



Client Name: _____ DOB: _____ Zip Code: _____

Client's Informed Consent for Clinical Services

Introduction

This Agreement is intended to provide _____ (herein "Client") and, if Client is a minor child, Representative(s)/Caregiver(s)/Parents(s) _____ (herein "Caregiver") with important information regarding the practices, policies, and procedures of the YMCA of San Diego County on behalf of Youth & Family Services (YFS) Clinical Services (referred to as "YMCA"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it. The Notice to Clients form in your intake packet lists your therapist's license type and status. Types of clinicians you may work with are Marriage and Family Therapists, Social Workers, Professional Counselors and/or Psychology students. All associates and trainees work under the supervision of a licensed mental health professional.

Your therapist is being supervised by _____ # _____. The supervisor and therapist will work closely together in order to provide the best possible services. Often clinicians are engaged in a clinical consult class, actively involved in clinical research projects, or analyzing quality of care. This may involve the utilization of aggregate data for thesis, dissertation purposes, or program development. Neither the data or the research disclose the identity of the Client.

Minor's Consent For Treatment

A therapist usually needs permission from both parents or the legal guardian(s) before providing therapy to a child. If there is any question about whether the person giving permission has the legal right to do so, the therapist may ask for legal paperwork, like a custody order, before starting therapy. In California, children who are 12 years old or older can agree to therapy on their own under California law. Under Health & Saf. Code § 124260, the Therapist is not required to obtain consent for treatment to hold an Intake session/call with a minor seeking to consent to their own treatment.

When a minor consents to their own treatment, Health & Saf. Code § 124260 requires the Therapist to notify a minor's parent(s)/guardian(s) that the minor will be consenting to their own mental health services, *unless* the Therapist determines it would be inappropriate to do so after consulting the minor.



Client Name: _____ DOB: _____ Zip Code: _____

Risks and Benefits of Therapy

Psychotherapy is a collaborative process that offers a supportive and safe environment to explore your thoughts, feelings, behaviors, and relationships. This process aims to foster personal growth, improve emotional well-being, and strengthen your connections with others. While some discussions may be challenging, addressing difficult topics is often an essential part of the therapeutic journey and your feedback is crucial to the experience. It's important to recognize that there are no guarantees of feeling better immediately. Therapy is a gradual process that takes time and is not a "quick fix."

Participating in therapy may result in a number of benefits to the Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the Client, including active participation in the therapeutic process, honesty, and a willingness to explore feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings such as sadness, anger, and fear. There may be times in which Therapist will challenge Client's perceptions and assumptions and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of their personal relationships is the responsibility of Client. Client should address any concerns they have regarding their progress in therapy with the Therapist.

Grievances

The Board of Behavioral Sciences (State of California) receives and responds to complaints regarding services provided within the scope of practice of Clinical Social Workers, Marriage and Family Therapists, and Professional Clinical Counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830. Within the YMCA Youth & Family Services organization, you can also speak to the pre-licensed therapist's clinical supervisor or the Program Director by calling 619-281-8313. By calling this number or speaking to any of our staff and therapists, you can get information about the YMCA's formal Grievance and Appeal Process which outlines a specific procedure with timelines to respond to your complaint. Concerns regarding safety and quality of care can be brought forward to The Joint Commission. To report a concern, please visit The Joint Commission



Client Name: _____ DOB: _____ Zip Code: _____

[Website Online](https://www.jointcommission.org/en-us/contact-us/report-a-patient-safety-event) at <https://www.jointcommission.org/en-us/contact-us/report-a-patient-safety-event>.

Confidentiality

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality include but are not limited to, reporting child, elder and dependent adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, or when a Client is dangerous to themselves or the person or property of another. Watching, sharing, or downloading minor (ages 0-17) pornography is reportable to Child Welfare Services.

In the event of a medical emergency during the course of treatment, it is important to understand that the Therapist/staff may need to take immediate and necessary actions to address the emergency. This could include, but is not limited to, seeking emergency medical assistance, hospitalization, or other interventions as deemed appropriate by the Therapist or staff.

Due to the nature of the program, I consent to _____ (program name) using a treatment team approach. This means that case information may be shared among YMCA program staff to ensure services are properly coordinated. Shared information may include program details, counseling intake forms, and other completed paperwork. Under HIPAA, providers are allowed to share information for treatment planning and care purposes. The treatment team may also include individuals from the Mental and Behavioral Health Department and other relevant parties involved in your care. Your current or returning therapist will have access to your full treatment record, including documentation from any previous therapy you received at this agency.

Tours of the facility may be conducted during your treatment for purposes such as audits, research, evaluation, licensing, or accreditation. However, all individuals participating in these events are subject to the same confidentiality and HIPAA regulations as our clinicians.

Professional consultation is an important component of psychotherapy practice. Therapists regularly participate in clinical, ethical, and legal consultation and supervision.

For pre-licensed Therapists, information is shared with the Therapist's supervisor and/or practicum cohort for the purpose of supervision and training. Sometimes these supervisors are externally provided by the students' universities.

Additionally, payment and billing information is shared with YMCA administrative staff and Current Medical Billing for purposes of processing payment.



Client Name: _____ DOB: _____ Zip Code: _____

With your consent, sessions may be recorded by the Therapist for educational or supervision purposes. These recordings will only be used for these specific purposes and will be deleted immediately after they are no longer needed. Clients are not allowed to record sessions without prior discussion and explicit approval from everyone involved. If you feel that recording during a session would be helpful for you, please discuss this with your Therapist. Any recording of sessions requires mutual agreement and pre-approval from all participants.

Psychotherapy can only be effective if there is a trusting, confidential relationship between Therapist and Client. While the parent(s), caregiver(s), or representative(s) can expect an update on the Client's progress in therapy, they will generally not have access to detailed discussions between the Therapist and the Client. However, the parent, caregiver or representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Client, including suicidality.

If you use your health insurance to help cover the cost of therapy, insurance companies require some information about your therapy. Managed care organizations usually only request your diagnosis, the fee, the dates we met, and sometimes a treatment plan. However, they may request session notes.

Psychotherapist-Client Privilege

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the Client is the holder of the psychotherapist-client privilege. If the Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, the Therapist will assert the psychotherapist-client privilege on the Client's behalf until instructed, in writing, to do otherwise by Client or Caregiver. When a client is a minor child, the holder of the psychotherapist-client privilege is either the minor, a court appointed guardian, or minor's counsel. Parent(s) typically do not have the authority to waive the psychotherapist-client privilege for their minor child(ren), unless given such authority by a court of law.

The client or caregiver is encouraged to discuss with their attorney the scope of psychotherapist-client privilege, the circumstances under which the privilege may be waived, who has the authority to waive it, and any related concerns.



Client Name: _____ DOB: _____ Zip Code: _____

For Minors:

The clinician assesses the family's and caregiver's expectations regarding involvement in treatment. The clinician will discuss the family and caregiver's role in achieving care, treatment, or service goals. The family and caregivers are involved in developing the plan for care, treatment, or services in accordance with law and regulation unless such participation is contraindicated. Family participation is documented.

Records and Record Keeping

The Therapist may take notes during session and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of YMCA of San Diego County Youth & Family Services. Please refer to HIPAA Notice of Privacy Practices for more information. Should Client or Caregiver request a copy of Therapist's records, such a request must be made in writing. These requests will be responded to in accordance with California law. If Client is a minor, Caregiver may have the right to access the records regarding the Client. However, this right is subject to certain exceptions set forth in California law.

A Therapist will maintain adult Client records for ten years after the last client session. Records for minors must be kept for 10 years past their 18th birthday. After this time, Client's records will be destroyed in a manner that preserves Client's confidentiality.

Data Collection and Usage

YMCA Community Support Services partners with local, state, and federal organizations, as well as funders, to provide services to participants. These partners require the program to collect, store, analyze, and report information like demographics, engagement, and outcomes. This data helps show who is using the services and the impact they have.

We follow the latest data governance policies to keep your information safe. Sometimes, we are required to share individual, de-identified data (where all personal details are removed). Other times, we share aggregate data, which combines information from many people to show overall trends or patterns. We always share data at the least detailed level required.

Any information that could identify you will be removed or changed before being included in reports or communication materials.



Client Name: _____ DOB: _____ Zip Code: _____

Client Litigation

Therapists will not voluntarily participate in any litigation or custody dispute in which Client(s), or Caregiver, and another individual, or entity, are parties. All legal matters or concerns can be directed to YMCA's legal department. Therapists will generally not provide records or testimony unless compelled to do so. If the Therapist is served with a court ordered subpoena to appear as a witness in an action involving Client, the Therapist will comply with California law.

Fee Arrangements

The fee for service is _____ per 50-minute session. Sessions longer than 50 minutes are charged for an additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client, or Caregiver(s), will be notified of any fee adjustment in advance.

If applicable,

The fee is covered by _____ (program) while enrolled. At the point in which Client is no longer receiving services from the stated program, Client, or Caregiver(s), shall be responsible for the Counseling fee, which is per session.

The fee is covered by _____ (program) while Client is participating in aftercare services. At the point in which aftercare services expire, the Client, or Caregiver(s), shall be responsible for the Counseling fee, which is per session.

Program and/or Therapist is a contracted provider with _____ insurance company, managed care organization. If the service is not covered by Client's insurance carrier, Client is responsible for the fee of _____.

Cancellation Fee

Your appointment time is reserved specifically for you. Once a session is scheduled, you are responsible for payment unless you provide at least 24 hours' notice of cancellation or notify your therapist as soon as possible. If you are more than 15 minutes late, you will be charged a \$60 cancellation fee. Insurance cannot be billed for missed sessions and will not cover no-shows or late cancellations. If you are self-pay or using insurance, you may be charged a \$60 cancellation fee.

In a situation where your absence was beyond your control and your therapist deems it a true emergency (at the ER, hospitalized, etc.) and where time permits, your therapist will attempt to reschedule your session within the same week and consider waiving the fee. If you are able to talk on the phone or do a video conference session, that may be an option to avoid the cancellation fee.



Client Name: _____ DOB: _____ Zip Code: _____

YFS MBH Services does not allow for a balance to accumulate, if your balance accumulates for more than 2 sessions, your therapist will discuss safely pausing treatment, until the balance can be paid and no additional debt is incurred.

Attendance Policy

In instances where a Client misses three sessions without providing prior notification to the Therapist, a thoughtful discussion will be initiated by your Therapist to consider the best course of action regarding the continuation of services. Your well-being and engagement in the process are of utmost importance, and we want to ensure a collaborative and supportive approach.

Cancellation notice should be left on Therapist's voice mail at _____ or I may email my therapist at _____@ymcasd.org.

If Therapist suspects that Client is under the influence of drugs or alcohol, the session may not proceed that day and will be rescheduled. The Client will be responsible for payment of the agreed upon fee.

Therapist Availability

Therapists are equipped with a confidential voice mail system that allows Client, or Caregiver(s), to leave a message at any time. The Therapist will make every effort to return calls within a reasonable amount of time but cannot guarantee the calls will be returned immediately. **The Therapist is unable to provide 24-hour crisis service. If the Client is feeling unsafe or requires immediate medical or psychiatric assistance, they should call 911 or go to the nearest emergency room. For non-life-threatening mental health emergencies, clients may call the Access and Crisis Line at 1-888-724-7240 or dial 988.**

Email and Cell Phone Communication.

I understand that email and texting is a non-secure form of communication and may be intercepted by unauthorized others. There is no guarantee of confidentiality with email or text correspondence. I understand that my Therapist will not conduct counseling through email or text. If my Therapist is permitted to correspond by email or text, all email and text correspondence should be strictly of a scheduling nature. For more information, please refer to the Telehealth Consent Form.



Client Name: _____ DOB: _____ Zip Code: _____

From time to time, the Therapist may engage in telephone contact with Client, or Caregiver(s), for purposes other than scheduling sessions. The Client, or Caregiver(s), is responsible for payment of the agreed upon fee (on a "pro rata basis" proportionally) for any telephone calls longer than ten minutes. In addition, from time-to-time, the Therapist may engage in telephone contact with third parties at Client's, or Caregiver(s), request and with Client's, or Caregiver(s)'s, advance written authorization.

On occasion, the Therapist may have an emergency or unplanned absence. In those cases, you can expect contact from a program manager or clinical supervisor. If you do not hear from them, you can reach our office during business hours (8am-5pm) at 619-281-8313.

Communication Preferences:

I give my permission for my Therapist to contact me through the following methods:

- Home phone at (____) _____ Able to leave a message? Yes No
- Cell phone at (____) _____ Able to leave a message? Yes No
- Work phone at (____) _____ Able to leave a message? Yes No
- Send Mail to my home address. Client Address: _____
- Text me at _____
- Communication through email is approved. My email is _____.

On occasion you may receive a satisfaction survey through email to help us assess our quality of services.

Termination of Therapy

Therapist reserves the right to terminate therapy at their discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or there is not adequate progress being made in therapy. The Client, or Caregiver(s), has the right to terminate therapy at their discretion. Upon either party's decision to terminate therapy, the Therapist will generally recommend that the Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The Therapist may also attempt to ensure a smooth transition to another therapist by offering referrals to the Client.



Client Name: _____ DOB: _____ Zip Code: _____

Acknowledgement and Consent

By signing below, Client and Caregiver(s) acknowledge that they have reviewed and fully consent to the terms and conditions of this Agreement. Client and Caregiver(s) have discussed such terms and conditions with the Therapist and have had any questions about its terms and conditions answered to the Client's, or Caregiver(s)'s, satisfaction. Client and/or Caregiver(s) agree to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the Therapist. Moreover, Client and/or Caregiver(s) agree to defend and hold the Therapist and the YMCA harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, except in the event of YMCA's negligence or willful misconduct, that may result from such treatment.

I have read this document, and my basic rights have been explained for my participation in this program. These include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision on whether to accept or refuse treatment.

I agree to abide by this agreement and consent to participate in the following psychotherapy sessions in the YFS Mental & Behavioral Health Programs (Check all that may apply):

- Individual
- Couple
- Family
- Group

Adult (18+) Client Signature:

Client Name	Signature	Date
-------------	-----------	------

Client Name	Signature	Date
-------------	-----------	------



Client Name: _____ DOB: _____ Zip Code: _____

If a Minor:

Parent/Guardian Name	Signature	Date
----------------------	-----------	------

Parent/Guardian Name	Signature	Date
----------------------	-----------	------

If Self-Consenting Minor (12 years or older):

Client Signature	Client Age	Date
------------------	------------	------

Parent/Caregiver was notified of self-consenting minor's treatment

Therapist Signature:

Therapist Name	Signature	Date
----------------	-----------	------