

Lisa Graff-Marsh LCSW (Lic. #LCS 16077)

4985 Park Rim Drive San Diego, CA 92117 858-272-9812

PATIENT INFORMED CONSENT

Please supply the information requested below for
record-keeping and billing purposes.
It is kept confidential except as indicated on the second page.

PATIENT INFORMATION

Date: _____

First Name: _____ Initial: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

eMail: _____

Age: _____ Date of Birth: _____ Sex: M F Soc. Sec.#: _____

Marital Status: S M W D

Employer: _____ Position: _____

Business Phone: (____) _____

If the patient is a child, what school do they attend? _____ Grade
Level: _____

Responsible Person Information

Responsible Person: _____ Soc.Sec.# _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Employer: _____ Position: _____

Business Address: _____

Business Phone: (____) _____

Please turn to page 2 to add insurance and other information →→→

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INSURANCE INFORMATION

(If you have insurance cards available to be photocopied, you do not need to fill in all of the details in this section.)

PRIMARY INSURANCE COMPANY: _____
Address: _____ Phone: (____) _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Relationship: _____
Insured's Date of Birth: _____ Insured's Soc.Sec.# _____
Group Number: _____ Member Number: _____
Employer: _____

SECONDARY INSURANCE COMPANY: _____
Address: _____ Phone: (____) _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Relationship: _____
Insured's Date of Birth: _____ Insured's Soc.Sec.# _____
Group Number: _____ Member Number: _____
Employer: _____

RELEASE OF INFORMATION FOR INSURANCE BILLING PURPOSES:

By signing here, you authorize me to release information to your insurance company for billing purposes. This information includes diagnosis codes and other basic information about the problems for which you are seeking help (each insurance company asks for different kinds of information). *I make every effort to protect your privacy and to minimize the details I release. Please ask if you have questions about this. As an alternative, some people choose to pay me directly, and then submit claims to the insurance company themselves, ensuring complete control over their personal information.*

Release signature: _____ **Date:** _____

Please turn to page 3 for confidentiality and fee information →→→

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CONFIDENTIALITY AND FEES

Usually psychotherapy is an entirely confidential procedure, where no Information about you (including the fact that you are coming to see me at all) can be revealed to anyone else without your written permission. However, there are several special circumstances that may change this, and you should know about them:

Use of insurance: In order for me to bill your insurance company (including Medicare or Champus), you must authorize me to release basic Information as noted on the previous page. This information includes diagnosis codes, other basic information about the problems for which you are seeking help, and Information about the progress of your psychotherapy (each insurance company asks for different kinds of information). I make every effort to protect your privacy and to minimize the details I release. Please ask if you have questions about this. As an alternative, some people choose to pay me directly, and to submit claims to the insurance company themselves —or not to use Insurance at all — to ensure complete control over their personal Information.

Children and adolescents: When young people are in psychotherapy, special confidentiality arrangements exist. I try to discuss these with each family. The aim of the arrangements is to make sure that the child has a sense of privacy in what they discuss with me, while at the same time the parent knows they are entitled to information from me about how their child is doing, my professional recommendations, etc.

Abuse laws of California: Although these circumstances are rare, in cases of child or elder abuse, or realistic, serious danger to yourself or someone else, the laws of California may require me to notify appropriate authorities. Please ask if you have questions about any of this.

Fees and Billing: Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation. You will be charged for all appointments for which you fail to appear at my full fee disclosed below. If you usually pay a co-pay, or your insurance carrier pays for your entire treatment, please note that your insurance company cannot be billed for any missed or cancelled sessions. Therefore, you will be responsible for the hourly rate of your therapy. Therapy sessions are 45 minutes with an additional 5 minutes to schedule additional sessions, pay, co-pays, etc.

My first session, which is a diagnostic interview is charged at \$175.00. My hourly fee for 50 minute sessions thereafter is \$150.00. My hourly fee for couples and family sessions is \$175.00. You will be expected to pay for each session at the time it is held with cash or check, unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Should additional services be provided or should fees be changed, fair notice will be given to you.

The forms of payment I accept are ACH bank transfers, cash, and check. I also reserve the right to utilize a collection agency for outstanding balances not paid in full by the time therapy is terminated.

It is my policy to request payment at the time services are provided, unless other arrangements are made in advance. Although I will assist in billing your insurance carrier and accept assignments of benefits on our behalf, your fees are a contract between you and me. You will be responsible for those fees, including those not paid by your insurance carrier. If circumstances have lead to a time of difficulty for you, I urge you to contact my office so we can make appropriate financial and session arrangements.

Please turn to page 4 for patients rights information →→→

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PATIENT RIGHTS AND THERAPISTS LIMITED LIABILITY

You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment nor risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

The information disclosed to me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you make my mental or emotional state an issue in a legal proceeding.

You have a right to access your personal information and copies of case records in accordance with California law.

If you are in crisis or in an emergency, you should call 911 or seek help from a hospital or crisis oriented health care facility in your immediate area. By signing this document you understand that emergency situations include: if you have thought about hurting or killing either yourself or another person, if you have hallucinations (see or hear things others don't or beliefs others may consider unrealistic), if you are in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if you are dysfunctional due to abusing alcohol or drugs. By signing this document, you acknowledge you have been told that if you feel suicidal, you are to call 911 or the National Suicide Hotline Toll Free Number 1-800-784-2433 or another suicide hotline.

You should know that psychotherapy, as a process that deals with people's innermost thoughts and feelings, may sometimes stir up emotions and create distress, even though the ultimate aim is to help with problems and alleviate unnecessary emotional pain. Because of the nature of the work, there is also no guarantee that specific improvements will be obtained, or that changes will occur within a specified amount of time.

Lisa Graff-Marsh is a licensed Clinical Social Worker in the state of California. By engaging with Lisa Graff-Marsh, you understand that the services provided are licensed in the state of California only. You agree to the terms and conditions of the State of California and the services provided within this state. Some sessions may consist of counseling, psycho-education, coaching, or other wellness activities including nature-based interventions. You understand that you are receiving services at your own risk and hereby release Lisa Graff-Marsh from any legal ramifications should you injure yourself in any way including but not limited to physical, emotional, mental, or psychological distress or injury.

Please turn to page 5 to sign the treatment consent form→→→

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By signing below, I _____ (printed name)
acknowledge that I have read this informed consent and have received answers to any questions to my
satisfaction.

Signed : _____
Signature of Client (#1)

Date: _____

Signed : _____
Signature of Client (#2)

Date: _____

Signed : _____
Signature of Therapist

Date: _____