Healing Change:
Therapy & Consulting

H. Ameeta Singh, MFT #50409
Licensed Marriage and Family Therapist

REGISTRATION FORM:

Client Information:

Today's Date: _____/_____/_____

Name: _____ D.O.B.: _____/_____/_____

Address: _____

City: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email: _____

How did you hear about me? _____

Reason(s) for coming to therapy:

_____

_____

What gender pronoun(s) do you use?

_____

Partner/Spouse/Other Parent information: (for couples clients only)

Name: _____ D.O.B.: _____/_____/_____

Address: _____

City: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Emergency contact:

Name: _____ Tel: _____ Relationship: _____

I authorize contacting this person in the case of emergency:

_____ _____/_____/_____

Client Signature Date

PO Box 93, Berkeley, CA 94701
Ph: (415) 203-3807/ ameetasingh@healingchange.org / www.healingchange.org

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OFFICE POLICIES &
AGREEMENT FOR PSYCHOTHERAPY SERVICES,

This information has been prepared for you so that you can have a clear understanding of what our agreement is regarding the psychotherapy services you will be receiving.

This agreement is between:

H. Ameeta Singh, LMFT #50409 (Therapist) and

_____ (Client).
Print Name

PAYMENT POLICY & FEE AGREEMENT:

Clients are expected to pay the fee for service at each session, unless other arrangements have been made. Acceptable forms of payment are cash, cheque or via a third party app. Please discuss with your therapist, your preferred payment method. If during the course of therapy, you experience difficulties regarding prompt payment for services, please let your therapist know and you can discuss it together.

The fee for your psychotherapy services is $_____

I agree to pay the above amount either prior to or at the beginning of each session.

Initial here: _____

CONFIDENTIALITY:

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couples or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or couples therapy. This means that if you participate in family, and/or couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with them, when working with other members of your family. Please feel free to ask your therapist about their "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to themselves. In these instances, only the bare minimum information required to access support for the client will be released.

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ATTENDANCE & CANCELLATION / MISSED APPOINTMENT POLICY

Your therapists' goal is to provide you with high quality psychotherapy services. Therapy is very much a collaborative effort between therapist and client. It is most effective when it happens on a regular and consistent basis. As such, it is expected that clients will attend all regularly scheduled sessions. If you cancel your appointment, your therapist cannot fill that slot with anyone else and so you will be charged the full cost of your session.

If you need to reschedule an appointment, please provide as much notice as possible so that we have the best chance of finding an alternate time to have the session that week. If we cannot find an alternate time, and the session has to be cancelled, you will be charged the full cost of your session.

If you have any questions or concerns around this policy, then I am happy to dialogue and problem solve around this with you. Please let me know if this is the case.

Initial here: _____

APPOINTMENT TIME:

Please be on time. If you are late for a session, we will still need to end within the time frame allotted for your session. The charge for these sessions will be the normal rate.

Initial here: _____

By signing below, I acknowledge that I have read, understand and accept the office policies outlined above and have raised any questions I might have about it with my therapist. I have received a full and satisfactory response and agree to the provisions freely and without reservations.

_____ _____

Client Name (please print) Signature

_____/_____/_____

Date

CONSENT FOR TREATMENT:

I consent to receiving psychotherapy services from H. Ameeta Singh, LMFT #50409. By signing below, I acknowledge that I have read, understand and accept the information and policies outlined in this document.

_____ _____

Client Name (please print) Signature

_____/_____/_____

PO Box 93, Berkeley, CA 94701
Ph: (415) 203-3807/ ameetasingh@healingchange.org / www.healingchange.org

Date

MINORS AND CONFIDENTIALITY:

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

GENERAL CONSENT FOR TREATMENT OF A CHILD/MINOR

I am the parent/legal guardian of the child/ren listed below and on their behalf authorize them to engage in psychotherapeutic services with H. Ameeta Singh, LMFT #50409. I understand that the policies set out in this document apply to all the children named below.

_____ _____

Child's Name (please print) Signature of parent/legal guardian

_____/_____/_____

Date:

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AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS VIA UNSECURED/UNENCRYPTED MEANS

Potential risks of using electronic communication may include but are not limited to:

- inadvertent sending of an e-mail or text containing confidential information to the wrong recipient.
- theft or loss of the computer, laptop or mobile device storing confidential information; and
- interception by an unauthorized third party through an unsecured/unencrypted network.

E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding to e-mail or text messages.

I _____(*print name*) hereby authorize H. Ameeta Singh, *LMFT #50409* to communicate with me electronically via the following unsecured/unencrypted means: (*initial all that apply)*

_____ Telephone
_____ Voicemail
_____ Email
_____ SMS/text messages
_____ Telehealth platform used for teletherapy
_____ Other (please specify): _____

- I understand that email and text messages should not be used to communicate emergencies or high-risk situations and that my therapist may not respond to emergencies via email or text messages.

- I have read and understand the risks of utilizing unsecured/unencrypted communications as listed above.

- I understand that phone, email or text communication can be relatively easy to access by unauthorized persons, which can compromise the privacy and confidentiality of the communication.

- I confirm that I have made an informed choice to request communications via unsecured/unencrypted means for information that may be of a confidential and private nature; and that I understand the risk that such communications may be intercepted.

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- I agree to hold H. Ameeta Singh, *LMFT 50409* harmless in the event any communications via unsecured/unencrypted means are intercepted or otherwise compromised.

- I understand that I may withdraw my consent for my therapist to communicate with me via unsecured/unencrypted means at any time without affecting my right to future care, treatment and services.

- I understand that I may revoke my consent in writing at any time by contacting my H. Ameeta Singh, *LMFT 50409* at 415-203-3807

_____ _____

Client Name (please print) Signature

_____/_____/_____

Date

PO Box 93, Berkeley, CA 94701
Ph: (415) 203-3807/ ameetasingh@healingchange.org / www.healingchange.org

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INFORMED CONSENT FOR TELEHEALTH SERVICES

This form is designed to allow you to give informed consent for the use of audio-visual technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

Telehealth, also referred to as Teletherapy, is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. internet or phone) to facilitate diagnosis, consultation, treatment, education, care management and self-management of a client's health care.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your cell phone call back number here: _____.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Teletherapy under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Agreement to Psychotherapy Services I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overhead by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-personal services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. Some Telehealth platforms allow for video or audio recordings. I understand that there will be *no recording of any of the online sessions* and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.
9. I understand that I am *not allowed to do any recording, screenshots, etc. of any kind, of any sessions.*
10. I have discussed the session fees with my therapist and agree to them.
11. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.
12. I agree to take full responsibility for the security of any communications or treatment on my own computer/phone and in my own physical location.
13. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services.
14. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

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I, _____(*insert name*) hereby consent to engage in Telehealth services with H. Ameeta Singh, LMFT #50409 for the purposes of receiving psychotherapy, assessment, continued care, treatment, or other services. I authorize H. Ameeta Singh, LMFT, #50409 to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through H. Ameeta Singh, LMFT #50409 at any time. I understand H. Ameeta Singh, LMFT #50409 will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for Telehealth services.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have read. understood and agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Print Name Signature

_____/_____/_____

Date

NOTICE TO CLIENTS:

The Board of Behavioral Sciences receives & responds to complaints regarding services provided within the scope of practice of Marriage & Family Therapists. You may contact the board online at www.bbs.ca.gov or by calling 916-574-7830

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at:
(415) 203-3807/ ameetasingh@healingchange.org

If you have any questions about my Notice of Privacy Practices, please contact me at:
415-203-3807/ ameetasingh@healingchange.org

I acknowledge receipt of the Notice of Privacy Practices of H. Ameeta Singh, MFT #50409.

Print Name: _____

Signature: _____ Date: _____
(client/parent/conservator/guardian)