TRAUMA&BEYOND
PSYCHOLOGICAL CENTER

14156 Magnolia Blvd. Suite 101 Sherman Oaks, CA 91423
818-351-3511

CONSENT FOR TREATMENT

I, _____, authorize and request that Trauma and Beyond ® team carry out psychological treatment, examinations, and/or diagnostic procedures, which now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me, and will be subject to my agreement. I understand that the therapy team at Trauma and Beyond are all licensed therapists/psychologists, or board certified supervisees, and that their license numbers are on the website or can be provided to me by the team for my reference.

OFFICE POLICIES

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child abuse, incest or elder adult abuse; where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm him or herself, unless protective measures are taken. Disclosure may also be required pursuant to legal proceeding. For collaboration of care and peer consultation, therapists may consult with the Trauma and Beyond Treatment Team.

Insurance: Although we are not in network, for PHP and IOP clients, our insurance biller will send statements directly to insurance for Trauma and Beyond reimbursement. However for outpatient (OP) clients, we will provide you with superbills, for Insurance purposes. Insurance companies may require disclosure of information in order to process claims. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.

Electronics: Use of text services, emails, cell phones, Skype, facetime cannot guarantee confidentiality and use of such services confirms understanding of this lack of guarantee of confidentiality with use of text, cell, email, and Skype or facetime.

Payment For Services: Patients are expected to pay for services at the time they are rendered unless other arrangements have been made. Outpatient clientele who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. We can provide you with a statement, which you can submit to your insurance company for reimbursement. Whereas with IOP/PHP if possible we will support PPO billing services. Though some insurance will not provide any reimbursement.

Cancellations: Since the scheduling of an appointment involves the reservation of time specifically for you, and your treatment team is booked for you we ask that you not miss treatment time. For IOP/PHP,

arrangements should be made in advance of contracts regarding any planned trips. IOP/PHP you are expected to be in treatment each day you have signed up for. Unexcused absences may be viewed as treatment abandonment

For OP clients, a minimum of 48 hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without 48-hour notification.

Availability: For IOP/PHP clients you will have a phone list and be advised who will be on call during the evenings or weekends for your support. For OP clients, we will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee the calls will be returned immediately.

OP Crisis: For OP, we are unable to provide 24-hour crisis service. In the event that a client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she/they should call 911, or go to the nearest emergency room.

IOP/PHP Crisis: For IOP/PHP you can call the TAB front office during business hours if you'd like to request crisis support from one of our team members at 818-351-3511. If it is after hours or over the weekend, your call will be forwarded to our answering service team, and you can request to speak with Dr. Lynne or Dr. Joanne. However, in the event you feel immediately unsafe or require urgent medical or psychiatric assistance, you should call 911, or go to the nearest emergency room.

Level of Care: You are currently admitted to TAB's _____. We reserve the right to upgrade our recommendation to a higher level of care, at our sole discretion.

Outcome Monitoring IOP/PHP: TAB utilizes therapeutic instruments called outcome measures to assess symptoms, inform intervention, and monitor progress over time. You will complete outcome measures at the start of treatment, and then at 30 days, 90 days, 6 months, 1 year, 18 months, and 24 months after the start of treatment. By signing this document, you are also consenting for outcome data to be utilized for program improvement and marketing purposes, in such a manner as to preserve client confidentiality.

THE THERAPY PROCESS

Our treatment program is focused on trauma, but effective treatment of trauma may also involve intervention from your clinical team in addressing substance use, disordered eating, and other co-occurring conditions that present a risk to health or safety.

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experiencing some discomfort.

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Remembering and resolving unpleasant events through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals, can also lead to discomfort and may result in changes that were not originally intended.

Signatures Verifying Agreement: Your signature below indicates that you have read the information in this document that you have understood it, and that you agree to abide by its terms as long as you are receiving services from Trauma and Beyond.

Client Name: _____

Client Signature: _____

Printed Date: _____

Contact Information

Address: _____

City: _____ State: _____ Zip: _____

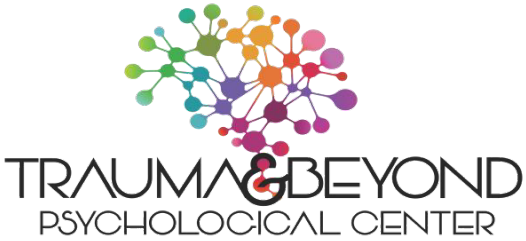
DOB: _____

Phone (Cell): _____

Phone (Home): _____

Email: _____

Insured's DOB: _____



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