CARE-LA

10323 Santa Monica Blvd, Suites 102 & 103
Los Angeles, CA 90025
(424) 421-CARE

CONSENT FOR TREATMENT

BILLING AND PAYMENTS
Once an appointment is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of cancellation. **Psychiatry appointments require 48 hour advance notice of cancellation.** Charges are due upon services rendered. I understand that I am financially responsible for the charges incurred for treatment including those not covered for reimbursement by my insurance plan(s).

INSURANCE REIMBURSEMENT
Once requested, CARE-LA provides you with super bills that have all the pertinent information that you will need to submit a claim for reimbursement; however, you are responsible for full payment of all fees upfront.

CONFIDENTIALITY
In general, the privacy of all communications between a patient and a therapist/psychiatrist is protected by law, and we can only release information about our work to others with your written permission. But, there are some exceptions:

1. There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

2. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, and seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

As a parent, I understand that I have the right to information concerning my minor child in treatment, except where otherwise stated. I also understand that the therapist/psychiatrist believes in providing a minor child with a private environment in which to disclose him/her/they/them to facilitate treatment. I therefore give permission to this therapist/psychiatrist to use discretion, in accordance with the professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Print Name of Patient Birth Date

_____ _____
Signature of Patient Date
or Parent/Guardian (if minor)