



32392 S. Coast Hwy, Ste. 250

Laguna Beach, CA 92651

(949) 499-2265

**PATIENT INFORMATION**

<b>DATE</b> / /	<b>DOB</b> / /
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Patient Name Last First Middle Initial	Relationship Status	Sex ( <i>assigned at birth</i> )	Age
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Home Address	City	State	Zip Code	Home Telephone
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Preferred Name ( <i>if different from legal name</i> )	Pronouns: He/Him She/Her They/Them Other: _____ Gender Identity: Male Female Non-Binary Other: _____	Cell Phone
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Occupation	Social Security Number	Employer/School	Work Telephone
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Preferred Phone Number : <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Consent to Leave a Voice Message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent to Leave Confidential Info? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Preferred Email Address:	Consent for Staff/Clinicians to Email You? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Pharmacy (Name, City & Phone Number):
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Name/Address of Financially Responsible Person (Where to send billing statements <i>if other than patient</i> ):	Cell Phone (if applicable)	Email (if applicable)
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Health Insurance Co. Name & Plan Type (HMO/PPO)	Name of Policy Holder & Relationship to Patient	Consent to Coordinate Financial/Billing with Policy Holder ( <i>only if needed</i> ): <input type="checkbox"/> Yes <input type="checkbox"/> No
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Insurance Co. Phone Number (back of card)	ID/Policy Number	Group Number	Policy Start Date / /	Policy End Date / /
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Referred By: <input type="checkbox"/> Friend/Family <input type="checkbox"/> Insurance <input type="checkbox"/> Laguna Family Website <input type="checkbox"/> Psychology Today	<input type="checkbox"/> Therapist <input type="checkbox"/> Primary Care <input type="checkbox"/> ER/Hospital <input type="checkbox"/> School <input type="checkbox"/> Internet Search <input type="checkbox"/> Google <input type="checkbox"/> Other: _____	Name of Referral Source ( <i>if applicable</i> )
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**COLLABORATION OF CARE AGREEMENT**

Name of Primary Care MD/NP:	City: Phone Number:	Consent to Collaborate on Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Current Therapist (if applicable):	City: Phone Number:	Consent to Collaborate on Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Current Psychiatrist/Psych NP (if applicable):	City: Phone Number:	Consent to Collaborate on Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name(s) of Additional Specialists/Healthcare Professionals you would like us to collaborate with in your health care (*if applicable*):

_____ <i>Patient / Guardian Signature</i>	_____ <i>Date</i>
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**LATE CANCEL & NO-SHOW OFFICE POLICY: 24 BUSINESS HOURS**

It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. Our clinicians will make every effort to also be on time, however *due to the nature of the practice and acuity of patient issues / symptoms, clinicians may run late on occasion*. Once your appointment is scheduled, you will be expected to pay for it unless you provide at least **24 business hours** advance notice of cancellation. *Business hours* are considered the weekdays between Monday and Friday. This means that if you have an appointment on Monday at 4 pm, you must cancel by Friday at 4 pm to avoid being charged. Please note, insurance companies will not reimburse for missed or late cancel sessions nor can they be billed. As a reminder, **credit card(s) on file will be charged for any of these fees**. If you do not provide at least 24 business hours notice, or fail to show for a scheduled appointment, you will be responsible for the **FULL** private pay cost of the session. A list of office visit fees is listed in this intake packet and also on our website.

Many practices overbook on purpose so that no-shows and cancellations won't limit access for other patients as well as cause a financial hardship for the practice. Our practice chooses not to do this practice as we prefer to focus on individualized care that is not rushed or expedited. We pride ourselves on offering care that allows each client the time needed to address their specific needs. Because of our practice specialties and the shortage of mental health providers, many of our clinicians have waiting lists and thus, no-shows or late cancels can take away from other clients seeking treatment. We understand that certain emergencies can arise that are beyond your control. Please discuss any concerns with our staff in these circumstances.

**CREDIT CARD AUTHORIZATION & PAYMENTS POLICY**

*Any copays, office visit fees, or other costs must be paid at the time of service.* It is our office policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant manner. Unless other arrangements are approved by us, the balance on your account is due and payable at the date it is requested in person or by billing statement, whichever is sooner. Accounts are considered past due and delinquent/subject to reporting to collections if not paid within 90 days. Any copays or deductibles are an insurance requirement and cannot be waived or reduced by our office. If a patient is not able to pay their co-payment or fees at the time of the visit with cash or check, signing this gives our office permission to process the payment for you with your card on file. Also, as noted above, if an appointment is canceled in less than 24 business hours or a patient does not show for a scheduled appointment, the full fee is due and will be charged to the card on file. No-shows and late cancels cannot be billed to insurance. Lastly, If a patient becomes 90+ days overdue, with any balance, we may process the payment using the credit card information on file. This would only occur if multiple attempts to reach the patient and/or set up a payment plan have not been returned.

I, \_\_\_\_\_, am authorizing Laguna Family Health Center to charge my credit card for the reasons stated above. Furthermore, for outstanding payments equal to or greater than 90 days, I authorize Laguna Family Health Center to charge my credit card for the full amount due. I am aware that my card will be manually entered and thus no signature obtained but I am consenting to this per the above parameters. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 business hours in advance. If I choose to dispute a charge to my credit card company, a copy of this credit card authorization will be provided.

Card Type (circle one):    Visa    MasterCard    American Express

Name on Card: \_\_\_\_\_ Relationship to Patient (circle one):    Self    Parent    Spouse    Other

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Cardholder (if different then patient)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient / Guardian Signature*

\_\_\_\_\_  
*Date*

## COMMUNICATION & EMERGENCY CONTACTS

Please list **ALL** individuals whom you consent may discuss your care with our office: **(please note if any limitations):**

1. _____			
Name	Phone	Email	Relationship
2. _____			
Name	Phone	Email	Relationship
3. _____			
Name	Phone	Email	Relationship

**IN CASE OF AN EMERGENCY ONLY**, please list the individuals whom we may inform:

1. _____			
Name	Phone	Email	Relationship
2. _____			
Name	Phone	Email	Relationship

## POLICIES & CONSENT FOR TREATMENT OF A MINOR (IF APPLICABLE)

### **OVERVIEW OF THERAPY WITH KIDS/TEENS:**

Confidentiality in working with kids/teens can be difficult for parents/guardians to understand. Children/teens won't feel safe to open up in therapy unless they can be assured that what they say will be kept private. On the other hand, as a parent, you have a right to know how your child is progressing. In general, we will tell children that while we will be speaking with their parents from time to time, we won't share specifics of our work unless the child and clinician(s) have agreed beforehand. The exception is when information is obtained that falls under mandated reporter status (child/dependent/elder abuse) and/or knowledge that the child is suicidal or involved in any dangerous activities. In these cases, parents and the appropriate agencies (for abuse) will be notified. *In working with kids/teens in therapy, the therapist/child/family are partners in the growth, but the therapist must serve as the guide while in treatment.* The frequency of parent meetings depends on the individual and is done periodically or as issues arise. In between sessions, *you are welcome to email any concerns or updates to our clinicians* with respect to the time it takes outside of the office to read these concerns/requests. Please use this mode of communication, including phone contact, to convey only the most important information and of course for any urgent issues.

### **OVERVIEW OF MEDICATION MANAGEMENT WITH KIDS/TEENS:**

Seeking psychiatric consultation can be an emotional and overwhelming process for parents. There is much to navigate when deciding whether medications are right for your child. Our nurse practitioners are very conservative with medications and will discuss all alternative treatments, the role of therapy, diet/exercise/sleep needs, medical issues, etc. as part of a treatment plan. However, for many, medications are an essential element to treating symptoms and illnesses in mental health, just as in any other area of medicine. There can be a great deal of stigma surrounding mental health, as well as inaccurate information in the media. One area surrounds the accusations of suicide risk in kids/teens on antidepressants, which is based on research that is not methodically sound. In addition, another challenge is that a majority of the medications needed to target certain biochemical pathways and areas of the brain are not FDA approved, but are standard of care when *practicing evidence-based medicine* and psychopharmacology. You can be assured that you will work closely with our NPs and collaborate on a plan that is best for your family.

*We/I, the undersigned \_\_\_\_\_, parent(s) and/or guardian(s) of minor child \_\_\_\_\_, give you full authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent/ guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child.*

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**Patient / Guardian Signature**

**Date**

## PATIENT HEALTH HISTORY & QUESTIONNAIRE

Current symptoms/reason for seeking treatment: \_\_\_\_\_

Please list any recent life changes/stressful events/losses: \_\_\_\_\_

### **Medical & Psychiatric History**

Please list any current or past medical conditions/surgeries: \_\_\_\_\_

Current Medications (with dosages): \_\_\_\_\_

Current Vitamins/Supplements: \_\_\_\_\_

Names of any past psychiatric medications: \_\_\_\_\_

History of Psychiatric Hospitalization(s)?: Yes No      History of Depression?: Yes No      History of Anxiety?: Yes No

History of Suicide Attempts or Self-Injury?: Yes No      History of Eating Disorders?: Yes No      History of Mania/Psychosis?: Yes No

Last Physical Exam & Labs?: \_\_\_\_\_ Allergies: \_\_\_\_\_ Height/Weight: \_\_\_\_\_

Avg # hours of sleep/night: \_\_\_\_\_ Avg # hours of exercise/week: \_\_\_\_\_ Balanced/Healthy Diet? Yes No Unsure

### **Family History**

List any family medical history (cancer, diabetes, thyroid, heart, etc): \_\_\_\_\_

List any family psychiatric or addiction history: \_\_\_\_\_

### **Social History**

Relationship Status: \_\_\_\_\_ Names/Ages of Children (if applicable): \_\_\_\_\_

Where did you grow up? \_\_\_\_\_ Who did you live with as a child/teen? \_\_\_\_\_

History of Foster Care/Adoption: Yes No      Do you have any history of abuse, neglect or trauma (childhood or adult): Yes No

Highest Level of Education \_\_\_\_\_ Military/Veteran Status Yes No      Military Branch/Years \_\_\_\_\_

Pertinent Cultural, Spiritual and/or Religious Identity: \_\_\_\_\_ Support System \_\_\_\_\_

### **Substance History**

Current alcohol use-number of days/wk and average # drinks/week: \_\_\_\_\_

Current cigarette/vape/nicotine-number of days/wk and average amount: \_\_\_\_\_

Current caffeine use-type and #drinks/day or week: \_\_\_\_\_ Current marijuana use & frequency: \_\_\_\_\_

Current use of other substances?: \_\_\_\_\_ Past Substance Use or Treatment? \_\_\_\_\_

\_\_\_\_\_  
*Patient / Guardian Signature*

\_\_\_\_\_  
*Date*

## **NOTICE OF PRIVACY PRACTICES**

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

*This is a SUMMARY of your rights and our responsibilities under the Code of Federal Regulations (45 CFR Parts 160, 162, 164) regarding your medical information and its privacy. A full version of this Notice is available in our office, per your request. If you have any questions, please contact our Privacy Officer-Holly Vilorio at (949) 499-2265. This notification was last updated on June 1, 2024 and will remain in effect until replaced.*

**Who:** All clinicians and staff at Laguna Family Health Center are committed to the privacy of medical information of our clients and are required by law to maintain the privacy and security of your protected health information.

**Protected Health Information (PHI):** refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health/condition, the provision of health care to you, or payments.

**How We May Use and Disclose Your Protected Health Information:** In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HIPAA Privacy Rule, HIPAA Security Rule, HIPAA Enforcement Rule and subsequent updates, we may use and share your information as we: Treat you; Run our organization; Bill for your services; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests; Work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions (with some exceptions and also provider-patient privilege declarations when applicable). We will not use or share your information other than as described or allowed under HIPAA provisions to other individuals/entities that are not permitted unless in writing via a signed Authorization to Release Information form, which you can also revoke.

**2013 Omnibus HIPAA Final Rule & 21st Century CURES Act amendments:** New privacy standards were adopted in 2013 and 2016 to further clarify and protect patients' health information/confidentiality when it is disclosed but also to facilitate the flow of medical information between providers with special attention to: Permission is no longer required for transfer of psychiatric and medical information between providers as long as only the necessary information is supplied. Collaboration of care agreements signed in the office can help to better specify this. Psychotherapy notes are not authorized to be released without patient consent and even if consent is obtained, our office often prefers to complete a treatment summary instead to protect your privacy and also better facilitate care. We may have to disclose some information when required to do so by law without your consent. This includes mandated reporting of child/elder/ dependent abuse, national security and public health issues and cases of legal/court order or subpoena (with some exceptions based on provider-patient privilege-see confidentiality in Office Policies).

**2020 CARES Act & Confidentiality of Substance Use Disorder (SUD) Records:** The U.S. Department of Health and Human Services' Office for Civil Rights and Substance Abuse and Mental Health Services Administration have finalized rules to better align Confidentiality of Substance Use Disorder (SUD) Patient Records Part 2 Regulations with certain requirements of the HIPAA and HITECH Acts. This also allows for a program to use and disclose SUD records based on a single prior consent signed by the patient for all future uses and disclosures for treatment, payment and healthcare operations.

**2024 HIPAA Privacy Rule to Reproductive Health Care Privacy:** The Final Rule strengthens privacy protections by prohibiting the use or disclosure of protected health information (PHI) by a covered health care provider, health plan, or health care clearinghouse or their business associate for either of the following activities: 1) To conduct a criminal, civil, or admin investigation into or impose criminal, civil, or admin liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided. -or- 2) The identification of any person for the purpose of conducting such investigation or imposing such liability. The prohibition applies where a covered entity has reasonably determined that one or more of the conditions exists: The reproductive health care is lawful under the law of the state in which care is provided under the circumstances in which it is provided. Reproductive health care is protected, required, or authorized by Federal law, including the U.S. Constitution, regardless of the state in which care is provided.

**Patient Rights Regarding Your PHI & Psychiatric Records:** You have the right to: Get a copy of your paper or electronic medical record. Correct your medical record. Request confidential communication. Ask us to limit the information we share. Get a list of those with whom we've shared your information. Get a copy of this privacy notice. Choose someone to act for you. File a complaint if you believe your privacy rights have been violated.

**Preventing Harm Exception:** It is not information blocking for an entity to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met. In cases where exposure to the record might be harmful to the patient, the clinician may deny the request. If you request a copy of your psychiatric record be sent to you, we will generally require that we review the record with you. If you request a copy of your records to be sent to a forwarding provider then we will generally not require you to meet and review the chart. Exceptions to the access of your records are also detailed in our Policies.

**Changes to the Notice:** We reserve the right to change this Notice and will post a dated copy of it in the office.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Office or with the Department of Health and Human Services. You will not be penalized for filing a complaint.

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*I hereby acknowledge that I have reviewed this summary of Notice of Privacy Practices, have been given access to a full copy of the entire HIPAA policy if requested, acknowledge that a copy of the most current notice will be available in the reception area and on the website and that a copy of any amended Notice of Privacy Practices will be available at each appointment.*

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*Patient / Guardian Signature*

*Date*

### **NOTICE TO CLIENTS (updated 7/1/25)**

This is to notify you that the below practitioners at Laguna Family Health Center are all fully licensed. Clinical Social Workers are licensed and regulated by the Board of Behavioral Sciences (BBS). The BBS receives and responds to complaints regarding services provided within the scope of practice of clinical social workers. You may contact the board to check a license or file a complaint at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830. Nurse Practitioners are licensed and regulated by the Board of Registered Nursing (BRN). The BRN receives and responds to complaints regarding services provided within the scope of practice of nurse practitioners. You may contact the board to check a license or file a complaint at [www.rn.ca.gov](http://www.rn.ca.gov), or by calling (916) 322-3350.

Etana Gabrielle Kempner-Licensed Clinical Social Worker-License #:LCS27177-Expiration: 12/31/26

Dara Lauren Cortes-Licensed Clinical Social Worker-License #:LCS27426-Expiration: 5/31/26

Aimie Louise Woods-Licensed Clinical Social Worker-License #:LCS29102-Expiration: 12/31/25

Holly Marie Vilorio-Nurse Practitioner-License #:14715-Expiration: 12/31/26

Robert Anthony Cadena-Nurse Practitioner-License #:95015427-Expiration: 11/30/27

*In signing below, I attest that I have been provided this notice in accord with applicable Board of Behavioral Sciences (BBS) and Board of Registered Nurse (BRN) requirements. I understand that I can ask the administration and my clinician for further information as well.*

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*Patient / Guardian Signature*

*Date*

## **LAGUNA FAMILY HEALTH CENTER-TELEHEALTH PATIENT CONSENT FORM**

In order to receive telehealth services from Laguna Family Health Center, you must be a California State Resident and/or be currently present in California during the time of your telemedicine appointment. Exceptions are made for this based on a case by case basis for clinical emergencies and for continuity and/or transfer of care. Telepsychiatry / Teletherapy is the delivery of psychiatric & psychological/counseling services using interactive audio and visual electronic systems between a provider and a patient/client that are not in the same physical location. These services may include consultation, treatment, assessment, diagnosis, electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, emails, telephone conversations and distribution of patient education materials.

### **I understand the following rights, risks and responsibilities with respect to telehealth services:**

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, I understand that the information disclosed by me during the course of my treatment is confidential. However, there are both mandatory and permissive exceptions to confidentiality, as outlined in the general intake packet.
3. I understand that there are risks and consequences from telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures and the transmission of my information could be interrupted by unauthorized persons.. Laguna Family Health Center utilizes software that meets the standards to protect the privacy and security of the sessions and is HIPAA compliant.
4. I understand that there could be some technical problems (video quality, internet connection) that may affect the telehealth session and could affect the decision making capability of the provider.
5. I understand that telehealth based services and care may not be as complete as face-to- face services. If my provider believes I would be better served by another form of services (e.g. face-to- face services), I will be referred to a provider who can provide such services in my area and/or be requested to come into the office. The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
6. I understand that there are potential risks and benefits associated with any form of psychiatry or psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse. I may benefit from telehealth services, but that results cannot be guaranteed or assured.
7. I understand that I have a right to access my medical information and copies of my records in accordance with California Law.
8. I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
9. I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
10. I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer/phone that is used for telepsych. I understand that it is my responsibility to ensure the proper functioning of all equipment before my session.

**I hereby consent to engaging in telehealth services with LAGUNA FAMILY HEALTH CENTER as part of my psychiatric/psychotherapy evaluation and treatment. I have read and understand the information provided above regarding telepsychiatry / teletherapy and understand my rights, responsibilities, and risks.**

*Patient / Guardian Signature*

*Date*

## Provider Fees & Good Faith Estimate Policy

Please review this document in its entirety and let the office know if you have any concerns or questions. The fees listed below are the fees for cash pay/out of network services. These are the fees that are due if your provider is NOT in-network with your insurance and when our office is not submitting claims for you or if you are currently on one of our office limited sliding scale agreements. These rates are also the rates for late cancel or no show less than 24 business hours per our office signed policy as these are not covered by insurance.

### Provider Fees (Effective 10/1/24)

#### Holly Vioria, NP-Family & Psychiatric Nurse Practitioner / Practice Owner

90 min Initial Psychiatric Appointment/Consult-\$450      20-30 min Follow-up-Meds and/or Brief Therapy-\$225  
45 min Follow-up-Meds and/or Brief Therapy-\$295      60 min Follow-up-Meds and/or Brief Therapy-\$350

#### Robert Cadena, NP-Psychiatric Nurse Practitioner

90 min Initial Psychiatric Appointment/Consult-\$375      20-30 min Follow-up-Meds and/or Brief Therapy-\$195  
45 min Follow-up-Meds and/or Brief Therapy-\$250      60 min Follow-up-Meds and/or Brief Therapy-\$325

#### All LCSW-Licensed Clinical Social Workers-Etana Kempner, Dara Cortes, Aimie Woods

60 min Initial Psychotherapy Appointment-\$225      50-60 min Individual Psychotherapy Follow-up-\$195  
50-60 min Family/Couples Psychotherapy Follow-up-\$225

#### ALL PROVIDERS

Document Prep Fees-Forms/Letters/Reports-\$50 to \$295/varies  
After Hours Phone Call w/Patient, Parent or Family-\$50 to \$225/varies  
Additional Services-check with office

### Good Faith Estimate / No Surprises Act

Under Section 2799B-6 of the Public Health Service Act, mental health care providers are required to provide a “Good Faith Estimate”(GFE) if requested, to patients who don’t have insurance or who are not using insurance for their appointments. This document serves as an estimate of the expected charges for medical services, including psychotherapy for these patients. Under the law, health care providers need to give these patients an estimate of the expected charges for medical services, including psychotherapy services. A GFE must be provided to the patient within three business days of the appointment, upon request.

Please let our office know if you would like a GFE, otherwise please know that our office will always have our current fees posted and will communicate to you should there be any changes to your account, new billings, etc. Most clients do not need a GFE because of the small size and great communication from our office staff, but it is your right to receive one should you want. Our office has always operated under a no surprises policy per say anyways and it is also each client’s responsibility to understand his/her own medical and insurance benefits, which our office can help you navigate and translate as well.

A GFE does NOT include no-shows, late cancellations, or other services related to crisis care, which by definition are unexpected and cannot be predicted for the purpose of compiling a Good Faith Estimate in advance. A GFE may also include consultations with client collateral contacts, fees related to paperwork requests, and other legal and administrative fees related to client care, when such items are scheduled in advance. You can ask your healthcare provider/office, and any other provider you choose, for a Good Faith Estimate before you schedule a service. If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill. For questions or more information about your right to a Good Faith Estimate, visit: [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises), or call 1-800-985-3059.

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*Patient / Guardian Signature*

*Date*

## OFFICE POLICIES & PROCEDURES

**Mission Statement & Practice Values:** *Our mission is to provide the highest quality mental health care that promotes empowerment, enhances wellness and strengthens our community.* At Laguna Family Health Center, we treat the whole client and strive to provide integrative care that considers all aspects of the individual and provides the best chance at recovery and growth. LFHC was founded out of the desire to provide mental health services in a client-centered model that focuses on wellness and prevention as much as treatment.

**Confidentiality & Reporting:** While one of the clinician's primary duties is to protect the patient's privacy and confidentiality, this duty is not absolute or without exceptions. Communications are confidential and generally no information will be released without your consent, except for the following: clinicians are considered *mandatory reporters* for child abuse and dependent adult/elder abuse. In addition, we have a duty to warn individuals in the rare case where specific and direct threats to harm are made to others. Clinicians may also have charts subpoenaed in legal cases however records may be subject to patient-therapist privilege and confidentiality is our utmost priority.

**Medical Records:** Both law and professional standards require that we keep appropriate treatment records. You are entitled to a copy of your records, unless the clinician believes seeing them would bring psychological harm, in which case, we can forward them to an appropriate mental health professional. We can also prepare a clinical summary for review. Clinicians may have charts subpoenaed in legal cases however records are usually subject to patient-therapist privilege and will only be released with your consent or court order. You must make your request in writing. *There is a fee for these copies.*

**Changes in Address/Phone or Insurance:** *Please notify us as soon as possible if you have any changes to your home or billing address, phone numbers and insurance coverage.* If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. California insurance laws require claims to be filed no later than 90 days after the date of service and for some, the timeframe is 30 days.

**Emergencies:** In the event of a psychiatric emergency, such as acute thoughts of harming oneself or others, a medically dangerous reaction to a medication, please call 911 or go to your local emergency room. For urgent matters, please call the office or if after hours, the emergency number listed on our office voicemail.

**Telephone Calls & Emails:** We must screen all calls to the clinicians during office hours while they are seeing patients. Calls deemed "non emergent" will be handled by the staff in the order received. If it is necessary to leave a message for the clinicians directly, *calls will be returned within 24-48 hours by either the clinician or staff, as appropriate.* Most of our clinicians have preference for email if it is a question or concern on a specific issue that falls beyond the role of the office staff to address. *Emails will be answered by clinicians directly and are confidential, but please keep in mind the limits of technology security.*

**Prescription Refills:** *Prescription refill requests will be handled within 24-48 hours of receipt during regular business office hours.* Prescription refills will not be handled after regular office hours or on the weekend. Please have your pharmacy send electronic refill requests to our office when possible, rather than calling and requesting refills. *Our clinicians reserve the right to deny refills or reduce quantity/doses.* Patient refills may also be denied if patients have not returned for follow-ups within the time frame agreed at the previous appt and thus a follow-up appt must be made before refills are authorized. *Furthermore, if accounts are past due and payments are not received or a payment plan initiated, clinicians' refills will not be granted.*

**Referrals/Authorizations:** *If your insurance requires a referral or preauthorization, you are responsible for obtaining it.* Failure to do so may result in payment denials from your insurance. If our clinicians refer you to another specialist, recommendations are based on their experience with the specialist but the specialist may/may not be an in-network provider with your insurance. You will need to contact the office or your insurance to determine if provider is covered.

**Children & Pets:** Children are very special to all of us and we are always happy to see them but for their safety and the courtesy of other patients we must ask that you keep your children with you at ALL times while in our office. Pets are not allowed in the office building except animals that are registered therapy/emotional support animals or when requested to office staff.

**Psychotherapy:** Psychotherapy may have benefits such as significant reduction in distress, improved social relationships, resolution of specific problems, and clearer understanding of yourself, your values, and your goals. *For therapy to be most successful, you will have to be able to talk openly and honestly, address any difficulties that arise, and put forth active effort outside our sessions.* Our therapists have expertise in several areas of therapy and will collaborate with clients to create individualized plans. Some therapy is brief and some requires a longer duration to address symptoms and treatment goals.

**Pharmacology/Medications:** Medications are often used as adjuncts to psychotherapy. If you are seeing clinicians at Laguna Family Health Center for medication management, we will work together to find the optimal combination of medication (if needed) and therapy that help to fulfill your personal goals. If a medication is indicated, we will discuss with you the reason for the medication, the likelihood of improving with and without medication, and any reasonable alternative treatments. As many conditions have an underlying biological basis, medications can be an important component of treating certain conditions. Medications are usually recommended in conjunction with therapy, with a focus on prescribing only when needed, and *customizing a pharmacological plan* specific to the unique needs and symptoms of the individual.

**Laboratory Tests & Procedures:** As part of your treatment plan, our NPs may recommend certain labs/blood work to be ordered to assist in diagnosis and rule out medical causes to symptoms. Many of our NPs are all dual-licensed in both primary care and psychiatry due to our practice focus on comprehensive care. Certain medications also require routine and periodic blood work. Please make sure to discuss any physical symptoms and past medical history that may be important in your current situation. *If labs are ordered, it is your responsibility to make sure that lab services are an included benefit in your insurance.*

**Cell Phones & Smoking/Vaping:** Please refrain from talking on your cell phone and smoking/vaping while in the office or waiting area. This is distracting to others around and also to the environment that we hope to create at our office. Please be mindful that there are several businesses within this building and thus respect their need for a quiet and healthy environment.

**Legal Testimony:** It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony can often be damaging to the relationship between a patient and clinician. Because of this, we require that you employ independent forensic services should this type of evaluation be required. *If for any reason, we are subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees, which our office can provide upon request.*

**Medicare Opt-Out Agreement:** Laguna Family Health Center, Inc. & affiliated clinicians do NOT participate in Medicare. By law, Medicare-eligible patients are required to enter into a private contract with Laguna Family Health Center and we deliver medical care on a fee-for-service basis, which is not reimbursable by Medicare. By accepting the treatment contract with Laguna Family Health Center you agree that you shall not submit a claim for payment under Medicare for services at our office.

**Insurance Policies:** You are responsible for any amount that is not covered through insurance and charges rendered at times when your insurance is inactive. *It is the responsibility of the patient to check your benefits and coverage before your visit(s)*, although our office will assist patients in navigating benefits. If we are contracted with your insurance (in-network provider), we must follow our contract and their requirements. We will bill your insurance and after claims are received, the patient and office will receive an Explanation of Benefits (EOB) that reviews the charges and coverage. Due to the complexity and requirements of coding, you may see charges on your EOB for services or additional costs (ie. after hours, consults, etc) but this varies. Please note as well that if you are choosing to use insurance for your visits, *the insurance carrier may request information such as diagnosis and copies of progress notes*. Many clients chose to not use their insurance for because of this element. Please notify our office if you have any questions.

**Patient-Provider Arbitration Agreement:** Lawsuits are something that no one anticipates and everyone hopes to avoid. The method of resolving disputes by arbitration is one of the fairest systems for both patients and clinicians. By signing this office policy contract, you are agreeing that all disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement with both parties. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Orange County, CA, in accordance with the rules of the American Arbitration Assoc. which is in effect at the time the demand for arbitration was filed. This agreement helps to limit the legal costs for both parties. Our goal of course is to provide care in such a way to avoid any such disputes. Most problems begin with communication and thus *if you have any questions or concerns about your care, please discuss with our office/clinician*.

**Grievance Policy:** Communication is an essential element of your healthcare and interpersonal relationships. If at any time you have concerns, please discuss with either your therapist/NP and/or our office manager. If resolve has still not been achieved, you have the right to request a meeting with the owner to discuss your concerns.

**This is an agreement between Laguna Family Health Center and the Patient/Client named on this form. By signing this agreement, you acknowledge that you have read and agree to the above office policies and procedures and are consenting to treatment.**

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*Patient / Guardian Signature*

*Date*