Eastlake
COMMUNITY COUNSELING
2400 Fenton Street, Suite 205
Chula Vista, CA 91914

Welcome to **Eastlake Community Counseling** and thank you for entrusting me with your treatment. **Please take your time to carefully review the following 8 pages** – ***YOU MAY PRINT AND SIGN THEM NOW (AND BRING THEM TO YOUR FIRST SESSION) OR YOU WILL BE REQUIRED TO SIGN THESE FORMS AT THE BEGINNING OF YOUR FIRST SESSION.*** Reading and signing these forms constitutes your informed consent to treatment. The information on the next 8 pages will help you understand the therapeutic process as well as important office policies/procedures. Please keep a copy of this agreement for your records. If you would like a copy made for you, please ask and one will be provided. *If you ever have any questions about the nature of your treatment or anything else about your care, please feel free to ask.*

IF YOU HAVE AN EMERGENCY

Call 9-1-1 or go to your nearest emergency room. If you have a crisis and you need to speak with someone immediately, call 1-800-273-8255 and someone will assist you 24 hours a day. If you absolutely must speak with Jeff, please leave a message at 619-271-8886 and your call will be returned as quickly as possible. PLEASE NOTE your call may not be returned for up to 24 business hours. When Jeff is on vacation or out of the office for any reason, his outgoing voicemail (619-271-8886) will provide instructions on how to deal with urgent matters. **In case of crisis, emergency or urgent matters please call - DO NOT text or email.** Routine (non-emergency/non-urgent) messages will be responded to within **48 business hours**.

ABOUT JEFF PALITZ, LMFT

Jeff Palitz, MS, LMFT #41250 has been providing mental health services in San Diego County since 1999. He is a licensed marriage and family therapist (LMFT) who established Eastlake Community Counseling (ECC) with the hope of bringing mental health support to the diverse families of Eastlake and its surrounding areas. Jeff earned his B.S. in psychology from the University of California, San Diego and went on to complete his M.S. in counseling at San Diego State University. Jeff is experienced at working with teens, parents, couples and individuals with a variety of mental health diagnoses. He also completed all three levels of training for Gottman Method couples counseling and uses Cognitive Behavioral strategies to address most other issues in his practice. If you have any questions about Jeff's background, training or areas of expertise, please ask any time, or visit www.eastlakecounseling.com for a full bio.

WHAT IS PSYCHOTHERAPY AND HOW DOES IT HELP

People seek therapy or counseling for many reasons. Some need to respond to unexpected changes in their lives, while others seek self-exploration and personal growth. In addition, when coping skills are overwhelmed by guilt, doubt, anxiety, or despair, therapy can help. Seeking support when all other efforts have failed is a true sign of strength. Therapy can provide support, problem-solving skills, and enhanced coping for issues such as depression, anxiety, lack of confidence, relationship troubles, unresolved childhood issues, bereavement, stress management, body image issues, and creative blocks amongst other things. People who benefit from psychotherapy or counseling are willing to take responsibility for their actions without blaming others, ready to work towards self-determined change and looking to create greater awareness in their lives. Psychotherapy is a collaborative process through which therapist and client explore different perspectives on the client's life and experiences to help achieve their goals.

What to expect in a therapy session

During sessions you are expected to talk about the concerns and issues in your life. Therapy works best when you have specific goals you wish to accomplish and you and your therapist work together to develop a treatment plan to achieve your goals. **All sessions lasts 45 minutes**. Usually weekly sessions are best for at least the first four to six sessions. Some people who are in crisis or extreme distress need more than one session per week at first. Although the length of treatment can wary widely, most people can expect to spend between 6 to 12 sessions in treatment. During the time between sessions it is beneficial to think about and work on what was discussed. At times, suggestions may be given to take certain actions outside of the therapy sessions such as reading a relevant book or keeping records. ***For therapy to "work," you must be an active participant, both in and outside of the therapy sessions.***

What benefits can I expect from working with a therapist?

A number of benefits are possible when participating in therapy or counseling. Often it is helpful just to know that someone is there to listen and understand. Therapy can provide a fresh perspective on a difficult problem or help point you in the direction of a solution. Many people find therapy to be a tremendous asset in managing personal growth, interpersonal relationships, family concerns, and the challenges of daily life. The benefits you achieve from therapy/counseling can also depend on how actively you participate in the process and put into practice what you discover. Some of the potential benefits of therapy include:

- Attaining a better understanding of yourself and your personal goals and values
- Developing skills for improving your relationships
- Finding resolution to the issues or concerns that led you to seek therapy
- Finding new ways to cope with stress and anxiety
- Managing anger, depression, and other emotional pressures
- Improving communications skills - learn how to listen to others, and have others listen to you
- Getting "unstuck" from unhealthy behavior patterns - breaking old behaviors and develop new ones
- Discovering new ways to solve problems
- Improving your self-esteem and boosting self-confidence

Therapy sessions are 45 minutes long

To make the most of our time together, please arrive a few minutes early for your session. All sessions will begin and end on time unless I have a treatment issue that requires immediate attention.

"No Touch" Policy

Regardless of your age, gender or the type of counseling you are seeking, you have the right to feel safe both emotionally and physically in your counseling sessions. For this and other reasons, "touch" between you and Jeff Palitz, LMFT will be limited to **hand-shakes only**. It is normal to have feelings of warmth and/or closeness with your therapist, but as a matter of policy, Jeff Palitz, MFT does not hug patients or touch them in any way other than hand-shakes. If you have questions about this policy, please don't hesitate to ask. Professional therapy **never** includes sex.

Note-Taking/Recording of Sessions

To increase the effectiveness of your treatment, I will be taking notes. These notes document the issues we are addressing which meet the "medical criteria" as required by your insurance company to ensure their ongoing support of your treatment. If you desire, you may also take notes, however, ***you may not record your sessions. Audio and/or video recording of your session is strictly prohibited without exception.***

To schedule, change or cancel an appointment

Whenever possible, please use the **24-hour, secure online scheduler** at www.eastlakecounseling.com. This service is available to view, schedule, change or cancel appointments 24 hours a day, 7 days a week. If there are fewer than 48 hours prior to your appointment, you must call or email me to change or cancel. If would prefer to schedule/cancel sessions over the phone or in person, please feel free, but your wait-time may increase.

Consistency of treatment

When scheduling an appointment, you will have the option of scheduling multiple appointments in advance. Weekly sessions are generally recommended for the first 4 to 6 visits but may be necessary for longer. If you have any specific scheduling needs, it is **strongly** recommended that you do this to avoid lapses in treatment and to ensure convenient appointment times. **Appointments before 10 a.m. and after 2 p.m. tend to fill up 4 to 8 weeks in advance.**

Consultation

To provide you with the best care possible, Jeff Palitz, LMFT will periodically meet with other licensed mental health providers to discuss his cases. If your case is discussed, every effort will be made to keep identifying information confidential.

Appointment Reminders

If you have provided a valid email address, you will receive email reminders to help you remember to keep your scheduled appointments. If you entered a valid cell phone number, you will also receive a text message reminder. If you do not wish to receive these reminders, you must log in to your account and turn off this feature or you may request that Jeff Palitz, LMFT disable this feature. If you have not provided a valid email address or cell phone **you will not receive an appointment reminder**. Reminder messages are a courtesy only – it is your responsibility to keep track of all appointments. **Even if you do not receive a reminder, you are still responsible for all late cancelation/no show fees.**

$60 Charge for Late Cancelled/Missed Appointments

If you cancel your appointment less than ***24 hours*** prior to your appointment time, you will be assessed a **$60 fee for which you are solely responsible.** If you arrive to your appointment **more than 15 minutes late**, your appointment will be considered missed (insurance cannot be billed for partial appointments). You will be assessed a **$60 fee for all missed appointments. Two consecutive missed appointments without contact be client or client's representative will result in all future sessions being cancelled. Appointments can be cancelled by leaving a voicemail at 619-271-8886 24 hours a day, 7 days a week.** All messages will be time and date-stamped.

BY INITIALING AT THE END OF THIS LINE, I ACKNOWLEDGE THAT IN THE EVENT OF A "NO SHOW" OR FAILURE TO GIVE 24-HOUR NOTICE PRIOR TO A CANCELLATION, **A $60 CHARGE WILL ASSESSED TO MY ACCOUNT. THIS CHARGE IS SOLELY MY RESPONSIBILITY AND WILL NOT BE PAID BY MY INSURANCE.**

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PATIENT'S INITIALS

Fees, Co-pays and deductibles

All fees, co-pays and deductibles must be paid before each session begins. **If client does not pay any balance due (including deductibles, co-payments, late cancellation and missed appointment fees), client will be billed after a 30-day grace period. Jeff Palitz, LMFT may, at his discretion, temporarily suspend client's treatment until arrangements are made to pay outstanding balances.** If clients do not have insurance, the fee for a 45-minute session will be $130 unless a written fee reduction agreement has been reached with Jeff Palitz, LMFT.

For Couples: No Secrets Policy

When working with **couples** it is essential for the effectiveness of treatment that you know I do not keep secrets between partners in couples. Should I happen to speak with either party individually the content of those conversations **will not be kept secret from the partner/spouse.** ***The only exception is if there is an immediate or ongoing safety issue.***

E-Mail Communication/Appointment Reminders

I consent to receive e-mail communication/appointment reminders from Jeff Palitz, LMFT at this email address:

Your email address: _____

I also acknowledge that although Jeff Palitz, LMFT has no reason to believe that my email communications will be read by any third party, communication via e-mail is, by nature, impossible to completely secure and it is possible that my information may be accessed by a third-party without the knowledge of Jeff Palitz, LMFT. I also understand that email communication is intended for practical matters such as appointment cancellations and changes. If I choose to include clinical information (any information I would not wish for a third party to view) in my email communication, Jeff Palitz, LMFT **will not be held liable for breach of confidentiality should these messages be viewed**. Should I choose to send an email containing personal/clinical information, I give Jeff Palitz, MFT permission to respond by referencing the information I have included. Furthermore, I understand that should I desire to change my e-mail address or rescind permission to communicate via email, I must notify Jeff Palitz, LMFT in writing.

Text Message Appointment Reminders

I consent to receive text message appointment reminders from Jeff Palitz, LMFT at this phone number:

Your cell phone number: _____

I understand that these messages come from a **no-reply** text message phone number and that I cannot reply to them. **Jeff Palitz, LMFT does not accept text message communication from clients for any reason, and any text messages I send will not be received nor will they be replied to.**

Social Networks/Dual Relationships

As a matter of policy, Jeff Palitz, LMFT will not accept friend requests or any other request to be added to any social network (including, but not limited to, Facebook, Twitter, Instagram, LinkedIn and Google+). In addition, Jeff Palitz, LMFT does not engage in friendships and/or business relationships with clients outside of their treatment, even after treatment has terminated.

Confidentiality and Mandated Reporting

All information exchanged between patient and therapist is strictly confidential. I will not release any information about your therapy unless such release is **permitted or required** by law. Examples include:

1. It is agreed upon **in writing** and complies with State Laws
2. The patient presents an imminent danger to himself or herself or to others
3. There is any reason to suspect the abuse or neglect of a child or a dependent elderly person
4. As necessary for continuity of care
5. If a judge determines that our discussions are not confidential, the judge may order that specific information be released
6. As requested by a court appointed attorney for a child involved in court proceedings.

7. If you are bringing in your child for treatment, it is up to the therapist to determine the level of confidentiality he or she will require. As a general rule, children ages 12 and up will retain confidentiality from their parents, prohibiting the therapist from discussing the content of sessions with parents. (Except in the cases of numbers 2 and 3).

In the cases of numbers 2 and 3, Jeff Palitz, LMFT is **mandated by law** to inform potential victims and legal authorities so that protective measures can be taken. **If you participate in couples counseling as part of your treatment, please be advised that no information will be released without the *written consent of both parties*.** As a standard, I will follow the "minimum necessary" rule for information being released.

General Consent To Treatment

By signing below, I authorize and request that Jeff Palitz, LMFT carry out psychological examinations, treatment and/or diagnostic procedures that now, or during my care as patient, are advisable. I also understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement.

I also understand that while the course of therapy is designed to be helpful, it may be difficult and uncomfortable, and may ultimately result in an increase in negative feelings and/or deterioration in functioning. Jeff Palitz, LMFT makes no guarantees regarding treatment progress or positive treatment outcomes.

I understand that while therapy can be helpful, it is not the only available method for addressing my treatment goals. Other methods include (but are not limited to) psychiatric treatment, spiritual/religious consultation and/or other psychotherapy modalities that differ from those employed by Jeff Palitz, LMFT. If I wish to explore other treatment options, I may, at any time, ask/inform Jeff Palitz, LMFT of my desire to do so and he will assist me as his expertise allows. I also understand that participation is psychotherapy is 100% voluntary and may be terminated at any time by the client.

For couples, we acknowledge that although therapy is intended to improve marital functioning and help keep marriages/relationships intact, during couples counseling marital/relationship functioning may worsen and it may even result in a couple deciding to divorce or otherwise end their relationship.

Further, **if I am consenting on behalf of a minor child, dependent or beneficiary**, I hereby authorize Jeff Palitz, LMFT to deliver mental health services to the minor patient. I understand that all policies stated in this packet apply to the patient(s). **I further accept that although my participation may be required as part of the patient's treatment, the patient's records are confidential, and by law I cannot access these records without the minor's consent and/or if Jeff Palitz, LMFT believes such access would be detrimental to the minor patient.**

Financial Terms

Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be electronically billed for me and my provider will be paid directly by the carrier. I will be responsible for any applicable deductibles and co-payments at the time of service, prior to the session beginning. **I agree to make payments at the beginning of each appointment. I understand that if I am not eligible at the time that services are rendered, I am solely responsible for payment, even if this determination is made after services are rendered.** If I do not have insurance, unless a fee reduction has been agreed upon in writing, I agree to pay the full $130 fee for each 45-minute therapy session.

Appeals and Grievances

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is denied certification. I understand that I would request an appeal through Jeff Palitz, LMFT and that I risk nothing in exercising this right. **I also acknowledge that I may submit a grievance to Jeff Palitz, LMFT at any time to register a complaint about any aspect of my care.** If I am not satisfied with the response I receive, I may submit grievance to my insurance directly or to the California Board of Behavioral Sciences at 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 or at 916-574-7830.

Health Insurance Billing/Payment Authorization

I authorize Jeff Palitz, LMFT to release any medical or other information necessary to process insurance claims for services rendered as part of my treatment. I understand that in order to establish and maintain the medical necessity of my treatment, this information will include a multi-axial diagnosis in accordance with DSM-V criteria and that I have a right to know what my diagnosis is at any time (unless Jeff Palitz, LMFT believes that it would be detrimental to me to know this information, in which case he may choose to withhold it). I also request payment of government benefits either to myself or to the party who accepts assignment of these benefits. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered as part of my treatment with Jeff Palitz, LMFT.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that **Eastlake Community Counseling** (ECC) and Jeff Palitz, LMFT have either provided me with a copy of the **ECC Notice of Privacy Practices** or that I will review/obtain my own copy at www.eastlakecounseling.com as required by the Health Insurance Portability and Accountability Act (HIPAA).

If you have questions

If you ever have any questions of any kind regarding your treatment or any issues related to your treatment, please feel free to ask me at any time. You may contact me via telephone or email at your convenience. All messages will be returned as soon as possible. Always remember that I am here to support you in every way I can.

By signing below, I acknowledge that I have read, understood and agreed to all of the aforementioned treatment guidelines, policies and procedures (pages 1 through 6). I am also aware that **Eastlake Community Counseling is a professional corporation owned and operated by Jeff Palitz, MFT, Inc.**

_____ _____ _____

#1: Patient/Legal Representative Signature | Date | **Provider Signature**

_____ _____

Please Print Name | Relationship to Client

_____

_____ _____

#2: Second Adult Patient Signature | Date

_____ _____

Please Print Name | Relationship to Client

A Message to My Clients About Arbitration

Please Read Before Continuing to the Next Page

The attached contract is an arbitration agreement. By signing this agreement, we are both agreeing that any dispute arising out of the services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates, and everyone hopes to avoid. I believe that the method of resolving disputes by arbitration is one of the fairest systems for both clients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the **place** where your claim will be presented. **You are not forfeiting your right to file a claim should you feel the need arises.** You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for **both** patients and providers. Further, both parties are spared some of the rigors of a trial and the publicity that may accompany judicial proceedings.

My goal is always to provide mental health services in such a way as to avoid any such disputes. Still, I know that most problems begin with miscommunication. **If you have any questions or concerns at any time about your care, please speak to me immediately.**

Please sign/initial the highlighted areas on the next page. A copy of this agreement will be provided to you upon your request.

THERAPIST-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical/mental health services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the therapist, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the therapist within 30 days, or signature. It is the intent of this agreement to apply to all medical/mental health services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical/mental health services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU WISH TO HAVE A COPY OF THIS CONTRACT, YOU MUST REQUEST ONE. PLEASE NOTIFY YOUR PROVIDER AND A SIGNED COPY WILL BE PROVIDED.

By: _____ _____
Therapist's Signature (Date)

By: Jeff Palitz, LMFT , President, JEFF PALITZ, MFT, Inc.
Printed Name of Provider

By: _____ _____
Second Adult Patient's Signature (Date)

By: _____ _____
Primary Patient's or Representative's Signature (Date)

By: _____
Print Patient's Name

_____
If Representative, Print Your Name and Relationship to Patient