Client Name: _____ DOB: _____ Zip Code: _____

Client's Informed Consent for Clinical Services

Introduction

This Agreement is intended to provide _____ (herein "Client Name") and, if client is a minor child, _____ (herein "Representative(s)/Caregiver(s)/Parents(s)") with important information regarding the practices, policies, and procedures of the YMCA of San Diego County Youth & Family Services (YFS) Clinical Services, 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. Signees agree that they are consenting to each item they initial on in this document.

_____ (herein "Therapist") is a

Graduate Student

☐ Master's level Counselor in training

Pre-Licensed

☐ Associate Clinical Social Worker (#_____)

☐ Associate Professional Clinical Counselor (#_____)

☐ Clinical Psychology Intern (in training)

☐ Marriage and Family Therapist Registered Associate (#_____)

Licensed

☐ Marriage and Family Therapist (LMFT)

☐ Clinical Social Worker (LCSW)

☐ Professional Clinical Counselor (LPCC)

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, or 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. This data and research does not disclose the identity of the client.

_____ Adult participating in treatment initials

If client is a minor child:

_____ Caregiver Initials

_____ Minor's Initials

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 I 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 I 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.

If client is a minor child:

_____ Minor's Initials

_____ Caregiver Initials

About Psychotherapy

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."

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Client discuss various issues, events, experiences, and memories for the purpose of creating positive change so Client can experience their life more fully. It provides an opportunity to better, and more deeply understand oneself and others, as well as any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to 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 Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield 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 of sadness, anger, fear, etc. 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.

During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Client should address any concerns they have regarding their progress in therapy with the Therapist.

Client Name: _____ DOB: _____ Zip Code: _____

_____ Adult participating in treatment initials
If client is a minor child:

_____ Caregiver Initials

_____ Minor's Initials

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.

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 their self 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 this 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. The treatment

Client Name: _____ DOB: _____ Zip Code: _____

team may also include individuals from the Mental and Behavioral Health Department and other relevant parties involved in your care.

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

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. Therapists cannot consent to being recorded without prior knowledge and agreement. If you feel that recording a session would be helpful for you, please bring it up so we can discuss your reasons and explore the best way to meet your needs. Any recording of sessions requires mutual agreement and pre-approval from all participants.

If Client is a minor, the parent(s), guardian(s) or representative(s), should be aware that Therapist will not relay most information from Client. 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.

_____ Adult participating in treatment initials

If client is a minor child:

_____ Caregiver Initials

_____ Minor's Initials

Client Name: _____ DOB: _____ Zip Code: _____

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 Representative 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, Parent(s)/Caregiver(s)/Representative(s) will generally 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.

_____ Adult participating in treatment initials

If client is a minor child:

_____ Caregiver Initials

_____ Minor's Initials

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: _____

I consent to the YMCA Community Support Services data collection and usage policy.

_____ Adult participating in treatment initials
If client is a minor child:

_____ Caregiver Initials

_____ Minor's Initials

Client Litigation

Therapists will not voluntarily participate in any litigation, or custody dispute in which Client(s), or Parent(s)/Caregiver(s)/Representative(s), and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's or Representative's legal matter. Therapists will generally not provide records or testimony unless compelled to do so. If the Therapist is subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, the Therapist will comply with California law.

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-client 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 Client's parent(s)/caregiver(s)/representative(s). 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 Parent(s)/Caregiver(s)/Representative(s) is encouraged to discuss any concerns regarding the psychotherapist-client privilege with their attorney. Client, or Parent(s)/Caregiver(s)/Representative(s), should be aware that they might be waiving the psychotherapist-client privilege if they make their mental or emotional state an issue in a legal proceeding. Client, or Parent(s)/Caregiver(s)/Representative(s), should

Client Name: _____ DOB: _____ Zip Code: _____

address any concerns they might have regarding the psychotherapist-client privilege with their attorney.

Fee and 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 Representative(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 Parent(s)/Caregiver(s)/Representative(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 Parent(s)/Caregiver(s)/Representative(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. Should Client, or Parent(s)/Caregiver(s)/Representative(s), choose to use their insurance, Therapist will provide a statement, which Client, or Parent(s)/Caregiver(s)/Representative(s), can submit to the third-party of their choice to seek reimbursement of fees already paid. If the service is not covered by Client's insurance carrier, Client is responsible for the fee of _____ .

Balances and Unpaid Bills

I consent to the YFS Clinical Services' policy which is to collect payment at the beginning of each session. YFS Clinical Services does not allow for a balance to accumulate. I consent to future therapy sessions being put on hold or my therapy services may be terminated if I do not pay my balance in full.

_____ Adult participating in treatment initials

If client is a minor child:

Client Name: _____ DOB: _____ Zip Code: _____

_____ Caregiver Initials

_____ Minor's Initials

Cancellation & Attendance Policy

Client, or Parent(s)/Caregiver(s)/Representative(s), is responsible for payment of the agreed upon fee for any missed session(s). Client, or Parent(s)/Caregiver(s)/Representative(s), is also responsible for payment of the agreed upon fee for any session(s) for which Client, or Parent(s)/Caregiver(s)/Representative(s), failed to give Therapist at least 24 hours' notice of cancellation. Cancellation notice should be left on Therapist's voice mail at _____ or I may email my therapist at _____ @ymcasd.org.

In instances where a Client misses three sessions without providing prior notification to the Therapist, a thoughtful discussion will be initiated 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.

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 Parent(s)/Caregiver(s)/Representative(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

Client Name: _____ DOB: _____ Zip Code: _____

correspondence should be strictly of a scheduling nature. For more information, please refer to the Telehealth Consent Form.

From time to time, the Therapist may engage in telephone contact with Client, or Parent(s)/Caregiver(s)/Representative(s), for purposes other than scheduling sessions. The Client, or Parent(s)/Caregiver(s)/Representative(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 Parent(s)/Caregiver(s)/Representative(s)s, request and with Client's, or Parent(s)/Caregiver(s)/Representative(s)'s, advance written authorization.

On occasion, the Therapist may have an emergency 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 _____ at_____

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 ok. 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 Parent(s)/Caregiver(s)/Representative(s), has

Client Name: _____ DOB: _____ Zip Code: _____

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 will also attempt to ensure a smooth transition to another therapist by offering referrals to the Client.

Acknowledgement and Consent

By signing below, Client and Parent(s)/Caregiver(s)/Representative(s) acknowledge that they have reviewed and fully consent to the terms and conditions of this Agreement. Client and Representative 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 Parent(s)/Caregiver(s)/Representative(s)'s, satisfaction. Client and/or Parent(s)/Caregiver(s)/Representative(s) agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the Therapist. Moreover, Client and/or Parent(s)/Caregiver(s)/Representative(s) agree to hold the Therapist and the YMCA free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, 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 Clinical Services program (Check all that may apply):

- ☐ Individual
- ☐ Couple
- ☐ Family
- ☐ Group

Client Name: _____ DOB: _____ Zip Code: _____

Client Name (please print) Client DOB

Signature of Client (12 years or older) Date

If the client is a minor:

Name of Caregiver Relationship to Client

Signature of Caregiver Date

Name of Caregiver Relationship to Client

Signature of Caregiver Date

Therapist Name (please print) Signature Date