

Tara J. Boerner, LMFT 45305

19720 Ventura Blvd Suite C Woodland Hills, CA91364

AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

Please indicate whether this contract is for minors or adult.
Thank you!

 Adult This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Tara J Boerner (herein “Therapist”), and _____ (herein “Patient”), to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing.

_____Minors Therapy Consent This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by

_____(Therapist) LIC
#_____for the minor child{ren }herein
“Patient”and is intended to provide BOTH [name of
parent(s)/legal guardian(s)]

X_____

_____ (herein “Representative(s)”) with important information regarding the practices, polices and procedures of Evolving Heart Therapy (herein “Therapist”), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be

discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor

Child Therapist generally requires the consent of **both parents** prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services. Initial here_____

Therapist Background and Qualifications

Therapist, Tara J. Boerner has been practicing as a licensed marriage and family therapist (LMFT) since 2008, working primarily with children, adolescents, families, ADHD, Autism Spectrum Disorders, and Learning Disabilities. Therapist,

Risks and Benefits of Therapy

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process.

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to

Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with

appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient or representative. Should Patient or Representative request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient, or Representative, with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Representative will generally have the right to access the records regarding Patient. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law. Therapist will maintain Patient's records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written

authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well being of Patient, including suicidality.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of \$150.00. In addition, Therapist **will not** make any recommendation as to custody or visitation

regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is \$150.00 per 50-

minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance.

The agreed upon fee between Therapist and Representative is \$ 150.00. Therapist reserves the right to periodically adjust fee. Representative will be notified of any fee adjustment in advance. From time-to-time, Therapist may engage in telephone contact with Patient or Representative for purposes other than scheduling sessions. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than **ten** minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient or Representative and with the advance written authorization of Patient or Representative. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than **ten** minutes. Representative is expected to pay for services at the time services are rendered. Therapists accept cash, credit cards and checks, made out to Tara J. Boerner. Please initial that you understand payment is due at time of session unless other arrangements have been made. If your check is denied or returned the patient/guardian/parent will be responsible for any and all bank fees incurred. Failure to pay any outstanding fees within 30 days may lead to further actions to collect monies owed. After 90 days your outstanding account will be turned over to a collection agency, with a 15% surcharge added.

Initial here_____

Insurance

Therapist is a contracted provider with some insurance companies, managed care organizations. Should Representative choose to use his/her insurance, a release of information will be required for us to speak with the insurance company. For other insurances Therapist will provide Representative with a statement, which Representative can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

I hereby authorize Tara J Boernerto discuss necessary information with my insurance company_____, such as diagnosis, reason for treatment, dates of service and to obtain any necessary information.

SIGNATURE OF AUTHORIZATION TO EXCHANGE
INFORMATION WITH INSURANCE COMPANY

Cancellation Policy

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail.

Tara Boerner 818-924-3960

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient or Representative to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot

guarantee the calls will be returned immediately. Therapist is unable to provide 24- hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient or Representative should call 911, or go to the nearest emergency room. Suicide Prevention Hotline, 1-800-273-TALK (8255).

Vacation/Out of State: Please note therapist is NOT licensed out of the state of California. If you are traveling outside the state of California, please check your local listings for a therapist or call 911.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

Acknowledgement

By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions

of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Patient Name (please print)

Signature of Patient _____

Date _____

Signature of Representative (and relationship to Patient)

Date _____

Name and relationship of person Responsible for payment:

HIPAA Privacy

What is HIPAA: HIPAA, The Health Insurance Portability and Accountability Act, mandates the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans),

and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

Treatment: Your mental health information may be disclosed to other health care professionals for the purpose of providing treatment. **My duties as your therapist:** I am required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. I am also are required to abide by the privacy policies and practices that are outlined in this notice. **Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement: In the event of reported violence or life threatening dangers your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law- enforcement investigations, and to comply with government-mandated reporting.

Other uses and disclosures that require your authorization: Disclosure of your mental health information or its use for any purpose other than those listed above requires your specific written authorization. Your mental health information may be transmitted electronically, either for collection of payment, collateral treatment, in email communication between us, or in any other health care operations in my practice. These HIPAA privacy practices are put forth in all of those circumstances. If you change your mind after authorizing a use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of

information that occurred before you notified us of your decision to revoke your authorization.

Individual rights: You have certain rights under the federal privacy standards. These rights include but are not limited to: The right to request restrictions on the use and disclosure of your protected health information. The right to receive confidential communications concerning your medical condition and treatment. The right to inspect and copy your protected health information. The right to amend or submit corrections to your protected health information. The right to receive an accounting of how and to whom your protected health information has been disclosed. The right to receive a printed copy of this notice. Request to inspect protected health information: You may generally inspect or copy the protected health information that I maintain. As permitted by federal regulation, I require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting myself during normal business hours. Your request may or may not be granted, depending upon the reasoning for disclosure.

Complaints: If you would like to submit a comment or complaint about my privacy practices, you can do so by sending a letter outlining your concerns to this office. If you believe that your privacy rights have been violated, you should send a letter describing the cause of your concern to this office. You will not be penalized or otherwise retaliated against for filing a complaint.

Signature

_____Date_____