Carol Harvey MFT
204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

Disclosure statement/Informed Consent

Welcome!

I view therapy as a collaborative endeavor. Much of the success achieved will depend on our working relationship.

So that therapy may be of maximum benefit to you, I ask you to agree to the following:

- Be on time for your appointments.
- Attend sessions as scheduled, since continuity is an important component of successful therapy.
- Call **at least 48 hours** in advance if you must cancel or change a scheduled appointment. A minimum notice of 48 hours gives me an opportunity to offer the appointment time to someone else.

Risks and Benefits of Therapy

Therapy is a process in which we discuss a myriad of issues, events and experiences for the purpose of creating positive change. 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, including, but not limited to: reduced stress and anxiety; a decrease in negative thoughts and behaviors; improved interpersonal relationships; increased comfort in social, work, and family settings; increased capacity for intimacy; increased self-confidence. Such benefits may also require substantial effort on your part, 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 all or any of the benefits listed above. If you have any questions or concerns about your progress at any point in therapy, please bring them up for discussion.

Fees

My fees are based on a 45-50 minute hour and are to be paid at each session.
Appointments canceled with less than 48 hours notice will be billed and shall be paid in full. Insurance companies do not cover missed appointments. So a missed appointment charge is what your insurance typically covers. I do consider emergency situations.
I do not charge for short phone calls (5 minutes or less). Longer calls or additional work requested by you will be prorated and billed at your established rate.
Fees are subject to an annual increase. You will be given a minimum of one month's notice of any increase.
I charge my full fee, at the time of service, for any work requested by you or on your behalf, such as legal issues, reports or letters of support.

Ethical responsibilities

As a licensed marriage and family therapist, I am legally and ethically required to keep conversations with (and information about) you in confidence. No information will be released without your written permission, except where mandated or permitted by law. I am required or permitted to break confidentiality in circumstances such as but not limited to:

- Reasonable suspicion or knowledge of child abuse.
- Reasonable suspicion or knowledge of elder or dependent adult abuse.
- Determination that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others.

I have a right to terminate therapy under such circumstances as: 1) you are delinquent in your payments **or** 2) it is my determination that the therapy or our therapeutic relationship is not working for you and you would be better served with a referral to another provider.

If you wish to end therapy, please bring this up for discussion in a session so that we can bring closure to our work together. If appropriate, we can clarify your needs and I can give you referrals.

Psychotherapist-Patient Privilege

Information disclosed by you, as well as any record created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between a therapist and a client in the eyes of the law. Typically, the client is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will

assert the psychotherapist-patient privilege on your behalf (meaning I will not disclose any information) unless instructed, in writing, to do otherwise by you or your representative.

Professional Consultation
As part of my commitment to provide quality service I participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you.

Records and Record Keeping
I may take notes during sessions, and will also produce other notes and records regarding your therapy. These notes constitute my clinical and business records, which by law, a therapist is required to maintain. Such records are the sole property of Carol Harvey MFT. I will maintain your record for ten years following termination of therapy. After ten years, records will be destroyed in a manner that preserves confidentiality.

Communication & Availability
You are welcome to leave me a confidential voicemail at any time at 707-765-2635 or email me at carolharveymft@gmail.com. I check my voice and email messages many times each day. I will make every effort to respond quickly. However I cannot guarantee that calls will be returned immediately. If you have not received a response from me within 24 hours, please call again.

If I need to reach you outside of our sessions, I will typically call or else use the same method you used to reach me. If you have given me permission, I may text you. I sometimes text appointment reminders, if requested. Since calls to or from cell phones, e-mails, and texts are not completely secure and confidential, I will be very brief. In texts, I will not identify myself as a therapist. I urge you to be very brief in any texts or emails and to not include any sensitive content.

Emergencies
I am unable to provide 24-hour crisis service. In the event that you feel unsafe or require immediate medical or psychiatric assistance, call 911 or Sonoma County Psychiatric Emergency Service at 707-576-8181. You can also call or text the National crisis and suicide lifeline at 988

Privacy
Since I live in Petaluma, it is possible we may run into each other as we go about our daily lives. To protect your privacy, I will not acknowledge you first. If you say hello or wave, I will respond in kind.

Social Media
It is my policy to dismiss any friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I take this position out of the utmost respect for your confidentiality and our mutual privacy.

Please keep a copy of this form for future reference or download the latest version of my policies at www.carolharveymft.com. If, at any time, you have questions, concerns, or suggestions about any aspect of my practice, please let me know. I value your feedback.

Statement of Understanding
I understand that I have a right to a copy of this agreement. I have had any questions I may have had, answered to my satisfaction.

I have read, understand, and agree to abide by these policies and consent to participate in therapy with Carol Harvey MFT.

client	date	client	date
client	date	client	date
client/parent/guardian	date	client/parent/guardian	date

Carol Harvey MFT
707-765-2635

Client Profile

(Use back if necessary)

Date: _____ Last name(s) of individual, family or couple: _____

Address: _____
City zip code

□ E-mail address (es): _____ □ _____

□ Preferred phone number: _____

□ Alternate phone number: _____

Is it OK to text you appointment reminders? Y N If so, check the best number above.

NOTE: Text reminders are a courtesy. You are responsible providing for 48 hrs. cancellation notice.

When I need to reach you, please indicate (✓) which of the above ways/numbers you prefer that I use.

Starting with you, please list relevant household or family members (whether attending these sessions or not):

name	age	birthdate	relationship	living at home?
			self	

Primary care physician: _____phone number: _____

Please list any current &/or significant medical conditions (illnesses, surgeries, allergies, etc.):

Please list any medications you are currently taking:

medication	dosage	reason	date started

Person to contact in case of emergency: _____

phone number(s): _____ relationship: _____

Are you now or have you been in therapy before? _____ if so, please list provider(s) & dates:

Reason you are seeking therapy at this time:

Please let me know how you were referred to me _____

Carol Harvey MFT
Petaluma, CA 94952 | 707-765-2635

Financial Agreement

Financially Responsible Person

Name: _____ relationship to client: _____

Address (if different): _____

Phone numbers (if different): _____ or _____

Payment policy

Fee, if applicable, is due at the time of each session. I accept cash, checks, Venmo, Square and Zelle. Any returned checks are subject to additional collection fees equal to the bank charges I incur.

Fees

The fees listed on my website are accurate and the most up-to-date. At time of this printing my fee for individuals is $160.00 per 50 minute session and $170.00 for families and couples. In order to make therapy more accessible for clients who might otherwise not be able to afford it—I offer a limited number of reduced fee slots. The fee we have agreed to $_____.

Insurance

Are you planning on using health insurance? ☐Yes ☐No If yes, please list:

Insurance company: _____

Group #: _____ Member #: _____

Employer or affiliation for coverage: _____

Relationship of client to insured: ☐ self ☐ spouse ☐ child ☐ other _____

Date of birth of insured: _____

Is there an annual deductible? ☐Yes ☐No If yes, in what amount? _____

Policy on Insurance

If you have Partnership MediCal I will bill them. If you have other insurance with out-of-network benefits, I can provide a superbill and/or help you submit a claim for reimbursement.

The following applies whether I am in-network for your insurance or not:

1. In order for therapy to be covered by your insurance it has to be medically necessary. That means I will need to provide a diagnosis that will become part of the medical record
2. I will be required to provide basic information about you, your family, or your minor child (ren) including an assessment and the focus of treatment.
3. Not all therapy services are covered by all insurance companies. Some insurance companies predetermine which services they will and will not cover. For instance, some policies do not cover family or couples counseling.
4. It is your responsibility to be informed about the policies of your insurance company.
5. If your eligibility or that of the insured lapses for any reason you will be held financially responsible for any sessions provided during that time.
6. **You will also be held responsible for any sessions provided that are not paid for by your insurance company. This means your usual co-pay plus the portion that your insurance typically covers. This includes a non-emergency cancellation with less than 48 hours' notice.**

Please let me know if you have any questions or would like me to explain these policies further.

Statement of Understanding

I understand that I have a right to a copy of this agreement. **I have read, understand and agree to abide by these policies.**

_____ _____

Financially responsible person date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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Telehealth Consent Form

I or we _____ (name/s) hereby consent to engage in Telehealth with Carol Harvey MFT.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of my health care and/or that of my minor child.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Disclosure Statement/Informed Consent form that I received from Carol Harvey MFT also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of Carol Harvey MFT, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and Carol Harvey MFT may occur due to the nature of Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session Carol Harvey MFT is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if Carol Harvey MFT believes I would be better served by in-person therapy, she will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor Carol Harvey MFT may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with Carol Harvey MFT and agree to them [or for insurance clients: I have discussed with Carol Harvey MFT and agree that Carol Harvey MFT will bill my insurance plan (if in-network) for Telehealth and that I will be billed for any portion that

is the client's responsibility (e.g. co-payments)], and I have been provided with this information in the Financial Agreement form.

10. I understand that Carol Harvey MFT will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that Carol Harvey MFT may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

Statement of Understanding

I understand that I have a right to a copy of this agreement. I have had any questions, I may have had, answered to my satisfaction.
I have read, understand, & agree to abide by this agreement & consent to participate in therapy via Telehealth with Carol Harvey MFT.

client	date	client	date
client/parent/guardian	date	client/parent/guardian	date

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with Client, Client understands and agrees to the above advisements, and Client has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

Therapist's Signature	Date

Carol Harvey MFT
204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (707)765-2635 or visiting my website at www.carolharveymft.com

If you have any questions about my Notice of Privacy Practices, please contact me at: 204 G Street Suite 205, Petaluma, CA 94952.

I acknowledge receipt of the Notice of Privacy Practices of Carol Harvey, M.F.T.

_____	_____
Printed name of client	Printed name of client
_____	_____
Signature Date	Signature Date
_____	_____
Printed name of client, parent or guardian	Printed name of client, parent or guardian
_____	_____
Signature Date	Signature Date