Cardiff Counseling Center

Individual, Couples & Family Therapy
Bonnie J. Rumble, MFT • License #MFC 31229
Locations in Cardiff & San Diego
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Disclosure Statement & Agreement for Services

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. And as we begin, please note and understand that Bonnie J Rumble MFT/ Cardiff counseling Center is a sole-proprietor, which means that she is in business for herself, and that Bonnie J. Rumble MFT and Cardiff Counseling Center are not engaged in any partnerships, joint ventures, or professional corporations, or any other form of business organization with any of the other practitioners in this suite of offices.

PSYCHOTHERAPY SERVICES
Psychotherapy varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

QUALIFICATIONS
I am a Marriage and Family Therapist (License #MFC31229) and have a Master of Science degree in Counseling Education. My education, training and experience include providing counseling and psychotherapy to individuals, couples and families since 1993. I am also trained in Eye Movement Desensitization and Thought Field Therapy.

MEETINGS
Sessions are typically scheduled weekly and are 50 minutes long. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. During your first session, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once an appointment is scheduled, you will be expected to pay for it unless you provide **24 hours [1 day] advance notice of cancellation** [unless we both agree that you were unable to attend due to circumstances beyond your control].

CONFIDENTIALITY – NOTICE OF PRIVACY PRACTICES

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

However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting couple or family therapy. This means that if you participate in couple and/or family therapy, I am permitted to use information obtained in an individual session that we may have had, when working with other members of your family. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

Additionally, federal privacy regulations known as the Health Insurance Portability and Accountability Act (HIPAA, eff. date April 14, 2003) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations"), including how to access your health information. Nevertheless, I will ask for your consent in order to make this permission explicit.

MY COMMITMENT TO YOUR PRIVACY

"I am dedicated to maintaining the privacy of your health information." Being required by law to maintain the confidentiality of your health information, I am also required to provide you with the following important information: ***Use and disclosure of your health information in certain special circumstances. By signing below, you acknowledge receipt of my notice of privacy practices.***

The following circumstances may require me to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official, for example by subpoena.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. I will only make disclosures to another person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities for national security.
6. To federal officials for intelligence or national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For lawsuits or claims for Workers Compensation and similar programs.

Please note: Your health information does not include progress notes and are therefore not subject to disclosure to an outside party.

Additional disclosures:

1. To obtain payment for treatment from your insurance company or health plan.
2. To disclose health information to others without your consent if you are incapacitated or if an emergency exists.
3. To remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that may be of interest to you.

Your rights regarding your health information

1. Communications: You can request that I communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that I contact you at home rather than at work. I will accommodate all reasonable requests.
2. Restrictions: You can request a restriction in the use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that I restrict disclosure of your health information to only certain individuals involved in your care or payment for your care, such as family members and friends. If you are referred to a physician or if I refer you to a physician for additional care, disclosure of your health information will most likely be made to that physician. I am not required to agree to a request not to do so; however, if I do agree, I am bound by this agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. An accounting of disclosures: You can request to receive an accounting of certain disclosures of your health information I have made, if any.
4. Receiving a copy of your health records: You can inspect and receive a copy of your health information that may be used to make decisions about your care, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. I will respond to your request within 30 days. In certain situations, I may deny your request, and if I do, I will explain the reasons for the denial and explain your right to have the denial reviewed.

Also, instead of providing the health information you request, you may be provided with a summary or explanation as long as you agree to receive one. I hold records for seven (7) years after termination except in the case of minors, which is seven (7) years or until age 19, whichever is later.

5. Amending your health information: You may ask me to amend your health information if you believe it is incorrect or incomplete. To request an amendment, you must provide the request and your reason for the request in writing. I will respond within 60 days. I may deny the request in writing if I feel your health information is correct and complete, are not part of my records, or may cause you harm. I will state the reasons for a denial and explain that your request and denial be attached to all future disclosures. If I approve your request, I will make the change and inform you that it has been done.
6. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask me to give you a copy at any time.
7. If you believe that your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.
8. I will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law.
9. I reserve the right to change this Notice in the future, and before any important changes to my policies are made, I will promptly change this Notice and offer you a new copy of the policy.

TREATMENT OF MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents or legal guardians the right to examine your treatment records. It is my policy to request an agreement from parents or guardians that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

TERMINATION OF THERAPY

The length of your treatment and the timing of the eventual termination of your treatment depend 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 determines 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.

CONTACTING ME: AVAILABILITY/EMERGENCIES

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. I am not available when I am with clients and my telephone will be answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. Please be sure to leave your name and phone number If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your physician or the nearest emergency room and ask for the psychologist, psychiatrist or Mental Health worker on call. **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency services**. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

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

Client's Signature: _____ Date:_____/_____/_____

Client's Signature: _____ Date:_____/_____/_____

Therapist Signature: _____ Date:_____/_____/_____