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La Vida Life Counseling Center

Phone (714) 883-9156 Email info@lavidalcc.com www.lavidacounselingcenter.com

Consent of Treatment

Welcome!

Here at Luisa Contreras Family Therapy Inc./ La Vida Life Counseling Center, we are a dedicated team of professionals working to ensure your quality service. Treatment will be provided by (Therapist's Name and License/s Information) _____ _____; registered with the Board of Behavioral Sciences.

I, (Client's Name) _____ authorize and request that (Therapist's Name and License/s Information) _____ _____; to perform assessment, diagnosis, and treatment which now or during the course of my therapy are advisable. The frequency and type of treatment will be decided by my therapist and me. I understand the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy, as there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy, as the process can sometimes be uncomfortable.

I certify that I have read and fully understand this Consent of Treatment, I agree to be treated (or my child) by the therapist mentioned above._____ _____

_____ _____
Name of the Client Date

_____ _____
Client Signature Date

_____ _____
Witness/Therapist/Interpreter Date

Preferred Name of Client: _____

Name of Client: _____

Date of Birth: _____

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Physician-Client Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceeding. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence, giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physicians partner, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator; together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations or (2) the claimant fails tor pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____
Client Initials

Effective as of the date of first medical services

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other person.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____	_____
Client Signature	Name of Client	Date

_____
Physician or Authorized Representative Signature

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Client Information

First Name: _____ Mi: ___ Last Name: _____

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Prefer not to say □ Other_____

Gender: □ Female □ Male □ Transgender □ Non Binary □ Prefer not to say □ Other_____

Preferred pronouns: □ She □ He □ Hers □ His □ They □ Other:_____ Date of Birth: _____
MM / DD / YYYY

Phone Number: __ _____ Email Address: _____
Do you authorize to receive communications via email? □ Yes □ No

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Other □ Prefer to not say

Spouse Name: _____ Phone Number: _____

Employer Information

Name of Employer: _____

Address: _____

City: _____ Zip Code: _____ Phone Number: _____

In Case of Emergency

Name of Friend or Relative: _____

Relation: _____ Phone Number: _____

Insurance Information

□ Medi-Cal □ Medicare □ Cigna □ None □ Kaiser (Hmo) □Other: _____

Primary Insurer: _____ Phone Number: _____

Insurance Company Name: _____

Address: _____

Policy #: _____ Group #: _____

Direct Victim's Information

Name:_____M.I._____Last Name:_____

Gender: □ Female □ Male □ Transgender □ Non binary □ Prefer not to say □ Other_____

Date of Birth:_____ Phone Number:_____ Email:_____

Address:_____Apt. #:_____

City: _____State:_____Zip Code:_____

Ethnic Origin

The following information is voluntary for the patient receiving treatment at ***Luisa Contreras Family Therapy, Inc. / La Vida Life Counseling Center*** and is used for statistical purposes only

At least one category must be marked:

□ Asian (Specify): _____

□ African American

□ Caucasian

□ Native American

□ Hispanic/Latino(A)

□ Other: _____

Mark at least one category if you are Hispanic/Latino:

□ Cuban

□ Mexica /Chicano (A)

□ Puertorican

□ Other Hispanic/Latino(A): _____

Primary Language:

□ English

□ Spanish

□ Other: _____

Assignment Of Benefits

I hereby authorize ***Luisa Contreras Family Therapy, Inc. / La Vida Life Counseling*** to furnish my psychological records to my insurance carrier(s) concerning treatment, relative to the treatment and/or evaluations received, and I hereby irrevocably assign all payments for services rendered. I understand that I am financially responsible for the said services rendered should insurance deny payment in regards to same (services).

I understand that notwithstanding all of the above, payee(s) understands that same (client) is not relieved of its personal responsibility for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. A copy of this authorization shall be considered s the original.

I have answered all questions to the best of my knowledge, and have read and fully understand this Assign of Benefits Form.

_____ _____

Name of Client Date

_____

Client Signature

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Emotional/Behavioral Measurement Scale -Adult

CURRENT SIGNS AND SYMPTOMS: (Please mark EACH category)	None	Mild	Moderate	Severe
	0	1	2	3
Depressed Mood	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Suicidal thinking	☐	☐	☐	☐
Disturbed sleep	☐	☐	☐	☐
Appetite changes	☐	☐	☐	☐
Psychomotor retardation	☐	☐	☐	☐
Significant weight loss	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Poor Grooming	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Mood Elated	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Inappropriate/ Liable affect	☐	☐	☐	☐
Obsessive thoughts	☐	☐	☐	☐
Tension/anxiety	☐	☐	☐	☐
Fearfulness	☐	☐	☐	☐
Somatization	☐	☐	☐	☐
Compulsive behavior	☐	☐	☐	☐
Loose inappropriate associations	☐	☐	☐	☐
Inappropriate speech	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Impaired higher intelectual functions	☐	☐	☐	☐
Impaired judgement	☐	☐	☐	☐
Long term memory deficit	☐	☐	☐	☐
Short term memory deficit	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hostility	☐	☐	☐	☐
Violent behavior	☐	☐	☐	☐
Lawbreaking	☐	☐	☐	☐
Authority conflict	☐	☐	☐	☐
Disruptive conduct	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐
Dissociative episodes	☐	☐	☐	☐
SCORE	_____	_____	_____	_____

TOTAL SCORE: _____

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Patient Policies

By signing below, you are acknowledging that you have received, read, and agree to Luisa Contreras' Family Therapy/La Vida Life Counseling Center's:

_____ **HIPPA Notice of Practices (attached)**
Initials I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal copy of the Privacy Practices will be available per my request.

_____ **Communication, Social Media, Confidentiality and Exceptions to Confidentiality**
Initials I hereby acknowledge the receipt of the Communication, Social Media, Confidentiality and Exceptions to Confidentiality form. A personal copy will be available per my request.

_____ **CALVCB Authorization to Release Confidential Records & Information**
Initials I hereby acknowledge the receipt of the Authorization to Release Confidential Records & Information. A personal copy will be available per my request.

Claim Number _____ (if available)
The name(s), date(s) of birth, and social security number(s), if available, of my minor child(ren), for whom I have authorized release information A personal copy of the Privacy Practices will be available per my request., are:

_____

_____

This authorization shall be valid for three years from the date of this signed release form. I understand that I have a right to receive a copy of this authorization.
Today's Date: _____

_____ **CALVCB Other Services Provided**
Initials I certify that I have received and read the services offered by CalVCB and its limitations. A personal copy will be available per my request.

_____ _____ _____
Client Signature Name of Client Date

<u>Use or Disclosure of Personal Health Information Authorization</u>

I authorize the release of my patient/client health information to the following personal contacts (spouse, child, assistant, etc.). I understand it is my responsibility to notify Luisa Contreras Family Therapy Inc./La Vida Life Counseling Center of any changes in the information below.

[□] Appointment Info
[□] Treatment Info

_____ _____
Name Relationship
Phone #: _____

[□] Appointment Info
[□] Treatment Info

_____ _____
Name Relationship
Phone #: _____

I understand that, as set forth in the facility's Privacy Practice Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Luísa Contreras Family Therapy Inc,/La Vida Life Counseling Center 162 N. Glassell Street, Suite C, Orange, Ca. 92866