Victoria Brown, LMFT
Tru Wave Psychology
Child, Adolescent, and Adult Psychological Services
15 Corporate Plaza, Suite 220
Newport Beach, CA 92660
Phone (714)730-0838

Consent to Treatment and Financial Agreement

Name of Patient:_____
Age/Date Of Birth:_____
Name of Parent/Guardian if Pt Under 18:_____
Email for Patient vs Parent/Guardian if Pt Under 18:_____
Telephone:_____
Address:_____

In applying for services with GUTS, Inc. (GUTS), I understand that I may be administered diagnostic and treatment procedures as may be determined by GUTS and as approved by myself, the parent or guardian.
Medical and other records may be maintained by GUTS for assessment and treatment. These records are confidential and are for the use of GUTS only.

I have read and understand the statements regarding HIPAA and patient's rights.

GUTS will attempt to safeguard the patients in their care but he will not be responsible for any accidental injuries and assumes no liability for injuries occurring without any fault or negligence.

GUTS accepts a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of GUTS he or she is not able to benefit, withdrawal will be recommended and other plans discussed.

I understand that while GUTS provides email for patients to contact them for the purposes of scheduling appointments and general communication; however, in signing the consent, you are acknowledging that email sent over the Internet is not secure and should not be used to communicate very confidential and/or health information directly. It may be accessed and viewed by other users without your knowledge while in transit and thus, its confidentiality cannot be guaranteed. If an email is sent from a patient with sensitive patient information, the patient will bear sole responsibility for any privacy related outcome of this communication, whether intended or not.

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I understand that while GUTS will provide information required to obtain insurance company reimbursement, they will not bill insurance companies directly, nor will they negotiate a settlement on disputed charges. I understand that I am fully and personally responsible for payment of GUTS' charges at time of services rendered. Failure to comply with this policy may result in postponement or cancellation of future visits. Furthermore, if the amount due is not paid in full, I agree to bear all collection costs, court costs and legal fees.

I understand that because of the highly specialized nature of their practice, GUTS does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, workers compensation cases or victims witness cases. GUTS is not a Medicare provider.

I understand that GUTS requests PAYMENT AT TIME OF VISIT BY CASH/CHECK/CREDIT CARD.

I understand that IF FOR ANY REASON AN APPOINTMENT NEEDS TO BE CHANGED OR CANCELLED BY THE PATIENT, 48
HOURS NOTIFICATION BY TELEPHONE OR EMAIL WILL BE GIVEN TO GUTS. Failure to properly notify will result in charges at the usual rate for that appointment. Exceptions will be made for legitimate emergencies as per our discretion. I am in complete agreement that remembering upcoming appointments as set forth by GUTS is my sole responsibility, and that GUTS is not obligated to send reminder emails/phone calls prior to upcoming appointments as reminders. If you miss a scheduled appointment, you will be charged the full fee for the scheduled visit.
I understand that GUTS may charge for telephone consultations and for all other uses of their time on my behalf, at the rate Licensed associate $175/45 min, $200 an hour (includes MCN and/or other Neuro technology), Victoria Brown $190/45 min $260 an hour. MCN charges $145/individual. Other licensed MFT/PSY $205/45min $225/60min.
I have read and understand the above mentioned policies and guidelines and will abide by ALL OF THESE POLICIES for services.
Date _____
Signature of Patient/Parent/Guardian _____

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Acknowledgment of Receipt of HIPAA Document

I, _____, have received a copy of the Notice of Privacy Practices.
(Name of patient or guardian)

_____	_____	_____
(Signature of patient or guardian)	(Relationship to patient)	(Date)

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I am granting permission for GUTS to bill my credit for visits. I am also aware that my credit card will be charged for sessions in the event of non-attendance of an appointment not canceled within 48 business hours of the appointment, or in the event of non-payment of a past due balance, or bill arising from professional services or obligation arising from care of the below mentioned patient.

I agree not to dispute charges for the reasons stated above. I further authorize GUTS to disclose information regarding my attendance/cancellation to my credit card company if I dispute a charge for these reasons.

Name of Patient: _____

Name on Credit Card: _____

Card Number: _____

Expiration Date: _____

CVV Number (3 or 4 digits): _____

Billing Zip Code:_____

Signature: _____

Date: _____

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New HIPAA Rules:

New HIPAA (health insurance portability and accountability act) privacy standards were created to protect patients' health information when it is disclosed but also to facilitate the flow of medical information between providers. With other medical providers and for safety or security reasons, there is less protection of confidentiality than there used to be. However, in other areas, there is more privacy protection. Please read the following so that you understand your rights as a patient as well of the new rules about patient confidentiality. Feel free to ask about privacy, confidentiality, or psychiatric records.

1. Permission from the patient is no longer required for transfer of medical information between providers as long as only the necessary information is supplied. This means that if your primary care doctor, pharmacist, or an emergency room physician calls to find out if you (or your child) are in treatment, what the diagnosis is, or what medications you (or your child) are on, we can convey this information if it is medically relevant to your (or your child's) treatment with them. In practice, we will almost always discuss this with you personally before or after the fact, depending on the urgency and depth of the request. If you think this might present a problem for you let us know ahead of time.
2. Remember that if all the records are requested, a treatment summary is usually given instead, exceptif the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, psychotherapy visits are specifically excluded, meaning authorization from the patient is still required for release of information in those notes and a summary is given in place of the record.
3. The substance abuse records from alcohol and drug programs are exempt from any disclosure with outpatient permission. If you (or your child) are admitted to a treatment program for substance abuse be sure to sign a release so that we can

talk to the providers and obtain a discharge summary and lab data upon discharge. Without this we cannot obtain any information.

4. We may have to disclose some information when required to do so by law without your consent. This includes mandated reporting of child/elder abuse and cases of legal order or subpoena.
5. National security and public health issues. We may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.

Individual (Patient) Rights

1. All patients have the right to inspect and copy their own protected health information (medical record) on request, except for mental health records, which must be reviewed. 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 record, we will generally review the record with you. It is unlikely that there would be information in the chart that a patient should not or could not read, but much of the information in the chart may require explanation.
2. Patients also have the right to amend or append their medical record. Physicians have the right to deny such a request if it is believed that the information in the medical record is accurate, but in that case the patient request must still be attached to the medical record.
3. Patients have the right to an accounting of all disclosures to other parties. This means that if you ask for a list of whom we have released information to we will supply it to you.
4. Patients have the right to have reasonable requests for confidential communications accommodated.
5. You can give written authorization to disclose your information to anyone you choose, and you may revoke the authorization in writing at any time.
6. Patients can file a complaint with GUTS at the office of civil rights in the Department of Health and Human Services about any violation of the rights listed above. There will be no prejudice for filing such a complaint.
7. Patients have the right to receive a written notice of privacy practices from providers and health plans.

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Personal Information

Name: _____ Date: _____
Address: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____Phone: _____

Issue

What is your major issue? _____
Start Date: _____ Have you previously suffered from this issue? _____
Previous therapist(s) seen for issue: _____
Previous treatment for issue: _____
Aggravating factors: _____
Relieving factor: _____

Current Symptoms (check all that apply)

☐ Anxiety	☐ Appetite issues	☐ Avoidance	☐ Guilt
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Libido Changes
☐ Hallucination	☐ Impulsivity	☐ Irritability	☐ Risky Activity
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐
☐ Sleep Changes	☐ Suspiciousness	☐ Crying Spells	☐

Medical History

Exercise frequency: _____ Exercise Type(s): _____
Allergies: _____
Current Medication: _____
Dates treated: _____
Previous Medical Conditions: _____
Previous surgeries: _____
Signature: _____ Date: _____

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