MATTSONTHERAPY INC.

Policies and Consent for Services

The following is an outline of my office policies. Please read this information carefully and feel free to raise any questions about my policies, experience, credentials, or approach to therapy.

I am licensed within the State of California as a marriage and family therapist (MFT 40746). I provide individual, couples, and family psychotherapy to assist people dealing with painful and distressing events in their lives, to help them better understand themselves in relationships, and to encourage them to define and reach their goals. I utilize a variety of treatment techniques.

Confidentiality: All information disclosed during sessions, including that of minors, is confidential, and may not be revealed by me to anyone without prior written consent by you, except where disclosure is either permitted or is required by law. Disclosure is *mandated* under the following circumstances:

1) When the client communicates a threat of bodily injury to another person.
2) When the client is imminently suicidal.
3) When there is a reasonable suspicion that child abuse or neglect or abuse to a dependent or elder adult has occurred or is likely to occur.
4) When information is ordered pursuant to a legal proceeding.

In order to provide you with the best care, I maintain regular professional consultation, and participate in mandatory continuing education. At no time is a client's name or identifying data revealed to others without prior written consent by you, the client.

Length of Session: Generally, a psychotherapy session is 50 minutes long. However, when seeing couples the first sessions or as indicated, I will schedule 75+ minute sessions. I will be prepared to begin and end our sessions at the designated time.

Additional Sessions: Optimal scheduling for psychotherapy sessions is once a week. Additional sessions may be arranged if a crisis arises, or on an as needed basis.

Payment and Insurance: My fee is $180.00 per 50-minute session. Please make payment at the **beginning** of each session, so that payment does not take time away from the end of your session. Payment can be made via check, cash, Visa and Mastercard. For Visa and Mastercard, there will be a $5 processing fee. To make payment electronically and avoid the processing fee, you can make payment using an application called Venmo at @Brian-Mattson-6. That application can be downloaded to your smart phone. **NOTE** – if you pay using Venmo, your payment and name may be visible to "friends" and/or public even if privacy settings are set to "private."

MAKE CHECKS PAYABLE TO: Mattson Therapy Inc.

Phone sessions, site visits, report writing and reading will be charged at a rate of $180.00 per hour.

Brian Mattson, M.A. MFT, Lic. 40746
Psychotherapy for Individuals, Couples & Families
302 W. Grand Ave., Suite 9, El Segundo, CA 90245
brianmattsonmft@gmail.com, (424) 442 - 9148

Some insurance companies will cover your mental health session. Please check with your insurance provider as to your coverage including your current deductible. I am not in-network with any insurance company, but will be happy to provide you with a statement (superbill) that can be submitted for reimbursement to your insurance provider.

Insurance companies do not always cover all costs associated with treatment including, but not limited to, report writing, phone sessions, or site visits. You will be responsible for any fees not covered by your insurance provider.

Cancellation: Since the scheduling of an appointment involves the reserving of a time set especially for you, a minimum of **24-hours notice** is required for cancelling an appointment. This time will allow me to adjust my schedule. To avoid being charged for the cancelled session, be sure to call, text, or email to notify me a full 24-hours in advance of the scheduled appointment. If a full 24 hours advance cancellation is not received, full payment for the missed session is due and will be charged to the credit card authorization I have on file unless other arrangements have been made. Insurance companies do not cover the cost of missed sessions. If you seeking reimbursement from an insurance company, please be aware that a cancelation with less than 24 hours notice, will not be reimbursed and you will be responsible for the entire amount.

Emergency Availability: Generally, I am not immediately available by telephone. Please note that while I check my messages throughout the day, I am not always available for immediate contact. If you have concerns about this, please bring it up to me.

Between sessions, if you feel you need to talk to me, I am available for brief conversations without charge. If the particular problem or situation requires **more than 10 minutes**, we can schedule time to meet prior to your next regular session or set up a session by phone. **The phone session will be subject to our pre-set fee.**

The undersigned client or responsible adult* consents to and authorizes mental health services by Brian Mattson MFT Lic. 40746.

The undersigned understands that psychotherapy is voluntary and he/she has the right to request a change in service provider or withdraw this consent at any time.

I appreciate the commitment you have made to this process and trust that these guidelines will provide a helpful structure for our ongoing work.

I am happy to welcome you to my private practice and look forward to working with you on your growth and healing.

I have read this form and by signing below indicate that I understand and agree to its terms:

_____

Client Signature **Date:**

_____

Signature of Responsible Adult* **Relationship to client** **Date**

***Responsible Adult= Guardian, Conservator, or Parent of Minor when required**

Client Information

Name:_____ Date of Birth:_____

Address: (street)_____ city)_____

(zip):_____

Phone: Home:_____ Work:_____ Cell:_____

Email:_____

Where would you prefer to be called?:_____

Is there any number where I can not leave a message?:_____

Referred by: □ PsychologyToday.com, □ NetworkTherapy.com, □ GoodTherapy.com,

□ Theravive.com, □ Friend/other client, Other: _____

Are you currently employed?:_____ If yes, who is your current employer?

_____

Business: (Name and Location)_____

_____

In Case of emergency, contact:

Name:_____ Relationship:_____

Phone:_____Cell_____

Married/Single/Divorced Number of Children, names & ages _____

_____

MEDICAL AND DRUG HISTORY:

Please answer the following questions as honestly as possible. **If any of the questions are causing you discomfort, we can talk about it together.**

Have you had previous psychotherapy? (Please list inpatient or outpatient)
Dates:_____

_____

Are you presently under the care of a Doctor or Psychiatrist? Yes_____No_____
Name:_____
Address:_____Phone:_____

If you are taking any medications, please list:
_____

Have you experienced:			
Depressed mood	yes/no	Frequent Body Complaints	yes/no
Mood swings	yes/no	Eating Disorder	yes/no
Rapid Speech	yes/no	Body Image Problems	yes/no
Anxiety	yes/no	Alcohol/Substance Abuse	yes/no
Panic Attacks	yes/no	Hallucinations	yes/no
Phobias	yes/no	Sleep Disturbance	yes/no
Any history of domestic violence, physical, sexual or emotional abuse?			yes/no
Have you experienced an event that is resulting in nightmares, intrusive thoughts, feelings, or flashbacks?			yes/no
Have you had suicidal thoughts or attempts in the past?			yes/no
If yes, were you hospitalized?			yes/no

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family member or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____

MEDICAL HISTORY:

How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes,
etc.):_____

_____

Do you have any other medical problems? If so, please list:

_____

_____

Are you taking any supplements: If so, please list: _____
_____

Do you: Drink Alcohol? Yes/No
If yes, approximately how many drinks per week?_____

What do you drink?_____

Smoke Marijuana? Yes/No
If yes, how often?_____

Smoke Cigarettes: Yes/No
If yes, how much do you smoke?_____

Are there any other recreational or prescription drugs you use or have history of using: Yes/ No
Please list: _____

(For women only) Are you pregnant? Yes/No

OTHER INFORMATION:

What is your main reason for starting therapy?

What do you consider to be your strengths?

What behaviors help you cope with stress, anxiety or depression?

☐ Initial this box to receive emails regarding groups, information and events presented by Brian Mattson, MFT.
Events include, meditation groups, educational workshops and relevant information about Brian's practice such as change of location or contact information. Email addresses will be kept confidential and never sold.

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Responsible Adult Relationship to Client Date

*Responsible Adult= Guardian, Conservator, or Parent of Minor when required

Credit Card Authorization Agreement

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the event that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

I, _____, authorize Mattson Therapy Inc., and Brian Mattson, MFT to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance, or if a check is returned for any reason. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): VISA MasterCard

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

By signing below I am authorizing Brian Mattson to charge for missed scheduled appointments.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
(HIPAA: HEALTH INSURANCE PORTABLIITY AND ACCOUNTABILITY ACT)

THIS NOTICE DESCRIBES HOW MEDICAL INFOMRATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a therapist who is required by law to maintain the privacy of your personal health information, Brian Mattson, MFT, will set forth for you his privacy policies herewith: *Any identifiable information relating to your physical or mental health, the health care you've received, or payment for your health care is considered "protected health information".*

I am required by law to:

- Keep private any health information that identifies you
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

Please note that the following information relates to your personal health information in general.
Certain kinds of personal health information are maintained with a greater level of confidentiality. *Specifically, we will not use or disclose psychotherapy notices, information related to HIV/AIDS status or alcohol or drug dependency issues without your prior written consent, except where required by law.*

YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED:

FOR TREATMENT: To provide you with treatment or services. We may disclose this information, *with your prior written consent,* to: doctors, psychologists, other licensed health care providers, who provide you with health care services or who are involved in your care.

For Payment: To obtain payment of services. We may also use your PHI to obtain prior authorization for proposed treatment or to determine your benefit eligibility. For example, your PHI may be included in a billing sent to your insurance company or to a governmental payer.

For Healthcare Operations: To support the healthcare services we provide. For example, for evaluating the quality of the services you receive; providing appointment reminders or sending you information about treatment alternatives or other health-related services.

To Individuals Involved in Your Care or Payment of your Care: To your family, or any other individual you identify, when they are involved in your care or in the payment of your care, *with your prior written consent, and we* will only disclose the protected health information directly relevant to their involvement in your care.

Emergencies: In emergencies only, to emergency health providers, after first attempting to obtain your consent.

Contracted Services: For example, answering services, translation services, in-home aides or other contracted healthcare providers. We may use or disclose your PHI in order to help them do their job. To protect your health information, however, we require each contracted service provider to appropriately safeguard your information.

Research: Information used or disclosed will be de-identified, so that your privacy is protected.

Public Health Risks: To prevent or lessen serious or imminent threats to your health or safety or the health and safety of the general public, or to prevent injury, disability, to report births, deaths, suspected abuse or neglect, reactions to medications or problems with products.

Where Required by Law: To applicable officials when a law requires us to report information to government agencies, law enforcement personnel, or when ordered to do so in a judicial or administrative proceeding. We may disclose to authorized officials: in response to a search warrant, to report a crime on our premises or to help identify or locate someone.

Lawsuits or Other Legal Disputes: To respond to a court order, subpoena, or discovery request and to the extent permitted by law, in defense of a lawsuit or arbitration.

Worker's Compensation Purposes: To comply with Worker's Compensation laws.

Abuse or Neglect: To report suspected child or elder abuse or neglect.

Government Function: To various departments of the government such as the U.S. military or the U.S. Department of State.

YOU HAVE THE RIGHT TO:

Request Limits on the Use and Disclosure of Your Protected Health Information: I will consider your request, but I am not legally obligated to agree to it. To request restrictions, you must make your request in writing to your treating therapist, who is your Privacy Officer.

See and Get Copies of Your Protected Health Information:

You may inspect and receive a copy of your health and billing records. Your request must be made in writing to me. A reasonable copying charge may apply. Under certain circumstances, certain information may not be made available to you. In that case, you will be informed, in writing, of the reason for the denial and explain your right to have the denial reviewed.

Update or Correct Your Protected Health Information:

You have the right to request that we correct or amend your PHI information. Your request must be made in writing to me and you will receive a written response within 60 days. If denied, the reason will be stated and will be included in your file.

Request Confidential Communications:

You have the right to request that I send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, email instead of regular mail). I must agree to your request as long as we can easily provide the information to you in the format you've requested.

Obtain a list of Disclosures:

You have the right to obtain a list of instances in which your PHI was disclosed by your treating therapist (other than for purposes of treatment, payment or healthcare operations). Your request must be made in writing and must specify a time frame of not longer than six years and not prior to 4/14/03.

Receive a Paper Copy of this Notice:

You have the right to receive a paper copy of this notice at any time.

Register a Complaint:

If you believe that your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Protected Health Information:

Other uses or disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose information about you, you may revoke that permission, in writing, at any time. However any disclosure, which has been made with your permission, cannot be recalled.

Changes to this notice:

I reserve the right to change this notice at any time.

Brian Mattson, M.A. MFT
302 W. Grand Ave. Ste. 7
El Segundo, Ca 90245

By signing this document, you are indicating that you have read, understand agree the stated privacy policies.

_____ _____

Signature of Client Date

_____ _____ _____

Signature of Responsible Adult* Relationship to Client Date

***Responsible Adult= Guardian, Conservator, or Parent of Minor when required**