

# New Client Intake Form

## Transcend Therapy, Inc.

**Legal Name:** \_\_\_\_\_ **Preferred Name** (if different): \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ (MM/DD/YYYY) **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Health Plan:** \_\_\_\_\_ **Health Plan ID:** \_\_\_\_\_ (if using insurance)

**Social Security #:** \_\_\_\_\_ **Sponsor SSN** (Tricare/Triwest only): \_\_\_\_\_

**Employer/School:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Pronouns/Identifies As:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Emergency Contact Relationship to Client:** \_\_\_\_\_

**Parent/Guardian Name** (if patient is a minor): \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medical Conditions:** \_\_\_\_\_

**Medications & Dosage:** \_\_\_\_\_

**Primary Care MD:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Reason for seeking therapy:** \_\_\_\_\_

**Client or Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Disclosure Statement & Agreement for Services

### Information about your therapist

Your therapist, \_\_\_\_\_ is a/an PhD/LCSW/LMFT/LPCC/AMFT/APCC/ASW (circle one). Your therapist may discuss their professional background with you and provide you with information regarding their experience, education and professional orientation. You are free to ask questions at any time about your therapist's background, experience, education and professional orientation.

### Individual or Conjoint Therapy

The fee for service is \$\_\_\_\_\_per individual therapy session.

The fee for service is \$\_\_\_\_\_per conjoint (family or couples) therapy session.

The fee for service is \$\_\_\_\_\_per phone session with your therapist. The first 15 minutes of a phone session are at no charge.

If you have insurance coverage, your co-payment is \$\_\_\_\_\_, as stated by your insurance carrier \_\_\_\_\_. However if your plan will not cover services, you may be responsible for the full cost of services rendered.

Your fees may be waived if you are unable to pay the full fee with the use of a sliding scale system. If or when you are able to pay the full service fee due to improved financial conditions, then the fee will be the entire fee with no further waivers.

If your fee has been reduced, please initial here \_\_\_\_\_.

Individual sessions and conjoint (couples or family) sessions are approximately 50 minutes in length. Fees are payable at the time that services are rendered. Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. Be aware that insurance plans generally limit coverage to certain diagnosable mental health conditions. You are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee if your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist. If your insurance company declines any of your claims and your therapist is not compensated for services, then you are solely responsible for payment of services rendered.

### Group Therapy

Group therapy sessions are at \$40.00/per 60-minute session. Initial assessment fee for new clients is \$100.00. Clients are strongly encouraged to attend as many group sessions as possible to gain maximum benefit. Since Commitment, Consistency and Courage are key factors in receiving the full benefits of group therapy, **we require a payment of 5 group sessions in advance at a time. Missed or canceled sessions are non-refundable, with the exception of illness.**

### **Confidentiality**

All communications between you and your therapist will be held in confidence unless you provide written permission to release information about your treatment. If you participate in couples or family therapy, your therapist will not disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release information.

There are expectations and limitations to confidentiality. Therapists are required or permitted to break confidentiality and report in the following areas:

- 1) Instances of suspected child or elder abuse. Suspected child abuse may include or present situations involving physical or sexual abuse of a child/elder, neglect, sexual exploitation (including the viewing of child pornography) or other forms of abuse. Your therapist is also permitted to report incidents of domestic violence in the home under the umbrella of child abuse.
- 2) When your therapist has determined that a client presents a serious danger of physical violence to another person.
- 3) When your therapist has determined that a client is dangerous to themselves.
- 4) In addition, a federal law known as the Patriot Act requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits your therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

Please refer to your copy of "Notice of Privacy Practices" for additional information on how your Protected Health Information (PHI) may be used/disclosed.

### **Minors and Confidentiality**

Communications between therapists and clients who are minors (under 18 years of age) are confidential. However, parents and legal guardians who provide authorization for a minor's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of their professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

### **Email and Text Message Policy**

Please be aware of the confidentiality and other issues that may arise when you choose to communicate via email or text message. Please understand all email and text messages are sent over the internet and phone and are not encrypted or completely secure, and may be read by others.

I understand my email and text message communications with my designated treatment provider will NOT be encrypted and therefore, my provider can NOT guarantee the confidentiality and security of any information I send to them, or they send to me, via email or text message. I understand that for this reason, my therapist will encourage me to not send identifying and/or sensitive clinical information via email or text. If I choose to communicate by email or text, I understand that I am taking certain risks and will not hold Transcend Therapy or any individual therapist at Transcend Therapy, liable for any breach in confidentiality which may result from the use of email or text messages.

If I choose to communicate by email or text message, I hereby give permission for my therapist to reply to my email and text messages, including any information they deem appropriate, which

would otherwise be considered confidential information. I understand that my therapist may at times email me information about resources that I can use as part of my treatment. I hereby consent to receive such information via email or text messages. **I understand email or text messages should NOT be used for emergency or urgent matters** since technical or other factors may prevent a timely response. I understand that if I use email or text messages to make or request changes in my scheduled appointments, it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. I will contact my therapist by phone if my issue is of a time-sensitive nature. If I do not receive an answer to a routine email or text message within two working days I understand I should call my therapist directly. I understand all email and text communications may be made part of my medical record and would be accessible to anyone given access to those records. I understand that I may withdraw permission for the therapist to communicate with me via email or text message by notifying my therapist in writing.

### **Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week. Your therapist may suggest a different frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. **You are expected to notify your therapist at least 24 hours in advance for cancellations or requests to reschedule. There is a \$75 fee for no-shows, missed appointments or late cancellations.** Please understand that your insurance company will not pay for missed or canceled sessions. Illness and emergencies are exceptions to this policy and can be discussed further with your therapist.

### **Therapist Availability**

Telephone consultations between office visits may occur. However, your therapist will attempt to keep those contacts brief due to the belief that important issues are better addressed within a regularly scheduled session.

You may leave a message for your therapist at any time, using their confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number, along with a brief message concerning the nature of your call. **Non-urgent phone calls are returned in 24 hours.**

### **Clinical Emergencies**

Clinical emergencies may include but are not limited to danger to self, danger to others, experiencing psychotic symptoms, inability to care for self due to mental illness, crisis issues (traumatic experiences, sudden death or loss), fear for your safety (domestic violence or child, dependent adult, or elder abuse).

If my therapist is an associate, I understand that I may call their clinical supervisor, Anna de la Paz, LMFT at (619) 813-7881 or the director Cecille Ahrens, LCSW, CEAP at (619) 823-1382 for assistance. My therapist has given me their direct phone number in the event of a clinical emergency.

**In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 or go to your nearest emergency room. You may also call the San Diego Access and Crisis Line at 1-888-724-7240 if you feel you are in crisis and need to speak to a counselor urgently.**

Please inform the therapist if you have called 911 due to a psychiatric emergency or have called the crisis hotline.

**About the Therapy Process**

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. Your therapist believes that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Termination of Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determine that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Transcend Therapy, Inc. Confidentiality Statement

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- **Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the healthcare professional is legally required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, we are required by law to take precautions to keep you safe, which includes contacting a family member or friend, a referral to a psychiatric hospital or police intervention if necessary.
- **Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the healthcare professional is required to report this information to the appropriate social service and/or legal authorities. A vulnerable adult is any adult over the age of 60 or who is dependent upon others for their care.
  - **Prenatal Exposure to Controlled Substances:** Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **In the Event of a Client's Death:** In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. If you are over 18, your records are strictly confidential unless you have otherwise specified this in writing, either to your attorney or have left specific instructions with us.
- **Court Orders:** Health care professionals are required to release records of clients when a court order has been placed. This does not include subpoenas from attorneys. If we are summoned to court or requested by you to attend and/or testify, you agree to pay our fees under separate fee agreement and arrangement.
- **Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. We ask all parents not to do this for the success of treatment of your child, but it is a parent's legal right, unless the minor meets the exceptions to mental health treatment under law.

## Informed Consent for Treatment

I, \_\_\_\_\_ (client) authorize \_\_\_\_\_ (therapist) (PhD/LCSW/ LMFT/ LPCC/ AMFT / APCC / ASW) to be my mental health service provider. The frequency and type of treatment will be decided between myself and my therapist. I understand that there is an expectation that I/we will benefit from psychotherapy (individual, couples, family, and/or group therapy), however there is no guarantee that this will occur. I understand that the maximum benefit of therapy may occur with consistent attendance. I understand that at times, I may feel conflicted about my treatment as the process can sometimes be uncomfortable.

### Release of Information - Insurance

I consent to the release of medical information to my health plan for the purposes of processing my claims. Purpose of the release of information may include or may not be limited to: eligibility, authorization, certification, case management and quality improvement.

### Authorization to Leave Voice or Phone Messages

I authorize my therapist to leave voice or phone messages, and identify themselves as mental health practitioners, on the phone numbers I provided on the new client intake form. I will notify my therapist about any specific requests I may have regarding voice and phone messages.

### Grievance and Complaints

The Board of Behavioral Sciences (BBS) receives and responds to complaints regarding services provided within the scope of practice of Licensed Clinical Social workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Psychologists and Associate Therapists (AMFT, ACSW, APCC). You may contact the Board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Transcend Therapy, Inc.**  
**Required HIPAA Notice of Privacy Practices**

**I. 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. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.**

**II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)** I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

**III. HOW I MAY USE AND DISCLOSE YOUR PHI**

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

**For Treatment.** I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

**To Obtain Payment for Treatment.** I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

**For Health Care Operations.** I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

**For Patient Incapacitation or Emergency.** I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

**1. When federal, state, or local laws require disclosure.** For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.



**2. When judicial or administrative proceedings require disclosure.** For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena. **3. When law enforcement requires disclosure.** For example, I may have to use or disclose your PHI in response to a search warrant.

**4. When public health activities require disclosure.** For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.

**5. When health oversight activities require disclosure.** For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization. **6. To avert a serious threat to health or safety.** For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.

**7. For specialized government functions.** For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

**8. To remind you about appointments and to inform you of health-related benefits or services.** For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

#### **C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

#### **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

**A. The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.

**B. The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

**C. The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

**D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized;

disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.

**E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

**F. The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via email.

#### **V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES:** Transcend Therapy Owner Cecille Ahrens, LCSW, CEAP. (619) 823-1382

#### **VII. Effective Date of This Notice**

This notice went into effect on April 14, 2003.

**PLEASE KEEP THIS NOTICE FOR YOUR RECORDS.**

## Notice of Privacy Practices Acknowledgment

I acknowledge that I have been given a copy of the Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can get access to the information.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Transcend Therapy, Inc.**  
**4452 Park Blvd., Suite 204**  
**San Diego, CA 92116**  
**Phone: 619-823-1382**

**Client-Psychotherapist Arbitration Agreement**

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical 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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided 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 relate to treatment or service provided by Transcend Therapy 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 both 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 Transcend Therapy must be arbitrated including and without limitation, claims for loss of consortium, wrongful death, emotional distress, or punitive damages. Filing of any action in court by Transcend Therapy to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Transcend Therapy, any fee dispute, where or not the subject of any existing court action, shall be resolved by arbitration.

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 neutral arbitrator by either party. Each party to the arbitration shall pay such parties 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, together with other expenses of arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's 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 the liability and damages upon written request to the neutral arbitrator. 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 Sections 340.5 and 667.7 and Civil Code Sections Civil Code 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Discovery shall be conducted pursuant to the Code of Civil Procedure Sections 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provision: 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 relation to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Transcend Therapy within 30 days of this signature. It is the intent of this agreement to apply to all behavioral services rendered at any time for any condition.

Article 6: Retroactive Effect: If Client intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), the patient should initial here effective as the date of first medical services. \_\_\_\_\_

If any provision of this Arbitration Agreement is held invalid or 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 MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

I, \_\_\_\_\_(client/parent/guardian), have read the above arbitration agreement document and agree to these terms.

Yes \_\_\_\_\_ No \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Client or Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Transcend Therapy, Inc. Credit Card Authorization Form

**\*\*\*Completion of this form is a REQUIREMENT for treatment. Please inform your therapist if you are unable to provide us with this information.\*\*\***

Agreed upon fee or Co-Pay: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Credit Card Type: Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ AmEx \_\_\_\_\_ FSA/HSA \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_

Security Code (back of card, or front of card for AmEx): \_\_\_\_\_

Billing address including zip code: \_\_\_\_\_

By signing below, you authorize Transcend Therapy to charge your credit card with any co-pays, unpaid charges (such as bounced checks), late cancellation fees and/or no-show fees (\$75.00). You will be notified if your credit card payment is declined by phone, email, mail or text. If your account is not rectified within 5 business days, it may be sent to a collection agency of choice, in addition to the penalties allowed to the maximum extent of the law of the State of California.

- Due to policy changes with our credit card merchant Square Pay, a **3.75%** merchant fee will be subtracted from any refunds processed. We sincerely apologize for this, however for each refund transaction that we process, Square no longer refunds the business the merchant fees. We can offer you a credit instead of a refund if you prefer this option.

**Client or Parent/Guardian Name:** \_\_\_\_\_

**Client or Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_