Lynda S. Hiatt LCSW

California License # LCSW14784

INFORMED CONSENT AND OFFICE POLICIES

To My Clients: The following information describes the operating procedures of my practice. Please read it over carefully. If you have any questions, I will be happy to answer them. Please sign and date where indicated. You may have a copy for your records if you wish.

Fees & Times for Sessions:

1. Fees are payable at each session unless other arrangements have been made.
2. There is a $20 Charge for all checks returned by the bank.
3. All individual therapy sessions, both adult and child, are 50 minutes long. If you are late for your appointment, the remaining time will be used for your session and you will be charged the full fee.
4. Please note: there will be a $50 charge for any appointments missed or canceled less than 24 hours in advance.

Insurance:

1. **FINANCIAL POLICY:** Payment in full or copayment is expected at the time of service. Services provided which are not covered benefit of your health plan will be your responsibility.
2. **CONSENT TO TREATMENT/RELEASE INFORMATION:** I grant Lynda Hiatt, LCSW, to perform Psychotherapeutic Services. I authorize the release of medical information to my insurer, or the insurer's agents to process my payment for service.
3. **ASSIGMENT OF BENEFITS:** My signature below will thereby assign all benefits payable by my insurance company to Lynda Hiatt, LCSW.

Confidentiality: Psychotherapy is confidential. No persons outside of this office will be told, by me, that you are receiving psychotherapy, or what is discussed in psychotherapy. There are exceptions to this policy under the following conditions:

1. You may give written permission to release information to, or request information from concerned third parties. These may include insurance companies, counselors, physicians, referring agencies, courts, etc...
2. Information will be released to concerned parties and the appropriate authorities if needed to protect the safety of yourself or others.
3. California law mandates the release of information to the appropriate authorities if information is divulged regarding suspected child abuse or neglect of your own or other children.
4. Information will be released to a court of law if your psychotherapy has been court ordered or if specific information is requested in a legitimate subpoena.
5. If you are a minor, your parents must be informed of your progress, if they ask. However, specific details of conversations may not be discussed.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that under the HIPAA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights to privacy regarding my protected health information (PHI). Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you are welcome to obtain a copy of the revised form from our office.

Signature: _____ Date: _____

Termination: A final "good-bye" session is essential to the therapy process. As a part of your contract with me, you agree to a final session regardless of the reasons for termination.

Complaint Procedure: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Click Here to Submit by Email

Agreement: I agree to all terms and conditions in this contract.

Signed_____ Date_____

Where "Families are First" with Individual and Family Counseling

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