

Progeny Psychiatric Clinic

Tina Tuyen Ho, ASW, MSW

Registered ASW #78641

17782 Cowan, Suite A

Irvine, CA 92614

Phone Number and VM: (657) 223-5461

Email: Tinah@progenyclinic.com

Office Number: (949) 722-7118

INFORMED CONSENT AND AGREEMENT TO SERVICES

Welcome! I am pleased you have selected me for your psychological services. This document is designed to inform you and to ensure that you understand our professional relationship. Please initial each section of the document and sign the last page to acknowledge that you have read, have full understanding of the content, and agreed to the terms of the document. Please feel free to ask any questions at any time upon signing this document.

PROVIDER INFORMATION: I am a Registered ASW (Associate Social Work #78641). I completed my MSW (Master in Social Work) at California State University, Long Beach with a concentration and emphasis in Integrated Health. I have 5 years of clinical experience in which I worked with children and adults with intellectual disabilities in addition to working with families and adolescents who have various emotional and behavioral issues in an outpatient and inpatient setting. Due to my pre-licensed status, I am currently providing treatment under the supervision of Dr. Jason Kellogg, MD and Brian Lam, PHD, LCSW.

CLIENT INITIALS _____

TREATMENT PHILOSOPHY/RISKS AND BENEFITS: Psychotherapy can have both risks and benefits and requires an investment of your time and energy in order to make the process of therapy most successful. The therapeutic process will require the efforts of both myself, and yourself, as it is your responsibility to apply what you learn in therapy outside of session in order for the therapy to be most effective. Benefits from therapy may vary, but no promises or guarantees can be made. Potential benefits from therapy may include an enhanced understanding of your strengths and personal goals that will ultimately lead to personal growth and development, in addition to helping you reframe the way that you think and respond to everyday situations or life/environmental stressors. Furthermore, you should be aware that psychotherapy may also involve risks. Occasionally, individuals may feel they go through periods in therapy which may evoke some emotional discomfort or temporary worsening of their symptoms as their level of awareness increases (i.e., feelings of hopelessness, fear, anger, sadness, pain etc.). However, such feelings are necessary in order to promote growth and healing and should be discussed with me should you have any concerns.

CLIENT INITIALS _____

PARENTS AND MINORS (under 18 years of age): While privacy to therapy is essential during the therapeutic process, parental involvement may also be beneficial. I request an agreement between the minor client and the parents allowing me to share general information pertaining to the treatment goals, plans, progress and attendance of their child as well as whatever information I consider necessary with the parent in order to provide the best treatment possible. Otherwise, everything that the child may disclose during therapy session will remain confidential, unless I feel like their safety is of concern.

CLIENT INITIALS _____

CLIENT RIGHTS: As a consumer of psychotherapy, there are certain rights you should be aware of. The following list is just to provide you with a basic outline of what your rights are:

- You have the right to receive therapy and to end the therapy at any time without notice or further obligation at your own terms.
- You have the right to be informed of my education and experience in psychotherapy
- You have the right to request changes in treatment and goals
- You have the right to refuse certain treatment approaches at any time.
- You have to right to ask questions regarding the length of therapy and the termination of therapy.

However, I am not able to guarantee or promise the precise length of therapy as each individual needs, goals, and growth will differ.

CLIENT INITIALS _____

APPOINTMENT AND FEES: The current fee is \$175 and is subject to change. In the event the fee changes, you will be given adequate prior notice to respond. I will adjust the fee according to individual circumstances. The sessions will be scheduled to last for an average duration of 38-60 minutes, depending on what I find most suitable for you. Therefore, I will inform you how long a typical session will last on a case by case basis. I will attempt to arrange a regularly scheduled time to meet with you. Due to the scheduling of my practice, you are responsible for all regularly scheduled meeting. **If you are unable to keep your appointment time or wish to reschedule, you must notify me no later than 24 hours in advance or you will be responsible for paying the regular session fee. If you miss a session without cancelling or cancel less than 24- hour notice, there will be a \$75 charge.** It is important to note that insurance companies usually do not provide reimbursement for cancelled sessions, thus you will be responsible for the portion of the fee described above. If my schedule permits, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your sessions on time, if you are late, your appointment will still need to end on time. After 3 cancellations or no shows within the group with any provider, I may choose to terminate further service due to company policy.

If you plan to use your insurance to cover a portion of your fee, we will discuss the billing procedures on an individual basis. Some health insurance companies will cover my services and some will not. Health insurance often require that I diagnose your mental health condition and indicate that you have a mental illness before they agree to reimburse you. Any diagnosis made will become part of your permanent records. In the absence of some explicit treatment objective, I will assume that your purpose in meeting with me is for open-ended self exploration and growth, involving having an opportunity for increased insight into your feelings, history, current conditions, personal relationships and interactions with me. Please refer to the Progeny Psychiatric Group's Informed Consent and Policies for more information regarding billing and payment.

It is strongly recommended that you have a thorough physical examination from a medical practitioner on an annual basis, and that you have a thorough medical examination within the first month of therapy to medically address any potential complaints or concerns, which may have an impact in your therapy.

CLIENT INITIALS_____

CONFIDENTIALITY: As an ASW, MSW I am ethically obliged to treat what you say as confidential, I am ethically obliged to treat what you say as confidential. This includes not disclosing, to anyone, the fact that you are in therapy, family information, discussions, appointments, or any information that is brought up about your therapy. There are however, legal and ethical exceptions to this:

- You consent in writing for me to release and disclose information.
- If there is reasonable suspicion of child, elder, or dependent adult abuse
- If I learn that there was a child being abused or in danger of being abused, I am legally obligated to report this child to protective services. Furthermore, my legal obligation to report abuse extends to the elderly and dependent adults.
- If I determine you are a danger to yourself or others, I am ethically obligated to intervene to insure your safety and legally obligated to report to the appropriate authorities that you are a danger to yourself or to others.
- In my discussion, decide to obtain consultation on your case with a colleague or a legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your billing being turned over to a collection agency or submitted to a small claims court.
- Upon notification of a social service agency case, wherein all information shared will be conveyed to the assigned social worker and/or other SSA representative and agents. If you are a part in litigation and you tender your mental condition as an issue, your privilege may be waived. In a custody case, you may be required to waive your privilege to facilitate evaluation by a court order evaluator. I may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders.
- These are a few exceptions; Please see Progeny Psychiatric Groups Informed Consent and Policies for a more extensive list and information.

CLIENT INITIALS_____

DUAL RELATIONSHIPS: In order to protect your confidentiality and avoid a dual relationship, if we happen to see each other outside of the therapy setting, I will not acknowledge you nor engage with you socially. If you acknowledge me, I may only nod or say a simple hello. In the chance this happens, I encourage you to process the encounter and feelings that come up in the following session.

CLIENT INITIALS_____

SOCIAL MEDIA/COMMUNICATION POLICY: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please bring them up when we meet and we can talk more about it.

CLIENT INITIALS_____

INTERACTING: please do not use messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. I have a confidential voicemail number that you can use to leave messages anytime. I will make an effort to respond within 24-48 hours. *Please note that I may not respond to you immediately in the event of an emergency. In the event of an emergency, please dial 911 or go to the nearest hospital emergency room. Direct email or voicemail: Tinah@progenypsych.com or 657-223-5461* is the second best for quick, administrative issues such as changing appointment times.

CLIENT INITIALS _____

EMAIL OR TEXT: You may email, call, or text me through my personal voicemail to arrange or modify appointments. It may take up to 24-48 hours for me to respond. Please do not email or text me content related to your therapy sessions, as email nor text is not completely secure nor confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CLIENT INITIALS _____

LOCATION BASED SERVICES (LBS): if you used location based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have a GPS tracking enabled on your device, it is possible that others may presume that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

CLIENT INITIALS _____

OTHER RIGHTS: If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process so that I can respond to your concerns. Your comments and concerns will be handled with the upmost care and respect. You may also ask to be referred to another therapist if you do not think that we are a good fit and you have the right to end therapy at any time. This can be an important part of therapy, even if you decide we are not a good fit. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Behavioral Sciences, which oversees licensing, and they will review the services I have provided.

CLIENT INITIALS _____

Thank you for reading my *Counseling Philosophy and Informed Consent Form*. I assure you that my services will be rendered in a professional manner consistent with acceptable ethical standards. If you have any questions, please feel free to ask.

General Consent to Therapy

I apply for and consent to the counseling, psychotherapy, and diagnostic testing as prescribed by the therapist. I have read and understood the disclosure statements, and all of my questions have been answered to my satisfaction

Signature(s) of Client(s) (and/or Parent/Legal Guardian if minor)

Date

Signature of Therapist

Date