **24 hours in advance** and that I will be charged a fee of **$70/hr** for individual sessions and **$30** for group sessions that are late changes/cancellations, no matter the reason. There is a fee of **$70/$30 (respectively)** for missed or forgotten sessions **regardless of the reason**. This fee is for the reservation of that appointment time. (Insurance companies will not pay for late cancels.)
___ I agree that no show/late cancel/late change will be automatically charged to my credit card:
#_____ Exp ___/___/___ Code _____ billing zipcode _____

____ I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SS#, 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.

TREATMENT OUTCOME: Although most clients do make significant progress in Cognitive Behavioral Therapy, there are no guarantees that treatment will be successful. The length and outcome of treatment is based on your and your child's motivation for treatment, how long your child has had the symptoms, the skill of the therapist, and other factors.

In case of a crisis: Please call the **San Diego Crisis Line at (800) 724-7240**. **For all life threatening or medical emergencies please dial 911.**

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

_____ _____
Client Date

_____ _____
Parent or Guardian Date

_____ _____
Parent or Guardian Date

_____ _____
Leanna Aubel, LMFT Date