Julia C Kitts, LCSW
LCS18488

12625 High Bluff Dr. #111
San Diego, CA 92130

Informed Consent:

General Information & Psychotherapist-Client Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Portability and Accountability Act (HIPPA), a new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPPA requires that I provide you with a Notice of Privacy Practices, which accompanies this document. The law requires that I obtain your signature acknowledging that I have provided you with this information and that you agree/consent to let me use your information as specified in the Notice of Privacy Practices.

Limits of Confidentiality:

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization for Release of Information that meets certain legal requirements imposed by state law and/or HIPPA. However, there are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, and /or contact family members or others who can help provide protection (CA Evidence Code 1024).

- If a client communicates a serious threat of physical violence OR if a client's family member reports that a client has made such a threat, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the client or contact others who can assist in protecting the victim (CA Evidence Code 1024, CA Civil Code 43.92).

- I am required by law to report any suspected child abuse, neglect, or sexual abuse to protect the child/children involved (CA Penal Code 11164-11174.4; 288; 261-269, Child abuse; CA welfare and Institutions Code 18951 ff.).

- I am obligated by law to report any suspected abuse, neglect, or sexual abuse of an elderly person or dependent adult to protect the elderly person or dependent adult involved (CA Welfare and Institutions Code 15630-15632; 1560-15610.6; 15633-15637).

- I may release information, upon request to the non-custodial parent of children under the age of 18.

- I may release information to parents, if the client is a minor under the age of 14.

In couples therapy please be aware that information shared with me will be disclosed to your partner if they are participating in treatment. I have a "no secrets" policy which means that I will not agree to hold secrets on any one partner's behalf. If you feel something should not be shared with your partner, please do not tell me your secret. If you do so but do not want your partner to know, I will first help you reveal the secret but will not promise to keep it longer than I deem appropriate. If you choose to not reveal your secret, it may be necessary for you to seek the support of an individual therapist who is independent of me, who I can consult with regarding broad issues, and not the specifics of your secret.

*Disclosures may be required to health insurers or collection agencies to collect agreed upon and/or overdue fees. In instances where insurance does not pay any benefits, you will need to pay for the service. If payment is not received within 90-days from the date the claim was submitted, you will become responsible for the full amount of the balance of the account. If you choose to break the financial agreement, I may release your name for collection purposes. If legal action is necessary, its costs will be included in the claim.

Please talk to me about any questions or concerns that you may have now or in the future. In situations where specific advice is required, formal legal advice may be needed.

Prior Authorization: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s). Initial here _____

Appointments: Your appointment time has been reserved exclusively for you. **Insurance does not cover late canceled or missed appointments. If you fail to cancel your appointment with at least 24 hours advance notice, you will be charged the full session fee of $175**. Initial here _____

Contacting Me: Generally speaking, I will respond on business days and not weekends, unless your situation requires my immediate attention. Please keep in mind that the most confidential way for us to communicate is during our sessions and in my office. If I will be unavailable for an extended time, I will provide you with the information of a colleague to contact in case of emergency. Initial here _____

Emergencies: Because I am not readily available by phone, I am not the best person to contact in an emergency. For cases of suicide, or other life and death emergencies when you are unable to reach me and feel that you can't wait for me to return your call, please call 911. You also can call the San Diego County 24-hour Crisis Team at 1-888-724-7240. Initial here _____

By Phone – Voice: Due to my work schedule, I am often not immediately available by telephone. You may leave a confidential message for me at (858) 243-0961. My voicemail will take your call 24 hours a day/ 7 days a week. I retrieve and return messages Monday through Friday. Messages left after 5 P.M. will be returned as soon as possible, and most likely, by the end of the following business day. If you do not hear from me at that time, please assume I did not receive your message and call again. Initial here _____

By Phone – Text: The response time for texts is the same as phone calls. Text messaging's intended use is for responding to a quick scheduling/NON-clinical question (for example: "can I move my appointment time?" or "I need to cancel my appointment"). It is for general questions but NOT for sensitive clinical information. Text messaging is NOT HIPPA secure. You can let me know if you wish to use text messaging as a form to communicate with me. Initial here _____

Emails: Using email may be used at your request but please know that the maintenance of your confidentiality cannot be guaranteed through email and sending messages containing confidential information is not advised. If we do decide to periodically communicate through emails, please write the specific nature of your email in the subject line as these emails will be kept part of your clinical record and need to be filed in appropriate places. If it appears that you have more than a brief question, I suggest that we talk about it when we meet rather than use email. If the nature of your email is urgent, please call me and leave a voicemail, as I do not check my emails as often as voicemail.
Initial here _____

Professional Fees: The fee for paying for services by cash (vs. insurance) is $175 per 50 minute session. Payment is due at the time of service. I accept cash or check. For cash paying clients only, please see optional credit card form at the end of this document, for your convenience only as I prefer cash or check due to high CC fees. Services involving additional fees include: report writing, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **Phone calls and letters/records are not billable to insurance**. You will be given an hour free for consultations with others involved in treatment (i.e., school teachers and counselors, other therapists, doctors). After the hour is used, you will be charged for my time at a rate of $80/30 minutes. Phone time outside of therapy sessions will be billed at the same rate per 50 minute session; $175 per phone session regardless of length of call. Please note that I will charge a $25 service fee for all returned checks. Initial here _____

Insurance Reimbursement: I will fill out forms and provide you with a superbill for my services in order to help you receive the benefits to which you are entitled, however, **you (not your insurance company) are responsible for full payment of my fees. It is your responsibility to understand your coverage plan and request authorization prior to services, if deemed necessary by your insurance company**. It is very important that you find out exactly what mental health services your insurance policy covers. It is sometimes difficult to determine exactly how much mental health coverage is available until payment arrives. Furthermore, "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Initial here _____

Client Rights: HIPPA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your record; requesting an accounting of most disclosures or protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your record; and the right to a paper copy of this agreement along with the attached form.
Initial here _____

Professional Records: Pursuant to HIPPA, I keep protected health information about you in two sets of professional records. The first set is your clinical record and includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to insurance carrier. Initial here _____

The second set includes my psychotherapy notes. These notes are for my own use and are designed to assist me in providing you the best treatment. These notes are kept separate from your clinical record. While insurance companies can request and receive a copy of your clinical

record, they cannot receive a copy of your psychotherapy notes without your authorization.
Initial here_____

Legal/Court Involvement: **If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings.** This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach. If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your legal involvement might affect our work together. It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. If you need a formal psychological evaluation, I will be happy to assist you to find a provider who offers this service. Initial here_____

Termination: Termination of therapy is inevitable. Sometimes this is because the issue or issues that you initially sought help from me for are resolved to your satisfaction. Other times, you or I may decide that your needs might be better served if you were to work with another provider. You will always retain the right to request changes in treatment or to refuse treatment at any time. However decided, termination can and ought to be made a valuable part of the therapy experience. I typically ask that we meet for one to two sessions after an agreement to terminate. These sessions can be rewarding, allowing us to review your goals and accomplishments, outline any further work to be done, and examine options for the future. Initial here_____

Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in relationships or temporary worsening of their symptoms. You may find it unpleasant to talk about negative experiences brought about through the course of therapy. These are common feelings shared by many people and should subside as the work progresses. Please feel free to share these experiences so that we may better work together, as I am open to receiving both negative and positive feedback from you.

In signing below, I agree to be treated by Julia C. Kitts, LCSW. I understand that I am financially responsible to Julia C. Kitts, LCSW for all services whether or not covered by insurance. I authorize the release of medical information necessary to process claims for services rendered by Julia C. Kitts, LCSW. I authorize payment of medical benefits directly to Julia C. Kitts, LCSW. These authorizations shall remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

Thank you for taking the time to review this information. I look forward to working with you.

_____ _____
Client or Representative Signature Date

_____
Printed Name of Client or Representative

If you are an adult who is signing on behalf of a minor or dependent, please indicate the name of the child or dependent and his/her age.

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_____ _____
Child's Name/Age Date

CREDIT CARD BILLING

Patient Name:_____

Person responsible for bill (Name on Credit Card):

I authorize Julia C. Kitts, LCSW to charge my credit card at the time of service. This will be a standing authorization, unless otherwise notified by myself. Julia C. Kitts, LCSW, will charge my credit card the amount owed at the time services are rendered. I understand I may request to have a Superbill sent to me at the end of each month outlining the charges incurred and payment applied.

Credit Card Type: VISA MC AMEX OTHER:

Credit Card Number:_____

Expiration Date:_____

Three Digit Security Code (on back of card): _____

Billing Address and Zip Code of Credit Card:_____

Would you like an email confirmation after each charge? Yes No

Email:_____

I authorize Julia C. Kitts, LCSW to automatically charge my credit card in the case that I don't show up for my appointment, or I have a late cancellation of my appointment (after 24 hrs prior).
YES_____ NO_____

Signature below indicates that card holder understands their credit card will be charged at the end of each session.

Signature of Credit Card Holder:_____

Date:_____

Comments:_____