FAMILY FORCES, INC.
13223 Black Mountain Rd, Suite 239
San Diego, CA 92129
Phone: (858) 277-7907
Fax: (858) 277-7908

Dear client,

We would like to take this opportunity to welcome you to Family Forces. We are looking forward to serving you and your family.

All of us here at Family Forces are committed to working with individuals and families to assist them with stressors related to military lifestyle both during deployment and non-deployment times. We understand the unique challenges that military members and their families face, and our therapists have extensive training and experience helping members of the military community. We also understand that many of our clients and families may have emotional, cultural, gender specific, and substance use issues, current or past, that affect their treatment needs. Therefore, our goal is to maintain an empathic, ethical, responsive, and professional attitude in all phases of care. We have developed a program that has proven both successful and meaningful to those we serve, and we strive to offer excellent care to all our clients.

You are an extremely important part of Family Forces and we value your input, cooperation and strengths. All Family Forces therapists are licensed in the state of California and are highly trained to provide interventions that will meet the special and unique needs of each family and client with whom they work. Our administrative support team is also highly trained and can answer any questions regarding your insurance coverage and if applicable, any co-pays or other service charges that may apply. Your Family Forces therapist and administrative staff welcome your feedback and are dedicated to creating an environment of hope, opportunity and choice for you and your family.

We look forward to working with you.

Sincerely,

Family Forces Team

FAMILY FORCES
COUNSELING FOR MILITARY FAMILIES

Statement of Understanding

Client's Name: _____ Address: _____
DOB: _____ Phone: _____
Tricare ID (Sponsor SSN): _____ Sponsor name: _____

Welcome to Family Forces! We look forward to providing therapy services to you and/or your family. Before delivering any services, we need to share some important information with you as outlined below. Please take a moment to read everything thoroughly. If you have any questions, please discuss with your therapist or call our office at 858-277-7907.

For all segments below, it is understood that if the client is a minor, the parent/legal guardian will be the responsible party accordingly.

Authorization for Evaluation and/or Treatment Initials_____
This is to authorize Family Forces, to evaluate and/or treat the client named above. The client understands and agrees that the treatment process may involve other members of the family and the exchange of information with other agencies and individuals with a signed release of information form. The client's privacy will be treated with utmost professionalism and respect. To provide the best quality of services possible, it is sometimes helpful for the therapist to consult with other professionals regarding a client's case. It is necessary to receive client's permission to discuss the case with other professionals, but refusal to give permission will not in any way interfere with receiving therapy services.

Insurance Notification Initials_____
If the client has other insurance coverage in addition to TRICARE, the additional carrier is their primary insurer. This will affect client's benefits and may lead to denial of claims that will become client's financial responsibility. If at any time, the client becomes covered by any insurance other than TRICARE, it is the client's responsibility to notify both Family Forces and TRICARE. Failure to notify us of any change in insurance coverage can cause client to be financially liable for the services provided by Family Forces.

No Show Policy Initials_____
We request at least 24hr notice if the client is unable to attend a session and needs to cancel or reschedule. Client can notify us by either calling the therapist or the scheduling office at 858-277-7907. Failure to do so will result in a no show fee of $60.00.

Limits of Confidentiality Initials_____
State and federal laws that govern the conduct of mental health professionals, mandates us to report suspicion of abuse of a child, disabled person or senior. Additionally, we are mandated by law to report when a client is in imminent danger of hurting him/herself of another person, in order to protect the individual who is at risk of being harmed.

Client Email/Text Informed Consent Initials_____
Transmission of information by email and/or text is not a secure form of communication and can compromise the confidentiality of the data exchanged. Client should take this into consideration prior to use of these forms to communicate with the therapist and other staff involved in their care. We cannot guarantee security and confidentiality of email and text information sent and received but will use reasonable means to do so. We are not liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Additionally, email and/or text is not appropriate for urgent or emergency situations. If such situations arise, please call 911 or the access and crisis line at 1-888-724-7240.

I, the undersigned, have read and understand the Statement of Understanding and agree with the information presented.

Client/Parent/Guardian Name	Client/Parent/Guardian Signature	Date

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Notice of Privacy Practices

This notice describes how health and mental health related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. General Information

Information regarding your treatment, including payment for treatment, is protected by federal law under the Health Insurance Portability and Accountability Act (HIPAA).

Generally, you must sign a written authorization before we can share your information. However, federal law permits Family Forces to disclose certain information *without* your written permission. We typically use or share information in the following ways:

1. To treat our clients.
2. To run our organization.
3. To help with public health and safety issues.
4. For research, audits, or evaluations.
5. To third party payors, other persons, or organizations to process insurance claims.
6. To comply with the law including Department of Health and Human services as well as other law enforcement agencies to report suspected abuse, neglect or domestic violence or to when a client presents an imminent danger to self or others.
7. To medical personnel in a medical emergency.
8. To a protection and advocacy agency to protect rights of certain individuals.
9. Basic demographic information only to a disaster relief organization for response to disaster welfare inquiries.

II. Your Rights

You have the right to inspect and ask for a copy your treatment information maintained by us, unless that information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances. We might charge a reasonable fee for copies as allowed by law.

You can ask us to contact you in a specific way (such as home of office phone) or to send mail to a different address and we will honor all reasonable requests. Under HIPAA, you have the right to request restrictions on certain uses and disclosures of your treatment information. Family Forces is not required to agree to any restrictions you request if it would affect your care.

You have the right, with some exceptions, to amend treatment information maintained in Family Forces' records, and to request an accounting of disclosures of your treatment related information made by Family Forces during the six (6) years prior to your request. We will include all disclosures except those made for treatment, payment, and healthcare operations, and certain other disclosures such as any that you have asked us to make. We will charge a reasonable fee when 2 or more accountings are requested within 12 months.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

You also have the right to receive a paper copy of this notice.

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III. Our Duties and Responsibilities

Family Forces is required by law to maintain the privacy of your treatment information and to provide you with notice of its legal duties and privacy practices with respect to your treatment information. We will not use or share your information other than as described here unless you tell us we can in writing. You must let us know in writing if you want to stop sharing your information that you have authorized.

Family Forces is required by law to abide by the terms of this notice. Family Forces reserves the right to change the terms of this notice and to make new notice provisions effective for all protected treatment information it maintains. You have the right to receive a paper copy of the new notice and we will make it available to you to review and sign.

IV. Complaints and Reporting Violations

You can file a complaint if you feel we have violated your rights by contacting us using the contact information listed at the end of this document. You can also file a complaint with the U.S. Department of Health and Human Services office for Civil Rights. We will not retaliate against you for filing a complaint.

All complaints will be logged and reviewed within thirty (30) days of receipt by the Privacy Official. You will not be retaliated against for filing a complaint.

V. Contact

For further information, contact:

Family Forces, Inc.
Attn: Privacy Official
13223 Black Mountain Rd, Suite 239
San Diego, CA 92129
Tel: (858) 277-7907

VI. Effective Date and Duration of This Notice

This Notice is effective on January 1, 2018

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have been offered a copy of the Family Forces Notice of Privacy Practices. I have been given the opportunity to review the notice and am aware that if I have any questions related to the notice, I may contact the program directly or the Chief Compliance Officer for clarifications.

For further information please contact:
Family Forces, Inc.
Attn: Chief Compliance Officer
13223 Black Mountain Rd,
Suite 239
San Diego, CA 92129
Tel: 858-277-7907

_____	_____	_____
Client/Parent/Guardian Name	Client/Parent/Guardian Signature	Date

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Authorization for Release/Disclosure of Client Protected Health Information (PHI)

Full Name (Please Print)	Client Number	Date of Birth

Address

Phone Number	Alias

I authorize the use and/or disclosure of my protected health information (PHI) contained in my clinical and billing records by Family Forces to the following:

Name/Agency: _____
Address: _____
Phone Number: _____
Fax Number: _____

The disclosure of PHI authorized here is required for the specific purpose of: _____

The following information may be disclosed: (*client must initial each item checked)*

☐ Mental Health Assessment	____	☐ Diagnosis	___
☐ Client Plan/Service Plan	____	☐ Billing Records	___
☐ Progress Notes	____	☐ Summary of Services/Treatment	___
		☐ Other (describe):	

PHI includes health information created by Family Forces, health information collected from me, or health information received by Family Forces from another health care provider or health plan used in the development of treatment. PHI may relate to my past, present, or future physical or mental health condition. I understand that the information in my records authorized for disclosure may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

I understand that my alcohol and drug treatment records are protected by the Federal Regulations governing Substance Abuse Patient Records (42 CFR, Part 2) and HIPAA (45 CFR, 160 & 164) and cannot be released without my specific written authorization unless the disclosure is authorized by these regulations.

Re-disclosure: I understand the Family Forces cannot guarantee the recipient of this information will not re-disclose my PHI to a third party. The recipient may not be subject to federal laws governing privacy of health information. California law generally prohibits recipients of my PHI from re-disclosing such information except with my written authorization or as specifically required or permitted by law. I further understand that any person/agency who has received any information related to alcohol and/or drug assessment, treatment, or referral program information shall not make another/any further release/disclosure

of this information unless expressly/specifically permitted by my written consent as allowed by Federal law/rule (42 CFR, Part 2). A general authorization of medical or other information is NOT sufficient for this purpose. Lastly, the Federal laws/rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

My Rights:
I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization; I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in Code of Federal Regulations (45 CFR, § 164.524).

I have a right to receive a copy of this authorization.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing to Family Forces 13223 Black Mountain Rd, Suite 239, San Diego, CA 92129. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: This Authorization will remain in effect until (insert date): _____

I agree that a photocopy or fax of this authorization will be as effective as the original.

I have read and understand the terms of this Authorization, had the opportunity to ask questions about the use and disclosure of my health information, and I hereby, knowingly and voluntarily, authorize the Family Forces listed program to use or disclose my health information in the manner described above for the purpose outlined.

Client/Parent/Guardian Name	Client/Parent/Guardian Signature	Date

Witness Name	Wittness Signature	Date

☐ Authorization revoked on _____ for the reason _____