Consent for Services

Suicide Prevention Counseling Center Informed Consent for Treatment

General Overview

We are honored that you have chosen to engage in your therapeutic journey with Didi Hirsch Suicide Prevention Counseling Center. Below are some of our policies and some legal and ethical issues that we would like you to understand before we begin. Although there are no guarantees regarding the outcome of psychotherapy, it has been shown to provide hope, improve resilience, provide symptom relief such as reduce emotional distress, assist in developing solutions to specific problems and improve relationships. Additionally, psychotherapy can provide one with a greater sense of self-awareness, empowerment, creativity, and vitality.

This document is a necessary part of our treatment relationship with you. It includes important information regarding your therapist's professional status, services and business policies. The law requires that we obtain your signature acknowledging that we have provided you with this information. We are also legally mandated to provide for you with your therapist's working status as a mental health professional.

Your Therapist is employed by or is a student of Didi Hirsch Suicide Prevention Counseling Center and is registered or licensed through the California Board of Behavioral Sciences or Board of Psychology. If not yet licensed or a student, your therapist works under the supervision of a licensed therapist who is employed by Didi Hirsch Suicide Prevention Counseling Center.

Confidentiality:

Your confidentiality is very important to us. We will ask for your consent to share your personal health information with others, with a few exceptions. Please refer to our agency's Notice of Privacy Practices. Everything we discuss in therapy is confidential with the exception of child abuse, dependent adult or elder abuse, or any intent to harm yourself or others, and in some cases, suicidal risk. See below for more information about steps we may take to support the health and well-being of you or others you know who may have risks to safety.

The law protects the confidentiality between a client and a psychotherapist. It is important that we inform you of the few situations outlined below, in which we are either permitted to or mandated to disclose information without your consent or authorization:

1. If we suspect that a child under 18 has been the victim of physical abuse, sexual abuse or neglect, the law requires that we break confidentiality and report suspicion to the Department of Child and Family Services.
2. If we suspect physical abuse, abandonment, abduction, isolation or financial abuse or neglect of an elder or adult dependent, the law requires that we report suspicion to the appropriate government agency.
3. If we have reasonable concern that a client is in such mental or emotional distress as to be a danger to themselves, we may need to take protective action, including contacting family members or others who can help provide protection. However, we aim to have this be a collaborative process and work to ensure that the least invasive intervention as is possible is utilized with 911 or hospitalization being the last, most invasive option.
4. If a client communicates a serious threat of physical violence against or threat to property of an identifiable victim, we must take protective actions, including notifying the potential victim and the police. We may also seek hospitalization of the client or contact others who can assist in protecting the victim.
5. If you are involved in a court proceeding and a request is made for information about the professional service that we have provided you and/or the records thereof, such information is protected by the psychotherapist/client privilege law. We cannot provide any information unless authorized by you, your legal representative, or ordered by the court.
6. If you file a worker's compensation claim or civil claim of pain and suffering, we must, upon appropriate request, disclose information relevant to your condition, to the worker's compensation insurer.

If any of these situations arise, we will make every effort to fully discuss any disclosures or reports we must make before taking action. Additionally, we will limit any disclosure to what is clinically relevant to the current situation.

"No Secrets Policy" for Couples and Family Therapy
Please note that when working with couples or families we have a “no secrets” policy. This means that we will not keep secrets from other members of the treatment unit (i.e., family or marital unit) if the secret will interfere with the goals of therapy. We will however work with each client to share difficult information with other members of the treatment unit in a manner in which they feel most comfortable. Together we will find a way to share information in such a way that it preserves the integrity of the therapy, while resolving problems.

Contact Information and Communication Outside of Session
You can leave us confidential voice mail messages for your therapist anytime at our Olympic location (424) 362-2900 or at our Orange County location at (714) 547-0885. With the exception of weekends, we aim to return calls within 48 hours. Please remember to leave your phone number and a good time to reach you when you leave a message.

Please note that while e-mail communication is available for non-clinical matters, there are inherent security risks with this form of communication. Please refer to our Electronic Communication Consent Form for additional information.

If you are experiencing a life or death emergency at any time please call 911 or go to the nearest hospital emergency room. If you are having an after-hours mental health issue and would like to speak to a crisis line counselor, please call the 988 Suicide and Crisis Lifeline.

Payment and Therapy Sessions
Session fees (see "Fees" section below for your location of therapy) are collected prior to each session. We accept payment in the form of cash, credit cards, or checks payable to Didi Hirsch Mental Health Services. While we try to be understanding of the financial constraints of clients, we may not be able to schedule any further sessions if the previous two sessions have not been paid. If session fees continue to remain unpaid, we may seek the assistance of outside services to collect unpaid fees. Sessions will be charged at full fee for missed appointments unless we receive a cancelation from you 48 hours in advance with the exception of emergencies and severe illness. Session fees also apply for telehealth and phone sessions; however, we do not charge for calls less than 10 minutes. There is a $25 service fee for bounced checks. On average, we adjust client fees on a yearly basis and any changes in fee structure will be discussed in advance.

Additional services including letter writing, coordination of care with other professionals that you have authorized, preparation of records or treatment summaries or time spent performing other services that you request may incur additional fees which will be discussed and agreed upon in advance. Please arrive on time for your session and be free of alcohol and drug intoxication for at least 12 hours. We make every attempt to maintain an ‘on time’ schedule. Therapy sessions are usually scheduled weekly unless we agree otherwise. When it is time to discontinue therapy, we ask to schedule a closure session to solidify the work we have done and bring closure to our relationship.

Fees for Olympic Location
Payment is expected prior to the time of service and is payable to Didi Hirsch Mental Health Services. Any requests for special payment options should be approved and arranged with the Therapist in advance. If I choose to pay in cash, I agree to bring exact change or to allow the Therapist to credit any excess to my account. I understand that individual, couples, and family sessions are 50 minutes long. I also understand that group sessions are one to two hours long. The standard fee for the group sessions is $60 per session. The standard fee for individual, couples, or family sessions is $150 per session. Please reference the Good Faith Estimate provided to you at intake for further explanation of fees for services.

For Orange County Location Only
I understand that Didi Hirsch Suicide Prevention Center Services in Orange County are funded by the County of Orange Health Care Agency. Behavioral healthcare services are provided at no cost, at this time. I understand that I must be an OC resident and be physically present in Orange County at the time of service.
Time with the Therapist via telehealth sessions may be arranged at the same rate.

At this time, the agreed upon fee for my services is: $_____.

I understand and agree to the payment options and fees detailed in the section above.

Cancellation Policy for Orange County Location:
I understand that if I need to cancel or reschedule an appointment, I will call to do so as soon as possible, preferably at least 24 hours in advance of the scheduled appointment. In addition, I understand that if I miss two consecutive therapy or group sessions without prior notification, I may be terminated from services (although I may reapply for services at a later date).

Grievance Policy
You have the right to file a complaint with Didi Hirsch Mental Health Services at any time if you feel you have been discriminated against, if you believe your privacy of been violated, or if you are dissatisfied with the services provided to you. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. The Suicide Prevention Center Complaint Form can be requested by emailing SPCDirector@didihirsch.org, or found at Didihirsch.org.

Litigation
We will not voluntarily participate in any litigation or custody dispute in which you or another individual or entities are parties. We have a policy of not communicating with attorneys and will generally not write or sign letters, reports, declarations or affidavits to be used in a legal matter. We will generally not provide records or testimony unless compelled to do so. Should the Division Director or Clinical Director be subpoenaed or ordered by a court of law to appear as a witness in an action involving you, you agree to reimburse us for any time spent for preparation, travel or other time at our court and expert witness service rates. Fees will be billed at no more than $400 per hour in addition to an $800 retainer.

Professional Records
The laws and standards of our profession require that we keep Personal Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that we believe record access may reasonably be likely to cause substantial harm to you or others, you may examine and/or receive a copy of your clinical record. This request must be made in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental health professional, so you can discuss the contents.

Insurance Reimbursement
At this time, we are registered with a few private insurance companies to provide mental health treatment to their clients. If you are insured with an insurance company we are not in network with, we can help determine if your plan may provide some coverage for mental health treatment from an out-of-network provider. It is important that you review your payment options and become familiar with your insurance company's policies and procedures regarding reimbursement for mental

health services. We can provide you with a monthly invoice (sometimes called a "superbill"), that you may send to your insurance company for reimbursement. Please remember though, that you (and not your insurance company), are responsible for full payment of our fees at the time of service. You should also be aware that your contract with your health insurance company may require that we provide them with information relevant to the services we provide to you. We may also be required to provide a clinical diagnosis, and in some situations, information such as treatment plans, summaries, or copies of your Clinical Record. However, before we can disclose this information, we must receive a written notification from your insurer stating: 1) what they are requesting, 2) why they are requesting it, 3) how long it will be kept and what will be done with the information. In such situations, we will make every effort to release only the minimum information in order to protect your confidentiality.

Security Cameras, Audio Recording, and Observation Mirrors

To allow for the safety of staff and our clients, there are some security cameras strategically placed around the perimeter of the building and general traffic areas of the interior of the building. However, there are no cameras inside the treatment rooms, and security footage is not stored permanently or shared with anyone outside of Didi Hirsch. If you are working with one of our unlicensed clinicians under supervision of a licensed clinician, there may come a time where audio recording or observation through a one-way mirror is conducted for the educational purposes of the clinician in training and to ensure the best treatment possible for you. This will not be done without your notice or consent via an additional signed form, and you have a right to refuse this recording or observation. This is not a requirement of you, nor will you be penalized in any way for your refusal.

Suicide Prevention Counseling Center Consent for Treatment Form

My therapist and I have discussed my case and I was informed of the risks, approximate length of treatment, alternative methods of treatment and the possible consequences of effects that treatment can have for me. While I expect benefits from this treatment, I fully understand and accept that, because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. I understand that regular attendance will produce the maximum possible benefits, but that I am free to discontinue treatment for myself at any time.

I understand that the Therapist does not provide emergency service. During evening or weekend hours, I have been informed whom/where to call for non-emergency matters**, instructed to call 911 if in imminent danger** or to call the **988 Suicide and Crisis Lifeline to speak to a crisis line counselor working for after-hours mental health issues**. I have been informed and understand the limits of confidentiality, and that by law the Therapist must report to appropriate authorities any suspected child, elder or dependent abuse or serious threats of harm to myself/my child's harm to themselves or to another person.

SPC Support Group Participation Agreement

General Overview

SPC provides support groups with the goal of providing a safe place for people to talk about their thoughts and feelings impacting their mental health, increase ability to recognize symptoms and risk factors, learn coping skills, and increase support systems to better cope with environmental stressors. Support groups are not therapy groups. This is not a substitute for psychiatric care, psychotherapy, or medical treatment. Although your group will be co-facilitated by a mental health clinician, the clinician is not your individual therapist. If you are interested in receiving therapy services at Didi Hirsch, please reach out to your group facilitator(s).

Confidentiality

Your confidentiality is very important to us. We will ask for your consent to share your personal health information with others, with a few exceptions. The clinician co-facilitating your group is a mandated reporter, therefore, everything discussed in group is confidential with the exception of child abuse, dependent adult or elder abuse, or any intent to harm yourself or others, and in some cases, suicidal risk. See below for more information about the steps your co-facilitator may take to support the health and well-being of you or others you know who may have risks to safety.

1. If we suspect that a child under 18 has been the victim of physical abuse, sexual abuse or neglect, the law requires that we break confidentiality and report suspicion to the Department of Child and Family Services.
2. If we suspect physical abuse, abandonment, abduction, isolation or financial abuse or neglect of an elder or adult dependent, the law requires that we report suspicion to the appropriate government agency.
3. If we have reasonable concern that a group member is in such mental or emotional distress as to be a danger to themselves, we may need to take protective action, including contacting family members or others who can help provide protection. However, we aim to have this be a collaborative process and work to ensure that the least invasive intervention as is possible is utilized with 911 or hospitalization being the last, most invasive option.
4. If a group member communicates a serious threat of physical violence against or threat to property of an identifiable victim, we must take protective actions, including notifying the potential victim and the police. We may also seek hospitalization of the group member or contact others who can assist in protecting the victim.

If any of these situations arise, we will make every effort to fully discuss any disclosures or reports we must make before taking action. Additionally, we will limit any disclosure to what is relevant to the current situation.

Contact Information and Communication Outside of Group

You can leave a confidential voicemail for your group facilitator(s) anytime at our Olympic location at (424) 362-2900 or at our Orange County location at (714) 547-0885. With the exception of weekends, we aim to return calls within 48 hours. Please remember to leave your phone number and a good time to reach you when you leave a message.

Please note that while e-mail communication is available, there are inherent security risks with this form of communication. Please refer to our Electronic Communication Consent Form for additional information.

If you are experiencing a life or death emergency at any time please call 911 or go to the nearest hospital emergency room. If you are having a mental health issue and would like to speak to a crisis line counselor, please call the 988 Suicide and Crisis Lifeline.

Payment and Group Sessions

Group fees (see "Fees" section below for your location of group) are collected prior to each meeting. We accept payment in the form of cash, credit cards, or checks payable to Didi Hirsch Mental Health Services. While we try to be understanding of the financial constraints of group members, we may not be able to schedule any further group meetings if the previous two groups meetings have not been paid for. If fees continue to remain unpaid, we may seek the assistance of outside services to collect unpaid fees. Meetings will be charged at full fee for missed groups unless we receive a cancellation from you 48 hours in advance with the exception of emergencies and severe illness. Fees also apply for virtual groups. There is a $25 service fee for bounced checks. On average, we adjust group fees on an annual basis and any changes in fee structure will be discussed in advance.

Please arrive on time for your group and be free of alcohol and drug intoxication for at least 12 hours. We make every attempt to maintain an 'on time' schedule.

Fees for Olympic Location

Payment is expected prior to the time of group meeting and is payable to Didi Hirsch Mental Health Services. Any requests for special payment options should be approved and arranged with your group facilitator in advance. If I choose to pay cash, I agree to bring exact change or allow the group facilitator to credit any excess to my account. I understand that group meetings are one to two hours long and the standard fee for the group meeting is $60 per meeting. Please reference the Good Faith Estimate provided to you at the start of services for further explanation of fees for services.

Fees for Orange County Location

I understand that Didi Hirsch Suicide Prevention Center Services in Orange County are funded by the County of Orange Health Care Agency. Support group services are provided at no cost, at this time. I understand that I must be an OC resident and be physically present in Orange County at the time of service.

At this time, the agreed upon fee for my services is: $_____.

I understand and agree to the payment options and fees detailed in the section above.

Cancellation Policy for Orange County Location

I understand that if I need to miss a group meeting, I will call and inform my group facilitator(s) as soon as possible, preferably at least 24 hours in advance of the scheduled appointment. In addition, I understand that if I miss two consecutive group meetings without prior notification, I may be removed from group (although I may reapply for services at a later date).

Grievance Policy

You have the right to file a complaint with Didi Hirsch Mental Health Services at any time if you feel you have been discriminated against, if you believe your privacy of been violated, or if you are dissatisfied with the services provided to you. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. The Suicide Prevention Center Complaint Form can be requested by emailing SPCDirector@didihirsch.org, or found at Didihirsch.org.

Insurance Reimbursement

At this time, we are registered with Aetna to provide support groups to their clients. If you have a different insurance company, it may provide some coverage for support groups to an out-of-network provider. It is important that you review your payment options and become familiar with your insurance company's policies and procedures regarding reimbursement for support group services. We can provide you with a monthly invoice (sometimes called a "superbill"), that you may send to your insurance company for reimbursement. Please remember though, that you (and not your insurance company), are responsible for full payment of our fees at the time of service. You should also be aware that your contract with your health insurance company may require that we provide them with information relevant to the services we provide to you. In such situations, we will make every effort to release only the minimum information in order to protect your confidentiality.

Security Cameras, Audio Recordings, and Observation Mirrors

To allow for safety of the staff and our group members, there are some security cameras strategically places around the perimeter of the building and general traffic areas of the interior of the building. However, there are no cameras inside the treatment rooms, and security footage is not stored permanently or shared with anyone outside Didi Hirsch. There may come a time when audio recording, observation through a one-way mirror or on Zoom is conducted for educational purposes of the group facilitators and to ensure that best support is being provided to you during group. This will not be done without your notice or consent via an additional signed form, and you have a right to refuse this recording or observation. This is not a requirement for you, nor will you be penalized in any way for your refusal.

Suicide Prevention Center Support Group Participation Agreement

I understand that the mental health clinician who is co-facilitating my group is not my therapist. I understand that if I want mental health services I should discuss this with my group facilitator(s). I have been **instructed to call 911 if in imminent danger** or to call the **988 Suicide and Crisis Lifeline to speak to a crisis line counselor for mental health issues**.

Consent of Minor

Please select the appropriate section(s) about the minor. One section MUST be completed.

☐ **EMANCIPATED**: (To be completed by staff) This minor has been declared emancipated from his/her parent/guardian by the courts and has been issued an identification card by the Department of Motor Vehicles (Cal Fam Code 7120). A copy of the identification card must be filed with this form.

☐ **ACTIVE DUTY WITH ARMED FORCES**: (To be completed by staff) This minor must be currently serving in the U.S. Armed Forces. A copy of his/her military ID must be filed with this form (Cal Fam Code 7002)

☐ **MARRIED**: (To be completed by staff) This minor is or has been married (Cal Fam Code 7002). A copy of the marriage certificate must be filed with this form.

☐ **SELF SUFFICIENT**: (To be completed by the client) This minor is self sufficient as exhibited by being able to declare all of the following (Cal Fam Code 6922).

- I am 15 years of age or older, having been born on (birthdate) _____
- I am living at the address given on admission for services, which is apart from the home/residence of my parents or legal guardian.
- I am managing my own financial affairs indicated by the financial information provided by me on admission for services.
- I understand that I am financially responsible for the charges for my mental health services and I may not disaffirm this consent because I am a minor.

The options below must be completed by an Authorized Mental Health Discipline (AMHD).

☐ **REQUEST** FOR **MENTAL HEALTH SERVICES:** This minor is mature enough to participate in mental health treatment. I certify that each of the below three criteria are met (Health & Safety Code 124260).

1. The client is 12 or older and mature enough to participate intelligently in the services provided.
2. The client's parent(s)/guardian(s):
   - ☐ Were contacted on _____ by _____
   - ☐ Were not contacted because _____
3. The client's parent(s)/guardian(s):
   - ☐ are currently involved in the services provided.
   - ☐ do not want or are unwilling to participate in the treatment.
   - ☐ are not appropriate to participate in the services provided.

Telehealth/Telephone Consent for Individual, Group, and Family Sessions

Didi Hirsch Mental Health Services is using telephone and telehealth (HIPAA compliant platform which involves interactive audio and video telecommunication) to continue to provide specialty mental health services. The purpose of this consent is to provide the client/caregiver/responsible adult with information that is important when deciding whether to participate in individual sessions by means of telehealth or telephone.

☐ **Staff: Please check off the box for each element to confirm that you have discussed with the Client/Caregiver/ Responsible Adult:**

- Individual, group, and/or family sessions will be conducted using approved secure platforms, but there is no way to guarantee that this software is completely failure-proof. As with any technology, there is a chance that information may be shared that would affect the privacy of your personal information.
- Technical difficulties may disrupt or delay services despite our best efforts to avoid this from happening.
- In case of an emergency, clinician will contact 911 or contact appropriate parties for assistance.

Since you will be participating in sessions in a remote location, we cannot guarantee your privacy. To strengthen privacy and confidentiality controls for yourself and other group/family members involved, we request that you:

☐ Are in a private area with no others in the room with you and where disruptions (e.g., others coming into the room or hearing what you say in another room) are minimized as much as possible.

☐ Use headphones to limit the possibility of other people overhearing confidential information.

☐ You are not to use any recording software during sessions. Likewise, services provided will be not recorded by Didi Hirsch unless you have consented to such.

Individual sessions:

☐ You have the right to withhold or withdraw your consent to participate in individual services via telehealth or telephone at any time during the course of your care and it will not affect your right to other care/treatment.

Group and/or family sessions:

☐ Refrain from using last names of other group/family members.

☐ All existing confidentiality rules for group and family sessions apply. However, given that other clients or family members will also be participating from a remote location, it is possible that your confidentiality could not be maintained if other members are not in a private area.

☐ You have the right to withhold or withdraw your consent to participate in group/family sessions via telehealth or telephone at any time during the course of your care and it will not affect your right to other care/treatment.

Informed consent for the use of Eleos Health Software

Didi Hirsch Mental Health Services currently incorporates Eleos Health (Eleos) software into clinical sessions. Eleos is HIPAA-compliant computer software that assists our clinical staff by listening to and identifying key information from your sessions to help draft documentation for clinical notes. With Eleos taking notes during sessions, clinical staff can be more present in your conversations, focus on your treatment goals, and provide you with the best care possible.

Eleos will be used during live or telehealth sessions by running silently alongside the session, so you should notice few if any changes to your overall experience. It is important to note that your sessions are not being recorded by Eleos nor are they being stored for future use.

The information gathered by Eleos may be used by Didi Hirsch for clinical supervision and documentation, as well as analytical, quality, and training purposes.

I acknowledge that I have read and understand this informed consent regarding the use of Eleos as part of my sessions. I understand that if I have additional questions about Eleos I can refer to Didi Hirsch staff for clarification. I acknowledge that I have the right to withdraw consent to the use of Eleos at any time by notifying Didi Hirsch staff both verbally and in writing.

Electronic Communication Consent

Didi Hirsch Mental Health Services (Didi Hirsch MHS) is dedicated to taking the precautions necessary to protect your confidential information. E-mail and text communications can be helpful in facilitating communication and coordination.

If you consent to the use of email communication, it will primarily be used for non-clinical issues such as scheduling and other logistics. It should never be used for emergency purposes. It will only be used for the below reasons:

- To schedule appointments or send appointment reminders
- To send links/passwords to video-conferencing sessions
- To share information related to billing and payment
- To relay limited basic mental health information or follow-up treatment instructions
- To collect and share surveys, outcomes measures, worksheets and forms
- To share newsletters or information on behalf of the agency
- To relay health records to the client or third party, only upon an additional written request and authorization to release in this manner
- For care coordination with third parties or as required by law

If you consent to **text messaging,** it will only be used for the below reasons and is explicitly not allowed for sharing clinical information.

- To schedule appointments or send appointment reminders
- To send links/passwords to video conferencing sessions or surveys

Risk Associated with Using Electronic Communication

Didi Hirsch MHS ensures that any transmission of electronic protected health information is in compliance with the HIPAA Security Rule requirements at 45 C.F.R Part 164 Subpart C. Didi Hirsch will always use a secure encrypted email system to communicate with a third party and put appropriate safeguards in place to protect your information. We will also use an encrypted system when emailing with you/your legal guardian unless you have specifically waived your desire to communicate via an encrypted system. Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to guarantee the security and confidentiality of the information. The use of electronic communication comes with the following risks. These include, and are not limited to:

- Electronic communication can be forwarded, intercepted, circulated or stored without the knowledge of the client or provider.
- Electronic communication can be misdirected, resulting in the risks of it being received by unintended or unknown recipients.
- Electronic communication is easier to alter and falsify than handwritten or signed documents.
- Backup copies of electronic communication may exist even after sender or recipients have deleted their copy.
- Electronic communication messages become part of the client's record and therefore can be used as evidence in court.

Conditions for the Use of Electronic Communication

Individuals must consent of the use of electronic communication with the following conditions:

- It should and will never be used for diagnostic or treatment purposes and requests to be assessed or treated through email will not be honored.
- Information provided within the electronic communication should contain the least amount of clinical and protected health information necessary.

- The email system does not have 24-hour monitoring services nor can the system guarantee delivery of email messages in a timely manner. Although we try to respond within two business days, we also cannot guarantee that any particular email will be read, received or responded to within any particular period of time.
- Urgent matters should be handled through contacting the agency's main line and asking for the Officer of the Day. For emergencies, please call 911 or go to the nearest emergency room.
- It is the client's or guardian's responsibility to notify Didi Hirsch of any changes in email address.
- Didi Hirsch MHS may forward emails internally between agency staff as necessary for treatment coordination and administrative handling.
- Didi Hirsch will not forward emails to independent third parties without the client's prior written consent.
- Health records will only be disclosed to clients via electronic communication upon additional written consent to do so via this modality.
- Didi Hirsch also employs social media platforms as a means of marketing and connecting with the community. It is your choice as to whether to connect with our business on these or other sites; however, we cannot guarantee your confidentiality on these sites if you choose to do so.
- In an effort to maintain the professional nature of our relationships, the providers as Didi Hirsch do not accept requests from current or former clients on personal social media sites.

Conditions for Use of Text Messaging

Messages sent via text are not encrypted and are therefore only allowed for two purposes: to send links to video appointments or surveys, or to send automated session reminders. The automated text reminders do not indicate the agency name or provide any identifying information. They state the following:

> You have an appointment with **[clinician name]** on **[session date]** at **[session time]**. DO NOT REPLY TO THIS TEXT! Please call **[main phone number of location]** if you cannot make it.

Your clinician will not text you outside of the two purposes above. If you contact your clinician via text messaging, the same security risk described above apply. Receipt and follow-up responses cannot be guaranteed and your clinician will not be able to engage in further communication via text.

Consent for Electronic Communication with Didi Hirsch MHS

I acknowledge that I have read and fully understand the above risks, limitations and conditions of Didi Hirsch's use of email and text to communicate personal health information. Didi Hirsch cannot guarantee security and confidentiality, and will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct.

I understand that I or Didi Hirsch may at any time withdraw the option of communicating via email and text upon providing verbal or written notice, especially if it is not believed to be the most appropriate means of communication.

Consents and Acknowledgments

☐ **Consent for Services**: I have reviewed and understood the above material. I agree to these conditions and give my permission to Didi Hirsch Mental Health Services to conduct the services necessary for evaluation and treatment. I also understand that I may, at any time and for any reason, withdraw my consent for treatment.

☐ **Group Participation Agreement**: I have reviewed and understood the above material. I agree to these conditions and give my permission to Didi Hirsch to conduct the services associated with my support group participation. I also understand that I may, at any time and for any reason, withdraw my participation from support group services.

☐ I consent to the use of Telehealth/Telephone services.

☐ I consent to the use of Eleos Health Software.

☐ I consent to the use of email communications sent via email encryption.

☐ I consent to the use of unencrypted text messaging for the purposes of session reminders and receipt of video conference links for telehealth services.

☐ You may ask us to communicate with you by regular email, which is not secured by a technical process called encryption. I consent to the use of email communication that is not sent encrypted.

Client or Guardian Email Address: _____

Client or Guardian Text Number: _____

Additional Email Address: _____

Authorization to Leave a Message

Accepted ☐ Declined ☐

Didi Hirsch staff are authorized to leave a detailed message at the telephone number(s) listed below if I cannot be reached.

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Client Acknowledgments

☐ I acknowledge that I have received a copy of Didi Hirsch Mental Health Services' Notice of Privacy Practices, which explains how my health information is protected and describes other rights that I have regarding my Protected Health Information.

☐ I have been provided information on the Advance Health Care Directive.

- ☐ Client currently has an Advance Health Care Directive in place.

I acknowledge that I have been provided information about my right to access protective and advocacy services (check one):

- ☐ Olympic. For private insurance clients, contact member services. For private pay clients, contact BBS or Board of Psychology.
- ☐ Orange County. Contact the Office of Ombudsman. Email: MMCDOmbudsmanOffice@dhcs.ca.gov

DIDI HIRSCH

SPC CONSOLIDATED CONSENT

I have read the information provided in this consent/agreement. I had an opportunity to ask questions about this information, and all my questions have been answered. I understand the written information provided.

Client Signature	Print Name	Date

Signature of Responsible Adult	Name and Relationship to Client	Date

Signator ☐ was given ☐ declined a copy of this consent on _____.

☐ Client is willing to accept terms of indicated consents/agreement, but unwilling to sign.

☐ Content of this document was reviewed verbally with client/responsible adult and client's/responsible adult's consent and understanding affirmed verbally.

This consent was interpreted in _____ by _____ on _____

Staff Printed Name and Signature	Date

This confidential information is provided to you in accordance with State and Federal laws and regulations, including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the participant/authorized representative to whom it pertains unless otherwise permitted by law.

Revocations

Revocation of Entire Consent
Client had previously provided consent but now wishes to withdraw consent. Consent is withdrawn as of signature date and time.

Signature	Print Name	Date

Revocation of Electronic Communication Consent
Client had previously provided consent but now wishes to withdraw consent. Consent is withdrawn as of signature date and time.

Signature	Print Name	Date

Revocation of Telehealth/Telephone Consent for Individual, Group, and Family Sessions
Client had previously provided consent but now wishes to withdraw consent. Consent is withdrawn as of signature date and time.

Signature	Print Name	Date

Revocation of Eleos Consent
Client had previously provided consent but now wishes to withdraw consent. Consent is withdrawn as of signature date and time.

Signature	Print Name	Date