

**Vanessa Isetta, Psy.D.
Licensed Psychologist
PSY20941**

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Informed Consent

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them during our meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you or your child bring forward. There are many different methods I may use to deal with the problems that you or your child hope to address.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you or your child will experience.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you or your child needs in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

PROFESSIONAL FEES

My hourly fee is \$160 and \$180 for family therapy. In addition to weekly appointments, I charge other professional services you may need such as phone calls, home visits, school meetings or observations, and IEP or SSI meetings. I charge \$50 per every 15 minutes for phone calls. For any school or home visits I will charge an additional fee for travel time. I will also charge for other services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

CANCELATIONS

If you need to make a cancelation, I require a 48 hour cancelation notice. If you call less than 48 hours, you will be charged the full fee. If you bill the insurance through out of network, insurance does not reimburse for canceled or missed appointments and you will be responsible for the full fee.

If you have Aetna Insurance and payment is billed through them, Aetna insurance does not cover for canceled appointments. You will be responsible for the full fee of the session not the co-pay.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an answering service voice mail. I will make every effort to return your call on the same day you make it but may not get back to you until the next business day, including weekends and holidays. If you call after 5pm or on weekends I will not return you call until the next business day. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

TEXTING AND EMAILING

I do not use texting or email to discuss therapy issues. I will only use email and texting for scheduling purposes. You can email me or text me issues or concerns, however, I will respond via phone. This will insure that nothing is misinterpreted or compromised via email or text.

Note: Email and text are unsecure and not confidential means of communication. If you choose to email please make note of this.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I 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, I recommend that you review them in my presence so that we can discuss the contents. I will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused, I am mandated to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.]

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CONFIDENTIALITY WITH MINORS

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. I will tell you if your child does not attend sessions. At the end of your child’s treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

Although my responsibility to your child, you may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$300 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Client’s Signature

Date

Parent’s Signature

Date

Parent’s Signature

Date

Vanessa Isetta, Psy.D.
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Confidential Client Information

Date of Initial Appointment _____

Client's Full Name _____

Address _____ City _____ State _____ Zip _____

Phone (Main) _____ Phone (Other) _____

Email Address _____

Date of Birth _____ Age _____ Gender F M Ethnicity _____

Name of Primary Physician _____ Phone number _____ Date of last exam _____

If using insurance, please complete the following:

Name of Insurance: _____ Plan Name: _____ Phone number: _____

Name of Primary Insured: _____ Relationship to Patient: _____ Employer of Insured: _____

Subscriber ID: _____ Group Number: _____ DOB of Primary Insured: _____ Deductible: _____

If client is an adult, please complete the following information:

Occupation _____ Highest Level of Education _____

Marital Status Single Married Partner/Significant Other Divorced Separated

Spouse/Significant Other/Partner's Name _____

Is your spouse supportive of you seeking counseling? _____

Do you have children? _____ Names and Ages _____

If client is a child, please complete the following information:

Name of Parent(s) or Guardian(s) _____ Phone _____

Name of Noncustodial/Other Parent _____ Phone _____

Names of Siblings _____ Others in the House? _____

Child's relationship with Other Parent/Guardian: _____

Is the Other Parent/Guardian aware of and supportive of counseling? _____

Child's School and Grade Level _____

Child's School Performance/Behavior _____

Emergency Information

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Referral Source

How did you hear about Dr. Isetta (or from whom?) _____

If from another person, initial here _____ if it is ok for me to contact that person/referral source to thank them for their referral.

If you are using insurance to pay for therapy, I need the following statement to authorize direct payment of benefits.

I authorize my insurance benefits be paid directly to the psychologist. I understand that I am financially responsible for any balance. I authorize my psychologist and my insurance company to release/exchange information required to process my claims.

Client/Parent/Guardian Signature

Date

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Confidential Client Information, Page 2 - Client Name: _____

Please complete the following information regarding the person who is seeking services:

Medical History:

Please list any major health problems, allergies, significant injuries, and history of head injury or chronic illnesses:

Please list any prescription or nonprescription medicines that are taken regularly:

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? _____

If Yes, what was helpful or unhelpful about that experience? _____

Briefly describe why you are seeking therapy: _____

How long have these concerns been causing you distress? _____

How do you hope counseling will help? _____

Please list anything else you feel that is important for us to know: _____

Please check any of the following difficulties that apply to the person seeking services:

<input type="checkbox"/> Abuse/Neglect	<input type="checkbox"/> Health Problems	<input type="checkbox"/> Relationship Difficulties
<input type="checkbox"/> Acting Out Behaviors	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> School problems/Poor Grades
<input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Insomnia/Sleep Difficulties	<input type="checkbox"/> Self Control
<input type="checkbox"/> Anger/Temper Issues	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sexual Problems or Sexuality Issues
<input type="checkbox"/> Anxiety, Nervousness or Fears	<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Shyness
<input type="checkbox"/> Career Difficulties	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Social Skills Deficits
<input type="checkbox"/> Concentration Problems	<input type="checkbox"/> Low Self Esteem	<input type="checkbox"/> Stress
<input type="checkbox"/> Depression	<input type="checkbox"/> Memory	<input type="checkbox"/> Suicidal Thoughts or Actions
<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Odd Behaviors	<input type="checkbox"/> Thoughts of Hurting Others
<input type="checkbox"/> Eating Problems/Disorder	<input type="checkbox"/> Panic	<input type="checkbox"/> Trauma History
<input type="checkbox"/> Family Conflicts/Dysfunction	<input type="checkbox"/> Parenting Difficulties	<input type="checkbox"/> Truancy
<input type="checkbox"/> Financial Difficulties	<input type="checkbox"/> Promiscuity	<input type="checkbox"/> Weight Gain/Loss
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Other: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE READ CAREFULLY!

During the process of providing services to you, the provider will obtain, record, and use mental health and medical information about you that is protected health information. This information is confidential and will not be used or disclosed except as described below.

II. Uses and Disclosures of Protected Information

A. General Uses and Disclosures Not Requiring the Clients Consent. The provider will use and disclose protected health information in the following ways:

Treatment: Treatment refers to the provision, coordination, or management of health care (including mental health) and related services by one or more health care providers. For example, the provider may use your information to plan your course of treatment and consult with other professionals to ensure quality treatment.

Payment: Payment refers to the activities undertaken by a health care provider (including mental health) to obtain or provide reimbursement for the provision of health care. The information sent may include information that identifies you, your diagnosis, types of service, date of service the provider's names, and other information about your condition or treatment. If you are covered by Medicaid, information will be provided to the State of California Medicaid Program.

Health Care Information: Health Care Operations refers to activities undertaken by the provider than are regular functions of a private practice. This includes, but is not limited to, monitoring service quality, staff training, legal services, auditing functions, licensing and credential activities. Some functions are provided by contracted business associates. For example, billing, legal, auditing, and practice management services. Anyone involved in administration is obligated to maintain the same confidentiality as the provider.

Contacting the Client: The provider may call you to remind you of appointments and inform you of other available services that may be of benefit to you. The may also contact you via email. Confidentiality of email and cell phone conversations cannot be guaranteed. If you do not wish to be contacted via these means, please alert your provider.

Required by Law: The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to, (a) reporting child abuse or neglect; (b) when a release of information is court ordered; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or other or gravely disabled; (e) when a coroner is investigating the client's death; (f) to health oversight agencies for oversight activities authorized by law.

Crimes on the premises or observed by the provider: Crimes observed by the provider, crimes toward the provider, and crimes occurring on the provider's premises will be reported to law enforcement.

Research: The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPPA Privacy Regulation are followed 45 CFR 164.512 (i).

Involuntary Clients: Information regarding clients who are being treatment involuntary, pursuant to law will be shared with other treatment providers, legal entities, third party payer and others, as necessary to provide the care and management coordination needed.

Family Members: Expect for minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent.

Emergencies: In life threatening emergencies the provider will disclose information necessary to avoid serious harm or death.

B. Clients Release of Information or Authorization: The provider may not use or disclose protected health information in any other way without a signed release of information or authorization. The release of information or authorization may later be revoked, provided that the revocation is in writing.

II. Your Rights as a Client

Access to Protected Health Information: You have the right to inspect and obtain a copy of the protected health information that provider has regarding you, in the designated record set. There are other limitations to this right, details of which if applicable, will be provided at the time of your request.

Amendment of Your Records: You have the right to request that your provider amend your protected health information. The provider is not required to amend the record if it is determined that the record is accurate and complete. For a request form or for more information about the process and applicable limits ask your provider.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures that the provider has made regarding your protected health information. However, the accounting does not include disclosures made to you, disclosures made pursuant to a signed release, or disclosures made prior to April 14, 2003. Other exceptions that may apply will be provided at the time of your request. To Make a request, ask your provider.

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your health information. The provider does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time o your request. To make a request, ask your provider.

Alternative Means of Receiving Confidential Communications: You have the right to request where and how you are informed of communications of protected health information from the provider. There are limitations to the granting of such requests, which will be provided to you at the time of the request is process. To make a request, ask your provider.

Copy of this Notice: You have a right to obtain another copy of this Notice upon request.

III. Additional Information

Privacy Laws: The provider is required by State and Federal law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information. That is the purpose of the Notice.

Terms of the Notice and Changes to the Notice: The provider is required to abide by the terms of the Notice, or any amended Notice that may follow. The provider reserves the right to change the terms of its Notice and to make a new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted at the provider's service delivery sites and will be available up request.

Comments, Questions or Complaints Regarding Privacy Rights: If you have comments, questions or believe that your provider has violated your privacy rights, you have the right to complain. You may contact the privacy officer, Vanssa Isetta, Psy.D. at 9107 Wilshire Blvd., Suite 215, Beverly Hills, Ca 90210, or by phone at 310-980-7352. You also have the right to complain to the United States Secretary of Health and Human Services. Mail to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.D. 20201. Or by phone at 202-619-0257 or toll free at 1-877-696-6775. No retaliation will be taken against you if you choose to file a complaint.

Additional Information: If you desire additional information about your privacy rights please contact your provider.

The original date of the Privacy Polices notice was April 14, 2003. This revised notice is effective December 1, 2006.