CONTRACT, OFFICE PROCEDURES, and FINANCIAL AGREEMENT
FOR PSYCHOTHERAPY SERVICES

Welcome to Olive Branch Counseling Center, Inc. This document contains important information about Olive Branch Counseling Center, Inc. professional services and business policies. We are governed by various laws and regulations and by the code of ethics of our profession. The ethics code requires that we make you aware of specific office policies and how these procedures may affect you. Therefore, we are providing this information in writing.

We encourage you to take the time to read through this carefully before your first appointment. Please jot down any questions you might have so that you and your therapist can discuss them at your initial meeting. When you sign this document, it will represent an agreement between you and Olive Branch Counseling Center, Inc.

OLIVE BRANCH COUNSELING CENTER, INC. (OBCC) is a not-for-profit, independent corporation that is educational, therapeutic, and benevolent by nature, with both a 501(c) 3 and a 509 (a) 2 status.

OBCC employs Marriage and Family counselors who are either:

a) Licensed by the State of California, and are practicing therapists;
b) Licensed/Registered Social Worker, and are practicing therapists;
c) Graduate interns who have a Master’s degree and are working towards completing their hours for licensure; and
d) Trainees who are working towards the completion of their Master’s degree program in counseling or social work.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client’s) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled.

Initial here: ______

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by OBCC. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. OBCC counselors will use their clinical judgment when revealing such information. OBCC will not release records to any outside party unless they are authorized to do so by all adult family members who were part of the treatment.

Initial here: ______

Health Insurance & Confidentiality of Records: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law recently took effect and is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). The Notice explains your rights regarding your private healthcare information, including your right to:

- Inspect and copy your medical records;
- Request an amendment or addendum to your medical records;
- An accounting of disclosures of your private health information;
- Request restrictions to release your medical information; and
- Request restrictions of confidential communications with you.
This document is included as part of the website First Visit Forms Packet that you can review and/or print out as you wish prior to your initial appointment. Upon request, paper copies may also be obtained from the front office receptionist.

By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. OBCC has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

*I have reviewed and understand OBCC’s HIPAA policies - Notice of Privacy Practices and have been made aware of how my records may be used and disclosed.*

<table>
<thead>
<tr>
<th>Signature of Client/Responsible Party</th>
<th>Print Name</th>
<th>Date</th>
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</thead>
</table>

**TELEPHONE & EMERGENCY PROCEDURES:**

- **The best phone number** for the offices is (909) 989-9030. If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office.

- **In a crisis,** if your therapist cannot be reached and you are in imminent danger, call the police (911), or go immediately to your local emergency hospital.

- If you need to contact OBCC between sessions, for an emergency, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and therefore, we cannot guarantee immediate return calls. OBCC counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call or consultation.

- If there is an emergency whereby an OBCC counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, the counselor will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care. For this purpose, the counselor may also contact the person whose name you have provided as an Emergency Contact on the Intake Form.

Initial here: ________

**INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT:** Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with OBCC constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Many people feel comfortable communicating via email, because they have installed programs designed to detect spy ware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.

2. Sent and received emails are stored on both OBCC and your computer until deleted. OBCC may or may not delete such emails. Any saved emails will be kept in a password-protected account that only OBCC has access to.

3. In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities to locate and read such emails under various circumstances, this is not a policy of OBCC, but is due to the nature in which email is transmitted using the Internet, and other services or networks. For more information on this, please contact your Internet Service Provider or email service.

4. By initialing below, I agree that I understand the disclosures listed above regarding communicating with OBCC using email. I also agree that if I send an email to an OBCC counselor and request a response via email, that I am willing to accept the above-stated risks. I also agree that I will not use email for emergencies.

Initial here: ________
Permission for OBCC to initiate emails to you:

Initial below if you give your permission for OBCC to initiate sending emails to you.

Initial here: ________
Print your email clearly: ____________________________

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I, (print name of responsible party) ____________________________ consent for treatment to be rendered by a therapist of Olive Branch Counseling Center. I grant the therapist to perform those procedures and treatments, which may include professional consultation or emergency telephone responses, necessary for my condition that are generally used in this and similar settings. I understand that information or opinions will be given to others only with my written consent.

Signature of Client/Responsible Party  Print Name  Date

APPOINTMENTS: All office visits are by appointment and may be scheduled through the office manager or your counselor directly. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. If you are unable to keep a scheduled appointment, you must notify OBCC at least 24 hours in advance to avoid having to pay for the canceled or missed appointment. Please leave a message if you get the voice mail. If you miss or cancel your appointment, you will need to contact the office for a new appointment time.

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. You will be charged for the full amount of a scheduled fee without such notification; $110 for licensed counselors and $60 for interns. Most insurance companies do not reimburse for missed sessions.

Your compliance in keeping appointments and active participation in treatment is vital.

Initial here: ________

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless other arrangements have been made.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Insured clients are expected to take care of their fees as services are rendered. Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.
- Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment, deductible, and insurance claims on your account.
- Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 30 days after the rendering of services.
- The client portion (co-pay) of fees is expected at the time of service. Co-pays are not negotiable. Failure to pay your part may jeopardize your benefits.
- Additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.
- There is a $30.00 service fee for checks returned for non-sufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay in cash the service charge PLUS the value of the check.
At any time during treatment should the client become ineligible for insurance coverage, the client and/or responsible party agrees to notify the counselor and will be responsible for 100% of the bill.

Initial here: ______

Collection Policy: Our office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to our collection agency, your financial records will be released to them and your delinquent balance will be recorded with the three (3) major credit bureaus, i.e., Trans Union, Equifax, and Experian.

- Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over for collection.
- A 12% fee will be added for balances over 30 days old.
- If legal proceedings become necessary, the client hereby agrees to bear all financial responsibility for all attorney and court costs associated with collecting an unpaid debt. Please be aware that we take this action only as a last resort.

Initial here: ______

Appeals And Grievances: I acknowledge my right to request reconsideration (an Appeal) in the case that client care is not certified by Managed Care Company. I understand that I would request an Appeal directly through my Managed Care Organization.

I also understand that I may submit a Grievance to my practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company. My practitioner has access to information to facilitate this.

I understand that the California Department of Managed Health Care (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan I can contact the Managed Care Company of the DHMC.

Initial here: ______

Consent To Treatment And Fee: By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, you are responsible for payment even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Olive Branch Counseling Center, Inc. and all insurance benefits due to me to the full extent of my financial obligation to OBCC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with California State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

<table>
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<td>--------------------------------------------------------------------------------------</td>
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</table>
THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that OBCC carry out counseling treatment and/or diagnostic procedures that now or during the course of your care as a client are advisable. Participation in therapy can result in a number of benefits, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy.

Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. OBCC will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. OBCC may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, OBCC is likely to draw on various psychological approaches according, in part, to the problem that is being treated and an assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

- I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. These are:
  - a) I sign a Release of Information Form or I verbally direct my counselor to tell someone else,
  - b) My counselor determines that his/her client poses a threat to self or others,
  - c) My counselor is ordered by a court to disclose information,
  - d) My counselor suspects child abuse has taken place and will notify Child Protective Services, or
  - e) Forensic consultation or treatment ordered by the courts.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that OBCC counselors are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: ________

Rights and Risks:

- Please feel free to ask questions about any aspect of the counseling process. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the OBCC counselor’s expertise in employing them, or about the treatment plan, please ask and you will be answered fully.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- You need to be willing to discuss what troubles you and be open to change.
- You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that OBCC does not provide, the therapist has an ethical obligation to assist you in obtaining those treatments.

Initial here: ________

PROFESSIONAL RECORDS: The laws and standards of the profession require that OBCC keep treatment records. You are
entitled to receive a copy of your records, or your therapist can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in the presence of your counselor so that she/he can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Initial here: ________

**TERMINATION:**

- An orderly end of therapy has positive effects for clients. It is suggested that you discuss openly with your counselor your wish to end therapy at least three (3) sessions before your last session. A final closure session has proved to be very important for clients. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. While not required they are strongly recommended; you have the right to terminate therapy at any time. If you choose to do so, OBCC will offer to provide you with names of other qualified professionals whose services you might prefer.
- If at any point during psychotherapy, an OBCC counselor assesses that she/he is not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, the counselor would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, the OBCC counselor will talk to the psychotherapist of your choice in order to help with the transition.
- If at any time you want another professional’s opinion or wish to consult with another therapist, OBCC will assist you in finding someone qualified, and with your written consent, will provide her or him with the essential information needed.
- If you don’t show-up for three consecutive scheduled appointments, your treatment will be considered canceled and terminated and you will be financially responsible for the fees of the missed sessions. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

Initial here: ________

**Consent:** In order to evaluate our services may we have permission to contact you once you have completed your counseling with the understanding your response will be held confidential? ____Yes  ____No

Initial here: ________

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

I have discussed these policies with an Olive Branch Counseling Center, Inc. staff person if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desire.

Signature of Client/Legal Representative  Print Name  Date

Additional Client Signature (Spouse, /Partner, Family Member)  Print Name  Date
## Counseling Request

What **type of counseling** are you pursuing?  
- ___ Adult Individual  
- ___ Child Individual  
- ___ Adolescent Individual  
- ___ Couples  
- ___ Family  
- ___ Group or Classes  

Please specify: ____________________________________________

Which **office location** would you prefer to receive counseling?  
- ___ Rancho Cucamonga  
- ___ Riverside  
- ___ Claremont  

When are you **available** for counseling sessions?  
- ___ Morning  
- ___ Afternoon  
- ___ Evening  
- ___ Saturday  
- ___ Certain days: ____________________________

All **OBCC therapists** are professionally trained; however their fees vary according to credentials.  Which level of therapist would you prefer?  
- ___ Licensed Marriage & Family Therapist (MFT)  
- ___ MFT Graduate Intern

## Client Information

**Client’s Name:** ____________________________________________  
(Last) (First) (Middle Initial)  
Today’s Date: ____________________________

**Soc. Sec. #:** ____________________________  

**Gender:**  M  F  
**Age:** ____  
**Birth date:** ________________  
**Birth Place (City & State):** ____________________________________________

**Address:** ______________________________________________________________________

**City, State, Zip:** ____________________________________________

**Home Phone:** ____________________________  
**May we leave a message at home:**  
- Yes  
- No

**Work Phone:** ____________________________  
**May we leave you a message at work:**  
- Yes  
- No

**Cell Phone:** ____________________________  
**May we leave a message on the cell:**  
- Yes  
- No

**E-mail:** ____________________________  
**May we email you or put you on our mailing list:**  
- Yes  
- No

**Responsible Party, if the client is an underage minor:** Who is the legal guardian?  
Name: ____________________________________________  
City, State & Zip: ____________________________________________

**Social Security #:** ____________________________  

**Home Phone:** ____________________________  
**Work Phone:** ____________________________  
**Cell Phone:** ____________________________  
**May we call you or leave a message for you at:**  
- Home [ ]  
- Work [ ]  
- Your Cell [ ]

**Important persons to contact in case of emergency (Please provide name and telephone number):**  
- [ ] Spouse  
- [ ] Parent  
- [ ] Other ____________________________

**#**  

## Employment Information

**Client Occupation:** ____________________________________________  
**Employer:** ____________________________________________  

**Employer Address, City, State, Zip Code:** ____________________________________________

**Phone #:** ____________________________  
Check One:  
- ___ Employed Full-Time  
- ___ Employed Part-Time  
- ___ Unemployed

**How long have you worked for your current employer?** ____________________________  
**What is your gross income?** ____________________________  
(We may need your income to set your fee)
Personal History

Primary Language: ___________________________  Ethnicity: ___________________________

Was the client adopted?  Yes____  No _____  Lived at any time in foster care?  Yes____  No _____

Is the client a student?  Yes____  No _____  Name of School/College ___________________________

____ Part-Time Student  __ Full-Time Student  Highest grade/education/degree completed __________________________

Marital Status:  ____ Never Married  ____ Married  ____ Separated  ____ Divorced

 ____ Widow  ____ Common Law  ____ Engaged  ____ Partners

Spouse/Partner’s Name: ___________________________________________  Soc. Sec. #: ___________________________

(Last) (First) (Middle Initial)

Gender: M  F  Age: __________  Birth date: ___________________  Length of Relationship: ____________

Work # ___________________________  Home # ___________________________  Cell # ___________________________

If separated: Address, City, State & Zip _____________________________________________________________

Occupation of Spouse ___________________________  Employer: ___________________________

Employer Phone # (_____) ______________________  Check One:  ___ Employed Full-Time  ___ Employed Part-Time  ___ Unemployed

Employer Address ____________________________________  City, State, Zip: ___________________________

How long working for the current employer? ____________  What is their gross income? ____________

(We may need this income to set your fee)

Children and/or dependents currently at home & their ages: __________________________________________

Referred By?  How Did You Hear About Us?  (Check all that apply):

___ I am a former client returning. How long ago? _________________  ___ Family or Friend

___ Brochure/Flyers  ___ Internet  ___ Yellow Pages

___ Employee Assistance Program  ___ Employer/Supervisor  ___ Colleague

___ Union Representative  ___ School

___ Insurance Company/Managed Care  ___ Physician

___ Court/Legal  ___ Probation

___ Another Therapist  ___ Minister/Priest/Rabbi

___ Word of mouth  ___ Other

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

Signature of Client ________________________________________  Date ______________________

Signature of Parent/Legal Guardian/Foster Parent/Conservator/Other
(Required if participant is a minor, under age 18) ________________________________________  Date ______________________
### INSURANCE INFORMATION

**Who is Responsible for this account? Who is the insured? What are your insurance requirements?**

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Insured is:</th>
<th>Self ___</th>
<th>Spouse/Partner ___</th>
<th>Child ______</th>
<th>Other __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the insurance company name?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing Address</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number (______)</td>
<td></td>
<td>Is it a</td>
<td>PPO? [ ]</td>
<td>or HMO? [ ]</td>
<td></td>
</tr>
<tr>
<td>Membership/Benefit Policy Number</td>
<td></td>
<td>Group #</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan #</td>
<td></td>
<td>Effective Date:</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>How much coverage do you have in a year?</td>
<td></td>
<td>Have you met your deductible? Yes ___ No ____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are your insurance company’s credential requirements for pursuing counseling? (e.g. licensed MFT, registered social worker, etc.)</td>
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</tbody>
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### Secondary Insurance: Insured is:

<table>
<thead>
<tr>
<th>Self ___</th>
<th>Spouse/Partner ___</th>
<th>Child ______</th>
<th>Other __________</th>
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</thead>
<tbody>
<tr>
<td>What is the insurance company name?</td>
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<td></td>
<td></td>
</tr>
<tr>
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*Please Provide A Copy of Your Insurance Card To Office Staff So Benefits May Be Verified. Thank You.*

Although **you are ultimately responsible for your fee**, health insurance may pay a portion of the charge. At your request, the Center’s office staff will contact your insurance company to file your claims.

If your annual deductible has been met, it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the Center. If the deductible has not been met, you will be responsible for paying the full fee until the deductible has been satisfied, or you may agree to a plan with the office manager for paying the deductible and co-payment amounts. **Co-pays are due at the time of your session.**

**Initial ______**

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**FOR OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Number of sessions per year:</th>
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<tbody>
<tr>
<td>Number of sessions in a lifetime:</td>
<td></td>
</tr>
<tr>
<td>Allowable charges: $</td>
<td></td>
</tr>
<tr>
<td>Do they consider a parity diagnosis?</td>
<td></td>
</tr>
<tr>
<td>Coverage per session: $</td>
<td>/</td>
</tr>
<tr>
<td>Allowable Co-payment: $</td>
<td></td>
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</table>

**SOURCE: __________________________________ DATE: __________________ STAFF INITIALS ______________**
Notice of Privacy Practices
We respect our clients’ confidentiality and only release information about you in accordance with state and federal laws.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes our policies related to the use of the records of your care at Olive Branch Counseling Center, Inc. We are required to give you this Notice about (1) the use and disclosure of your health information, (2) our legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional information, contact Olive Branch Counseling Center, Inc., 9033 Baseline Road, Suite H, Rancho Cucamonga, CA. 91730, 909-989-9030.

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
We use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for Olive Branch Counseling Center, Inc.'s mental health care operations.

a. For Treatment. We use and disclose your health information internally in the course of your treatment at Olive Branch Counseling Center, Inc. For example, we may give information to another Olive Branch Counseling Center, Inc. health care professional for the purpose of referral within Olive Branch Counseling Center, Inc. If we wish to provide information outside of Olive Branch Counseling Center, Inc. for your treatment by another health care provider, we will have you sign an Authorization For Release Of Information.

b. For Payment. We may use and disclose your health information to obtain payment for services we provide to you as delineated in the “Contract, Office Procedure, and Financial Agreement” form. For example, we may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service we have provided to you.

c. For Health Care Operations. We may use and disclose your health information within Olive Branch Counseling Center, Inc. as part of our internal health care operations. For example, this could mean a review of records to assure quality. Alternatively, we may provide information to the student intern who is your therapist and is authorized to receive training at Olive Branch Counseling Center, Inc. and to staff who supervise him or her. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

2. INFORMATION DISCLOSED WITHOUT YOUR CONSENT
Under California and federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for Workers Compensation.

c. Public Health Activities. If we felt you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. We may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. We may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.

g. Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. Business Associates. Olive Branch Counseling Center, Inc. may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, Olive Branch Counseling Center, Inc. contracts with a financial audit firm to review the finances of Olive Branch Counseling Center, Inc. on a yearly basis. In the process of the audit, they may encounter client-billing records. All of our business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
I. Research/Supervision. Under certain circumstances, Olive Branch Counseling Center, Inc. may use and disclose health information for research and/or supervision. Before we do so, the project will go through a special approval process that includes a consent form for clients to sign if they are included in the research study/supervision. Even without the special approval, however, Olive Branch Counseling Center, Inc. may permit researchers affiliated with Olive Branch Counseling Center, Inc. to look at non-identifying information to help them plan research projects.

j. Marketing. Olive Branch Counseling Center, Inc. may send you newsletters or information about services we provide in which we feel you might be interested. You may at any time request that your name be removed from our mailing list. We will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic mail.

k. Fundraising/Activities. Olive Branch Counseling Center, Inc. may use certain client demographic information—such as your name and address—to contact you about fundraising, ministries, workshops, training events, calendars of events, etc. Olive Branch Counseling Center, Inc. regularly seeks contributions from the general public to support our charitable and educational programs such as free care for children and families in low-income communities, a reduced-fee clinic, student scholarships, and research projects. If you do not wish to be contacted about fundraising, send a written request to Olive Branch Counseling Center, Inc., 9033 Baseline Road, Suite H, Rancho Cucamonga, CA 91730, 909-989-9030.

I. Scheduling Appointments. Olive Branch Counseling Center, Inc. may use your phone number to call you and leave messages to schedule or remind you of appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. Right to Amend. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We have the right to deny your request under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to the Executive Director. Such accountings are available for disclosures beginning April 14, 2003, and remain available for eight years after the last date of service at Olive Branch Counseling Center, Inc.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you could ask that we not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. While you are in treatment, a written request should be made with your therapist. To request a restriction after therapy is completed, you must make your written request to the Executive Director of Olive Branch Counseling Center, Inc. We are not required to agree to your request, but we will consider the request very seriously. If we agree, we will abide by our agreement unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every attempt to accommodate reasonable requests.

f. Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available at the reception desks or lobbies at each Olive Branch Counseling Center, Inc. site. You may also obtain a copy of this notice at our web site, www.olivebranchcounseling.org. Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by the records department of Olive Branch Counseling Center, Inc., and will only be for disclosures not already completed.

We reserve the right to change our privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, we will change this Notice and make a new Notice available to you at the reception desks or lobbies at each Center site and on our web site.

Beginning April 14, 2003, we are required to abide by the terms of Notice.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the U.S. Department of Health & Human Services www.hhs.gov/ocr/hipaa/. To obtain additional information, or to file a complaint with us, contact us at (909) 989-9030. We will not retaliate in any way if you choose to file a complaint.

This Notice is effective 4-1-07 (Revised 09/09)