Informed Consent- Adult- Medi-Cal

Confidentiality
We honor the importance of your confidentiality in the counseling process. We want you to know that any information you share is protected by professional and ethical standards, and will not be released without your written consent. The only exceptions to this are to protect the safety of you and others. We may need to report reasonable suspicion of child abuse; elder abuse; dependent adult abuse; or intervene if you present a danger to yourself or to others; or by court order.

Consultations & Supervision
Clinical services are provided by clinicians who are either currently licensed or who are in training to become licensed therapists. Our clinical group supervisors* provide supervision to our unlicensed clinicians on a weekly basis. Additionally, your clinician may have an individual supervisor. Ask your clinician if you want to know who their individual supervisor is. During supervision meetings, your information may be discussed. All information shared between clinicians, supervisors and administration is handled confidentially within our agency. *(Jenn Farley, LPCC #2700, Tim Hartnett, LMFT #27228)

Emergency Contact Policy
Please note that Shine a Light Counseling Center is not a crisis counseling center or an emergency provider. If you experience a mental health crisis, please call the Santa Cruz County Access Team (Santa Cruz county) at 800-952-2335, or the Monterey County Mental Health Crisis Line (Monterey county) at 831-755-4111, or Suicide Prevention at 877-663-5433, or 911.

Contacting Your Counselor
Please call your counselor's direct phone number, as that is the best way to assure they receive your message in a timely manner. Be sure to get your counselor's contact information directly from them. Do not call the Shine a Light main phone number to communicate with your counselor or give notice about late arrivals or cancellations.

Session Length
Your session length is 53 minutes. If you require a longer appointment, your counselor can work with you to determine an appropriate length of time; and the fee will adjust accordingly.

Using Medi-Cal Benefits
As providers for Medi-Cal/Beacon Health Strategies (BHS), we will need to verify coverage in order to bill for services. In order to be treated under BHS we will need to give you a formal diagnosis, and your file may be audited by BHS at their discretion. In signing this form you will therefore be authorizing the exchange of information between Beacon Health Services and Shine a Light Counseling Center for the purpose of billing and possibly auditing your health record.

Your Initials:_____

Late Cancellations & Missed Appointments
Cancellations must be made 24-hours in advance. If you arrive late for your appointment, your session will be shortened in order to finish on time. We are required by BHS to report any late cancellations or missed appointments by clients, Repeated missed appointments may cause BHS to discontinue our treatment.

Child Custody, Legal Proceedings, and Costs
It is the policy of Shine a Light Counseling Center not to participate in any litigation, including child custody evaluations/recommendations. We do not voluntarily testify in any court proceeding or disposition. We generally do not write or sign letters, reports, declarations, or affidavits to be used in any legal matter. If any officer or employee of Shine a Light Counseling Center is called to testify or provide disposition in court, proceeding, or other meeting on your behalf, Shine a Light Counseling Center charges $250.00/hour and reasonable travel and hotel costs for any and all related time spent on the case.

Your Counseling Experience
Counseling is a unique and highly individualized experience. Please let your counselor know what you need to feel safe and supported in your growth. Your openness and honesty are important for a healthy therapeutic relationship.

Ending Therapy
You have the right to discontinue therapy at your discretion. And there are some conditions under which your counselor may recommend termination. If you decide to stop therapy, your counselor will generally recommend that you participate in one or more (optional) closing sessions. These sessions are an opportunity to reflect on the work that has been done, and to discuss next steps, including possible referrals for alternative sources of support.

Beacon Health Options Member Rights and Responsibilities
Beacon Health Options asks us to include this description of your rights and responsibilities as a Medi-Cal subscriber:

Rights:

1. You have the right to receive information about Beacon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines. You have a right to receive this information in a manner and format that is understandable and appropriate to your condition.
2. You have the right to receive oral interpretation services free of charge for any materials in any language.
3. You have the right to be treated with respect as an individual in a manner that protects your privacy and dignity, regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
4. You have the right to have all communication regarding your health information kept confidential by Beacon staff and contracted providers and practitioners, to the extent required by law.
5. You have the right to participate with practitioners and providers in your own treatment planning and decision making regarding your care, and to include family members when appropriate and/or requested. Treatment planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/or cost implications.
6. You have the right to decide who will make medical decisions for you if you cannot make them.
7. You have the right to give or refuse consent for treatment and give or refuse consent for communication of treatment information to your PCP and/or other behavioral health providers.
8. You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.

9. You have the right to appeal a Beacon Health Options authorization decision resulting in denial of any aspect of care or service.
10. You have the right to submit a complaint or concern (or have a designee do so on your behalf), verbally or in writing, about the care you have received.
11. You have the right to have questions or concerns answered completely and courteously by your providers and Beacon staff.
12. You have the right to contact Beacon's Office of Ombudsman to obtain a copy of Beacon's member rights and responsibilities statement. You may make recommendations about the member rights and responsibilities statement to the Ombudsperson
13. You have the right to participate in the Member Advisory Council. You may make recommendations about the member rights and responsibilities statement to the council.

Responsibilities:

1. You are responsible for choosing a primary care provider and site for the coordination of all your medical care.
2. You are responsible for carrying your HP/MCO member ID card and showing the card whenever you seek treatment.
3. You are responsible for understanding your benefits, what's covered and what's not covered.
4. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the Covered Services List for your coverage type.
5. You are responsible for providing information, to the best of your ability, to Beacon and treating providers that is necessary to ensure effective behavioral healthcare for you.
6. You are responsible, to the best of your ability, to understand your behavioral healthcare needs and participate in your treatment including developing, following and revising as necessary, mutually agreed upon treatment and aftercare plans.
7. You are responsible for contacting your Behavioral Health Provider, if you have one, if you are experiencing a mental health or substance abuse emergency.

HIPAA Notice of Privacy Practices

1. This notice describes how medical information about you may be used and disclosed electronically and how you can get access to this information. Please review it carefully.
2. We have a legal duty to safeguard your protected health information (PHI) when we transmit information electronically. We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care.
3. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our agency; PHI is "disclosed" when it is released, transferred,has been given to, or is otherwise divulged to a third party outside of our agency. With some exceptions, we 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.
4. By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes; all of our notes can be found in the client file. Your PHI will not be disclosed for marketing purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.
5. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to the PHI on file with us already. Before we make any changes to our policies, we will promptly change this notice and post a new copy of it in our offices and on our website. You can also request a copy of this notice from us, or you can view a copy of it in our office or on our website. Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Shine a Light Counseling Center.

BBS Notice to Clients:
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Initials: _____

Adverse Childhood Experiences Revised Questionnaire

The California Surgeon General's Clinical Advisory Committee requests that you fill out this form.

Our relationships and experiences—even those in childhood—can affect our health and well- being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the total number at the bottom.

- ☐ Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
- ☐ Did you lose a parent through divorce, abandonment, death, or other reason?
- ☐ Did you live with anyone who was depressed, mentally ill, or attempted suicide?
- ☐ Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?
- ☐ Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?
- ☐ Did you live with anyone who went to jail or prison?
- ☐ Did a parent or adult in your home ever swear at you, insult you, or put you down?
- ☐ Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
- ☐ Did you feel that no one in your family loved you or thought you were special?
- ☐ Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

Fill in the total number of checked responses:

Do you believe that these experiences have affected your health? ☐ Not Much ☐ Some ☐ A Lot

Experiences in childhood are just one part of a person's life story. There are many ways to heal throughout one's life. Please let us know if you have questions about privacy or confidentiality.

Coordination of Care
Beacon Health Strategies encourages the collaboration of care between healthcare providers in order to provide the best care possible. For this reason, we request that you permit us to contact your primary care physician and other relevant health care providers. Please use the following forms for this purpose.

Consent to Release Confidential Information

By signing this document, I, _____

authorize the mutual exchange of health information between the following individuals and my therapist

or my child's therapist at Shine a Light Counseling Center: _____
(Therapist at Shine a Light)

Name: _____
(doctor/therapist/family member/other)

Phone:_____ Fax:_____ Email: _____

Name: _____
(additional person, if applicable)

Phone:_____ Fax:_____ Email: _____

Rights:

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits
- The information disclosed by this authorization amy be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws
- You have a right to revoke this authorization at any time. But if you revoke this authorization, the revocation will not affect the disclosure of any information that Shine A Light has already sent to the recipient.

Name of client if client is a minor: _____ Date: _____

Your signature when you upload this form indicates your agreement to this entire document.