Kat Moghanian, MS; LMFT #95752

Psychotherapy for Individuals, Couples, Families and Groups

San Francisco, California

INFORMED CONSENT

The following information is given to acquaint you with my office procedures and to better assist you in your therapeutic process.

I have a Masters Degree in Counseling Psychology from the University of San Francisco, California. I currently work as licensed Marriage and Family Therapist with the Board of Behavioral Sciences (BBS).

_____/____I. **Your Rights as a Client**
(initials)

1. You have the right to ask questions about any methods used during therapy.

2. You have the right to decide at any time not to receive therapy from Kat Moghanian. I can provide you with the names of other qualified professionals whose services you might prefer upon your request.

3. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

_____/____II. **Confidentiality**
(initials)

1. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times therapy will involve the participation of more than one family member and/or significant persons. If we are doing Couple or Group Therapy, while I will attempt to follow your wishes, I do not guarantee confidentially among participants in the therapy.
2. There are certain situations in which I, as a registered mental health professional, am required by law to reveal information obtained during therapy to my supervisor, other persons or agencies without your permission. These situations include:
   a. If you threaten bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies.
   b. If you threaten bodily harm or death to yourself, I will inform the appropriate law enforcement agencies and others (such as spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
   c. If you reveal information related to current abuse or neglect of a child, dependent adult, or elderly person, I am required by law to report this to the appropriate authorities.
3. Social Networking and Internet: I do not accept friend requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

_____/____III. **Therapy Services and Fees**
(initials)

1. An individual therapy session is often 50 minutes or 90 minutes long. A family, couple, or group's therapy session is typically 90 minutes or more in length. I typically see clients on a weekly basis; however, we may see each other more than once a week or every other week depending on need. If you are unable to attend your scheduled appointment, you must call 48 hours in advance or you will be charged half the full fee for the first missed session. Thereafter, you will be charged the full fee for a missed session without 48 hours cancellation. **If you cancel less than 48 hours before one of the discounted sessions, you will be charged the full discounted rate and it will be counted as one of the discounted sessions.**

2. Payment is required at the time of your appointment, unless other arrangements have been made in advance. If at any point in the course of treatment you are unable to pay your fee, please communicate this to me and fee arrangements may be renegotiated.

I receive payments in cash, Venmo or check.

Clients assume a $20.00 penalty fee associated with NSF checks. If there is a fee increase, I will give you at least one-month notice beforehand.

3. I can often be reached at 415-562-6383 Monday through Friday 9am to 9pm. I usually return calls within 24 hours. If you have a counseling emergency or are feeling suicidal after hours please call the 24-hour Emergency Crisis line in your county or 911. You can visit my website for crises numbers or see below.

   Alameda County: 1.800.309.2131
   Contra Costa County: 1.800.833.2900
   San Francisco County: 415.355.8300
   San Mateo: 650.579.0350

4. Email and phone communication are typically reserved for scheduling communications only. As the confidentiality of email is uncertain, I do not conduct therapy by email. I typically respond to email within 48 hours during the workweek, unless I am out of town or not at work for some reason. If you are canceling an appointment with less than 24 hours notice, **please leave me a voicemail message, text or email me.** A confirmation of receipt of your email or telephone call will confirm my receipt. My email address is: **Kat@greenlighttherapy.com**

____/____IV. **HIPPAA Notice**
(initials)

Notice of Policies and Practices to Protect the Privacy of Your Health Information

1. Uses for Treatment, Payment, and Health Care Operations:

I may use your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your consent. The "consent" is given when you sign the Psychotherapist-Client Services Agreement.

2. Client's Rights and Counselor's Duties:

Client's Rights:

a. Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
b. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your statements and communications to another address.)
c. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless I make a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the request and denial process.
d. Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
e. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. The cost is 35 cents per page.

Psychotherapist's Duties:

f. I am required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.
g. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

3. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may discuss this with me at this office. You may file a written complaint to

the California State Board of Behavioral Sciences at 1625 North Market Blvd., 2nd Floor, Suite S-200, Sacramento, CA 95834, (916) 574-7830 or email BBSWebmaster@bbs.ca.gov

4. Effective Date, Restrictions, and Changes to Privacy Policy This notice went into effect on January 27, 2014.

I will limit the uses or disclosures to the minimum necessary. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. A copy is available on request.

By signing this you are agreeing to the terms and conditions of therapy and acknowledging that you have read and understand the above information.

#1) Client Signature:_____ Date:_____

Client Address_____ Phone: _____

Emergency Contact: _____ Phone: _____

#2) Client Signature:_____ Date:_____

Client Address_____ Phone: _____

Emergency Contact: _____ Phone: _____

Therapist Signature:_____ Date:_____