Sarah K Bunter, LMFT 99202

100 E. Thousand Oaks Blvd. Suite 231

Thousand Oaks, CA 91360

CONSENT FOR TREATMENT

I, _____, authorize and request Sarah K Bunter, LMFT, a California Licensed Marriage and Family Therapist to provide psychological examinations, treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and me.

I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement.

I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Signature:_____ Date: _____

(Client or Parent/Guardian)

Signature:_____ Date: _____

(Client or Parent/Guardian)

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TELEHEALTH CONSENT FORM

I,_____, hereby consent to engage in Telehealth with Sarah K Bunter, LMFT, a California Licensed Marriage and Family Therapist.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Consent for Treatment Form I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, I will be referred to other therapists who can provide such services.

6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

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8. For patients not using insurance, I have discussed the fees charged for Telehealth with my therapist and agree to them. For patients using insurance, I have discussed with my therapist and agree that my therapist will bill my insurance plan and, if there is a co-pay, I will be charged for it. I have been provided with this information in the Office Policies Form.

9. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Signature:_____ Date: _____

(Client <u>or</u> Parent/Guardian)

Signature:_____ Date: _____

(Client <u>or</u> Parent/Guardian)

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Please Present Insurance Card for Photocopying Today's Date: _____

Client's Name: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Current Problem: _____

_____

_____

Have you had therapy or been treated for emotional/psychological problems before?

_____

_____

_____

Describe any **Current Medical** or **Health** problem(s): _____

_____

_____

Are you currently taking any medications? ☐ **Y** or ☐ **N**

Medication Name	Dosage	Frequency	Length of Time

Current use of Cigarettes, Alcohol, and/or Drugs: _____

Authorization to Pay

I/We _____ do hereby authorize _____ to pay directly to Sarah K Bunter, LMFT medical benefits otherwise payable to me for mental health services. I understand that I am financially responsible for charges not paid by my insurance company.

Signed: _____ Date: _____

Release of Medical Information

I/We hereby authorize Sarah K Bunter, LMFT to release to my insurance company and/or EAP any information acquired in the course of my treatment.

Signed: _____ Date: _____

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OFFICE POLICIES

Payment: Co-payment or full payment for service is due at the end of each session unless other prior arrangements have been made. Please notify me if any problem arises during the course of therapy regarding your ability to pay for services and/or copayments.

Insurance: If an insurance company is paying for part or all of your session, I will bill your insurance company for services. Please notify me if you change insurance companies or no longer have insurance coverage. If you continue seeing me while uninsured or insured with a company for which I am not currently a provider, you will be responsible for a fee of $150 per session. At intake, please have your insurance card ready for copying.

Confidentiality: All information disclosed in sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law.

Legal and Court-related: I do not voluntarily engage in legal processes concerning my current patients or patients that I might start with in the future. I do my best to focus on the clinical issues and growth rather than legal issues that can cloud the clinical process. Examples of legal processes that I do not voluntarily engage with include child custody arrangements, testimonies that require a court appearance, court appearances in general, and any legal precedings involving divorce that require a court appearance or court documents.

Appointment Reminders: I send out a text reminder of your appointment the day before the session. If you would not like to receive text reminders from me, please mark the box below. If you would like to receive email reminders instead of text reminders, please mark that box and list the email address you would like used in the space below.

- ❑ **I do not wish to have appointment reminders texted to me.**
- ❑ **I want appointment reminders emailed to me here:** _____

Cancellation: If you do not call or text at least 24 hours in advance of any appointment you miss, you will be charged for that appointment.

Notice to Clients: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists. You may contact the Board online at www.bbs.ca.gov or by calling (916) 574-7830.

Name: _____

Signed: _____ Date: _____