Linda M. Rio, M.A.

Marriage and Family Therapist
CA License # MFC 23156
(805) 619-0950

Intake Packet and Professional Policy

Dear Clients:

Welcome! I would like to clearly communicate to you my policies about my psychotherapy practice. Your (or your family member's) participation in psychotherapy can result in many benefits to you. These may include a better understanding of your personal goals, values, thoughts, and feelings, as well as improved relationships, changed behavior, and resolution of the specific concerns that bring you here. This all requires effort on your part, which may also involve emotional discomfort. Change occurs differently and uniquely for each person, and is often slow and sometimes frustrating. In order to assist you I use many techniques as part of my practice that includes: talk therapy, visualization exercises, hypnosis, Eye Movement Desensitization and Reprocessing (EMDR), hypnosis, play therapy, art, and other psychotherapeutic methods I have been trained to perform. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these and any other questions with me.

Private Practice:
I am an independent/sole proprietor, which means I am in business for myself not engaged in any formal partnership, joint venture, or professional corporation.

Therapy Time and Fees:
1. Sessions are generally 45 to 50 minutes in length unless other arrangements have been made in advance.
2. IF YOU NEED TO CANCEL AN APPOINTMENT, please remember **I require 24 hours notice,** otherwise **there will be a charge for your missed session.** You can leave a message on my voice mail 24 hours a day, 7 days a week. **You will be charged my standard fee of $200.**
3. **If you are late**, we will meet for the remainder of your scheduled session. If you are more than 15 minutes late and I have not heard from you, I will assume you aren't coming and may leave the office.
4. Telephone time is limited to 10 minutes, beyond which I will bill you (not your insurance) at my standard rate of 30 minutes minimum. Payment will be expected at your next regularly scheduled appointment or prior through my website www.lindamrio.com.
5. Telehealth appointments may be available and charged at my standard rate.
6. I can provide a statement for you to bill your insurance.

Emergencies and Contacting Me:
I utilize a Google phone number which can be accessed 24 hours a day, 7 days a week. I return normal business calls during weekdays only. In case of a crisis or urgent matter call me and please specify you need a response quickly. If I cannot be reached, nor do not respond and you feel you are having a life-threatening/mental health emergency please go to the nearest emergency room, call the **Ventura County Crisis Team (805) 383-4806; Los Angeles County Crisis (800) 854-7771,** or call 911.

Vacations etc.:
When I will be unavailable, I will notify you, record a message on my voicemail as well as outgoing email. If you have an emergency when I am gone you may call 911, contact your primary physician, psychiatrist, or designated provider contact I have provided.

Termination:
Termination from therapy is an important process which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to partake with me in this process of finding out what was helpful and what could have been more helpful. It is your right to terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions (unless a special arrangement has been made), or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

Financial Policy:
I accept cash, check, credit/debit/PayPal. My standard fee is **$200.00 per hour**. I no longer contract or bill insurance companies. Upon your request I can send you an electronic copy of a bill for insurance submission.

Credit/Debit/PayPal payment: https://www.lindamrio.com/contact-me--make-payment.html
or through my Telehealth platform at the time of a session: https://doxy.me/lindamrio

Additional Charges:
Additional charges may be incurred for the following: letter writing at client request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office, special meetings. Time outside this office is usually charged door to door at a separate rate. Any additional charges will be discussed in advance and agreed upon. **NO SHOW APPOINTMENTS** i.e. you give less than a 24hr notice or do not show for your appointment **will be charged a $100.00 fee**, due prior to the next scheduled appointment.

***Note:** Children under the age of 18 years **must have the consent of all parents/guardians who hold "legal custody**". **I will not treat children without this written consent** except in rare instances. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case.

Communications/Technology/Social Media Policy:
In an age of fast changing technology, it is important to understand the risks and benefits involved in any communication, especially of a private nature such as in therapy. I take reasonable steps to protect your privacy, however, it is important to understand and accept the risks to privacy by using these methods of communication. If you provide your email address, I will presume you have granted me permission to use this method of communication. **PLEASE NOTE:** I ask that **all text** communications be limited to **non-urgent** matters as there can be a delay in my receipt and/or response using such methods. Also, since text messages are not truly private, I will not respond to any message that contains clinical/personal information so PLEASE CALL me instead.

If you have any questions about how best to communicate with me, I encourage you to discuss this in person with me when we meet. Communication via technology should not be considered a substitute for face-to-face therapy communication. Please note that any and all communication of any sort between a client and therapist is part of the permanent clinical record.

I do not accept personal friend or contact requests from current/ former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. I do have a **Professional Facebook page: *Linda M. Rio, Marriage and Family Therapist***. The purpose of this is to provide the general public with information that may benefit the community. You are most welcome to view and "like" it if you wish to follow the posts. There is no confidentiality or privacy on Facebook therefore this should not be considered an

appropriate way to communicate with me, therefore only used to view or share information that is completely public.

Family/Couple Therapy:
If multiple members of the same family are being seen each adult member of the family must authorize participation in treatment. At times it may be appropriate to see individual family members or a grouping of members. Confidentiality for all is to be maintained, however, the therapist is not responsible for holding "secrets", but will assist when it is necessary and appropriate to find optimal ways of sharing with one another.

Telemedicine/telehealth Informed Consent and Understanding

I/we (name(s) of all those participating as client(s) listed below) hereby consent to engage in telemedicine/telehealth with Linda M. Rio, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
I/we state that I am using my own equipment to communicate, and specifically not that owned by another person.
I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine/telehealth. As such, I understand that the information disclosed by me during the course of my therapy 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 I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to anyone shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine/telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area (or schedule an appointment with Linda M. Rio face-to-face). I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(4) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

(5) I understand that telemedicine/telehealth requires that the provider keep and maintain patient records and is bound to abide by state laws regarding any psychotherapy record.

(6) I understand that I may decline any telehealth services at any time and may request a referral to another provider if I so desire.

In case of a medical or mental health emergency the following is the nearest services to my location: (Please list closest hospital, police department name, and any other emergency services). I

understand that my therapist may contact such emergency services if it is deemed medically and/or psychologically necessary.

Nearest (to me) medical/mental health emergency site:

Site name: _____

Site address: _____

Site phone number: _____

Suggestions to prepare for your telemedicine session:

- Choose a private location that will be free of interruptions for the duration of the session.
- If an interruption occurs such as a family member comes into the room or your phone or computer delivers an important message plan how you will handle this.
- If you have to cancel/postpone your session how will you contact your therapist in a timely manner? Have you discussed any financial consequences for a cancellation?
- If you have children and they see or hear you talking via the computer what will you explain to them?
- If you live with a spouse or significant other have you discussed with them that you will be having sessions via computer?
- If a spouse or significant other is at home or nearby at the time of your session you might want to turn Bluetooth off so someone else cannot listen to the clinical exchange from another room.
- You and your therapist may want to develop a code word you both agree upon that indicates there may be an unwanted person nearby who may be able to overhear. The therapist in such a case may agree to feign an excuse to leave the session so as to preserve client confidentiality**. The CODE WORD agreed upon is _____.**
- Technology sometimes fails, bad connections happen, power outages occur. **What is the backup plan** should this occur?

  _____
- Plan and practice the lighting so that your face/body is well-lit prior to a videoconference.
- Discuss with my therapist the pros and cons of psychotherapy delivered via telehealth.

I have read and understand the information provided above. I also understand **that I must be physically in the State of California at the time of a telehealth session.**

Printed Name: _____Signature: _____

Printed Name: _____ Signature: _____

Printed Name: _____Signature: _____

Printed Name: _____ Signature: _____

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. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

PHI USE AND DISCLOSURE POLICY (HIPAA)

This information may not apply to all but is important to know regarding safety of all medical records

1. Your client record or PHI (Personal Health Information) is confidential. Client information can only be released pursuant to a signed release, a court order, or if one of the exceptions to confidentiality discussed below applies. If you are in individual therapy and are an adult, I will generally not release any PHI except pursuant to your written authorization, a subpoena, a court order, or one of the exceptions to confidentiality discussed below. If you are in conjoint therapy, then I will not release information about any participant in therapy without the written consent of all the participants, unless one of the exceptions to confidentiality set out below applies.

   If a minor child is my client, generally I will require the signature of the parent or parents who have legal custody of the child. Depending on the child's age, I may also obtain a release from the child. If a minor's counsel has been appointed for the child, then under California Family Code §3151, only the minor's counsel can release the child's privilege. Under California Health and Safety Code §123115, I may withhold information or records if I determine producing them would have a detrimental effect on my relationship with the child or would have a detrimental effect on the child's physical safety or psychological wellbeing. In such a circumstance I will use my clinical judgment to protect your child's therapeutic interests.

2. If you have insurance which is being billed for our professional services, some information regarding you may be requested by the carrier. The amount of information varies depending upon the kind of plan you have. (HMOs for example often want periodic written reports and will contact the providers directly.) Insurance plans may make use of and/or require electronic communications by fax or computer. While I will make every reasonable effort in this office to protect your privacy, I have no control of, and am not responsible for, any problems which occur once the information has left our office. If you have any questions about this or your particular insurance plan, please contact me to discuss it.

3. In most instances I use a laptop computer to store most clinical files. This computer is protected by encryption software, and several levels of passcodes and has a regular backup procedure. I do not allow third parties to have access to this computer.

4. I am legally required to protect the privacy of your PHI which includes information which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this healthcare. I am required to provide you with this notice about my privacy practices which explains how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, and analyze such information within my practice. A disclosure of PHI happens when it is released, transferred, is given to or is otherwise divulged to a third party who is outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is reasonably necessary to accomplish the purpose for which the use or disclosure is made.
5. I reserve the right to change the terms of this notice and my privacy policies at any time and any such changes will apply to PHI which is on file with me already. If I change this notice, I will post a new one on my website. You can request a copy of this notice from me or obtain it from the website.
6. I keep treatment notes in client files. These are generally not disclosed directly to clients in order to protect the emotionally charged nature of such. A summary can be provided, or with client authorization these can be shared with a qualified medical or psychological professional deemed by the client and/or legal representative.

6 A. **USES AND DISCLOSURES OF PHI THAT DON'T REQUIRE YOUR CONSENT**

Uses and disclosures relating to treatment, payment or healthcare operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:

1) **For treatment**. I can disclose your PHI to licensed health care providers who provide you with healthcare services or involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care. However, I would not be able to disclose your PHI to a healthcare provider who is not involved in providing care to you.
2) **To obtain payment for treatment**. I can use and disclose your PHI to bill and collect payment for treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to either get paid for the health care services or have you reimburse for health care services that I have provided to you. I may also provide your PHI to my business associates such as billing companies or others that help process my claims for care provided to you.
3) **For health care operations.** I can 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 another health care professional who provided services to you in our office. I may also provide your PHI to our accountants, attorneys, or consultants to make sure that I am complying with the laws that are applicable.
4) **Other disclosures**. I may also disclose your PHI to others without your consent in certain situations. For example, if you need emergency treatment or you're unable to communicate with me due to being unconscious or severe pain and I think it is likely that you would consent to treatment if you were able to do so.

6. B. **USE AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT**

There are certain circumstances where I can use and disclose your PHI without your consent because of federal or state law which authorizes such disclosures to be made or requires them to be made.

1) **Child or elder abuse reporting**. If you report information to me that gives me a reasonable suspicion that child abuse, elder abuse or abuse of a dependent adult has occurred, then I am required by law to report such abuse to the appropriate

governmental agency. This reporting will be by telephone and in writing and, in addition, I may be required to have discussions with government employees who are investigating the abuse report.

2) **Threats.** If you make a threat that I believe to be a serious threat of bodily harm or death to another person, or if I am advised that you have made such a threat by a member of your family or a significant other, I am required by law to notify the person who you have expressed the threat regarding and law enforcement.

3) **Danger to Self.** If I determine that you pose an imminent risk of harm to yourself, I may disclose information to the necessary authorities to try and protect you from harming yourself.

4) **Subpoenas.** If I receive a subpoena from a Federal or State court or an administrative agency concerning you, then I may be required to disclose PHI in response to the subpoena. If I do receive such a subpoena, I will make reasonable efforts to notify you in advance to discuss it. Under California law, if a subpoena is served for psychotherapy records, the person issuing the subpoena is required to give you notice that your records are being sought and you have the opportunity to both object and file a motion to prevent the disclosure. The issuance of a subpoena by itself is not sufficient to compel me to disclose information about you without your consent. Of course, if you choose to consent to comply with the subpoena and provide me with an appropriate written release, I will comply with the subpoena.

5) **Minors.** As noted above with regards to patients who are minors, generally the consent of both parents will be required before I can release information, records or testify. In some instances, the court will have appointed a minor's counsel who by operation of law is the sole person who can make decisions on the child's privilege.

6) **Health oversight activities.** I may have to provide information to governmental agencies when conducting an investigation or inspection of health care provider organization.

7) **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations as required by law. I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.

8) **For workers compensation purposes.** I may provide PHI in order to comply with Workers Compensation laws and orders from the Workers Compensation Appeals Board.

9) **Appointment reminders and health related benefits of services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits I offer.

6. C. **USES AND DISCLOSURES WHICH REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT**

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

6. D. **MINIMUM NECESSARY DISCLOSURES**

When using or disclosing PHI and was requesting PHI from another therapist, hospital or facility, I will make reasonable efforts to use, disclosure or request the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request.

However, among the uses, disclosures and requests, which the minimum necessary standard does not apply to, are:

1) Disclosures to a request by a healthcare provider for treatment purposes;
2) Disclosures to you as the patient who is the subject of the information
3) Uses or disclosures made pursuant to a valid authorization signed by you
4) Uses or disclosures that are required for compliance with the HIPPA privacy standards;
5) Disclosures to the Department of Health and Human Services when required by them for compliance and enforcement purposes; and
6) Uses or disclosures that are otherwise required by law.

7. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures in ways that prevent me from doing things I am legally required to do or allowed to do.

B. The right to choose how I send PHI to you. You have the right to ask that I send 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, email instead of regular mail. I must agree with your request as long as I can easily provide the PHI to you in the format you requested.

C. The right to see and get copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that I have but you must make the request in writing. Depending on whether your request is made under federal or state law, the length of time in which I have to respond will vary. I will respond to you within the period of time the law allows me to respond. In some situations, I may be required and in use of my clinical judgment, to deny your request. If I do, I will explain in writing my reasons for the denial and your right to have my denial reviewed. The amount of costs you can be charged for copying a PHI is governed by different statutes and I will charge you the statutorily set rate for such copies. I may elect to provide you with a summary or explanation of the PHI.

D. **The right to get a list of disclosures I have made.** You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those made for treatment, payment or health care operations, directly to you or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. I will respond to your request for an accounting of disclosures within 60 days of receiving your 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 of disclosure, to whom 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 will charge you a reasonable cost for the additional request.

E. **The right to correct or update 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 update or correct information. You must provide the request and the reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing. PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my record. My written denial will state the reason for the denial; explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request at your request to my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, will you I have done it, and tell others that need to know about the change to your PHI.

F. **The right to get this notice by email.** You have the right to get a copy this notice by email. Even if you have agreed to receive notice by email, you also have the right to request a paper copy of it.

G. **How to complain about my privacy practices.** If you think I may have violated your privacy rights or you disagree with the decision I have made about access to your PHI, you may file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, Southwest Washington D.C. 20201. I will not take any retaliatory action against you if you file a complaint about my privacy practice.

H. **Notification of breach of unsecured PHI.** You will receive notification of any breach of unsecured PHI.

I. **Clients have the right** to restrict disclosures of PHI to health plans for certain payment or health care operations purposes, assuming the PHI pertains solely to a health care item or service that clients have paid for out-of-pocket in full.

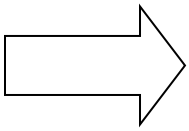
J. **PHI will not be sold**

K. **PHI will not** be disclosed for marketing purposes.

8. **PATIENT CONSENT** and/or Parent/Guardian Signature(s): ***ALL* LEGAL PARENTS** and **Adults** Participating in Treatment **MUST SIGN***

I consent to the use or disclosure of my protected health information by Linda M. Rio, MA for the purpose of diagnosing or providing to me and/or my child, obtaining payment for my health care bills, or to conduct health operations of Linda M. Rio, MFT.

I have read, understand, and agree to the professional policy for Linda M. Rio, MA, MFT

Please Sign Here 

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

CLIENT DEMOGRAPHIC INFORMATION

Date of First Appointment: *Therapist 's Name* **Linda M. Rio, MA, MFT**

PRIMARY CLIENT's NAME

Primary Address Birth date / /

Gender: Female Male

Secondary Address (please designate)

Relationship: Single Married Divorced
(circle which applies)
Domestic Partner Other

Phone: Home: Cell:

Client's Occupation

Employer Name or School | Work Phone | Ext.

Who referred you? | E-Mail address

Physician | Physician Phone

Nearest Hospital Name/Address_____

Date of Last Physical / / | Major Illness(es)

Current Medications

Previous Psychotherapy? No Yes

(with whom?)

Please list OTHER FAMILY MEMBERS:
(for children please list all parents/guardians)

Name	*Birth date*	*Relationship*	*Living at home*
			yes / no
			yes / no
			yes / no
			yes / no
			yes / no
			yes / no

*Person(s) Legally Responsible*_____

Phone

Signature Date / /

Address *(if different from "client's)*

Signature

*I AUTHORIZE TREATMENT **FOR THE MINOR CHILD(REN)** UNDER MY CARE.*

Signature Date / /

Signature Date / /