SOCIAL SKILLS DEVELOPMENT CENTER

Specializing in teaching social skills to children, teens and young adults

SOCIAL SKILLS DEVELOPMENT CENTER
TELEPHONE RELEASE

_____ is currently attending the Social Skills
First and Last Name
Development Center PEERS Program to enhance appropriate peer social behavior. An integral aspect of this program is the communication with other clients outside of the Social Skills Development Center setting.

I hereby give permission for my son/daughter to exchange our telephone number with other group participants so they may contact each other during the week as directed by the group leader.

I understand that the group participants are involved in a learning process and may not appropriately use the telephone.

I agree on behalf of myself and my son/daughter to hold harmless Social Skills Development Center, its employees, and agents from any injury or damage that arises or is alleged to arise from the disclosure of our telephone number.

_____ ( )_____
Parent/Guardian Printed Name Phone Number to Use

_____ _____
Parent/Guardian Signature Date

Phone: (714) 658-0797

E-mail: lisap@socialskillsdevelopmentcenter.com

17284 Newhope Street, Suite #211
Fountain Valley, CA 92708
www.socialskillsdevelopmentcenter.com

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OFFICE POLICIES AND PROCEDURES

Please read and initial each section

_____ **Financial Terms**: Services are $1,500 for the 14-week intervention and includes intake appointment. If services are not contracted, the intake appointment will be billed at $125 and payable at time of intake. This amount can be applied towards a future class as long as enrollment takes place within one year of intake.

_____ **Payment in full** is due prior to the beginning of the 14-week intervention.

_____ **Cancellations/Missed Sessions**: Since this is a 14 consecutive week intervention program, there are no cancellations or make-up classes offered. Please make arrangements to attend each class as scheduled.

_____ **Tardiness policy**: Please be on time for each class as sessions will begin promptly.

_____ **If the Client is a Minor**: Both parents agree to treatment especially in the case of divorce or separation, unless treatment is court ordered.

I understand and agree to above:

_____ _____

Client's Signature (parent/guardian if Clients is a minor) Date

_____ _____

Social Skills Development Center Signature Date

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CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Social Skills Development Center (SSDC) is a parent-assisted intervention focusing on children who are having difficulty making or keeping friends. Our program is in accordance with California State law. California law requires that therapy relationships be both professional and confidential. What is revealed in therapy is protected by legal, professional and ethical standards such that, with a few exceptions, all material is confidential and not released without your consent. Ethically and legally, however, there are some circumstances in which confidentiality must be broken. Failure to report these incidents will result in a therapist losing her license, paying a large fine, and/or imprisonment. These limitations are as follows:

All information between SSDC and client is kept strictly confidential unless:

1. You authorize the release of information with your signature.
2. You present a danger to self.
3. You present a danger to others.
4. Child or elder abuse if suspected by SSDC.

In the latter two cases, SSDC is required by law to inform potential victims and proper authorities so that protective measures can be taken.

I have read the above and understand the concept of confidentiality and the limits of confidentiality.

_____ _____

Client's Signature (parent/guardian if client is a minor) Date

_____ _____

SSDC's Signature Date

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NOTICE OF PRIVACY PRACTICES

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

How this psychotherapy practice may use or disclose mental health information

This psychotherapy practice collects mental health and related identifiable client information (such as billing information, referral, and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. This information is considered "protected health information" under the HIPAA Privacy Rule. The law permits us to use or disclose mental health information for the following purposes without the patient's written authorization:

Treatment – We use mental health information to provide care. We disclose this information to our employees and others who are involved in providing the care our clients need.

Health Care Operations – We may use and disclose information to obtain payment for the services we provide. For example, we give your name, address, and financial information to our billing service if you use a credit card, debit card, or electronic check for payment.

Required by Law – As required by law, we will use and disclose our client's mental health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report child or elder abuse, neglect, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with their requirements. We may and are sometimes required by law to disclose our clients' personal and mental health to public health agencies in the instances of neglect, child or elder abuse, or if the client presents as a danger to self or others.

When this psychotherapy practice may not use or disclose mental health information

Except as described in our Notice of Privacy Practices, this psychotherapy practice will not use or disclose personal or mental health information which identifies individual clients without their written authorization. If a client authorizes this psychotherapy practice to use or disclose this information for another purpose, the client may revoke the authorization in writing at any time.

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Our Client's Mental Health Information Rights

Right to request special privacy protections – Our clients have the right to request restrictions on certain uses and disclosures of their mental health information, by a written request specifying what information they want to limit and what limitations on our use or disclosure of that information they wish to have imposed. We reserve the right to accept or reject these requests and will notify each client of our decision.

Right to request confidential communications – Our clients have the right to request that they receive their mental health information in a specific way or at a specific location (i.e. an email address or work address). We will comply with all reasonable requests submitted in writing which specify how or where they wish to receive these communications.

Right to inspect and copy – Our clients have the right to inspect and copy their mental health information, with limited exceptions. To access their information, they must submit a written request detailing what information they want access to and whether they want to inspect it or get a copy of it. We will respond to every written request within the time (2 weeks) required by California and federal law. We may deny requests under limited circumstances. The client has a right to appeal this decision.

Right to amend or supplement – Our clients have the right to request in writing that we amend any information that they believe is incorrect or incomplete. The request must include the reasons for the change. We are not required to make the requested changes, but if we refuse, the client will be provided with an explanation of this psychotherapy practice's denial and how they can disagree with the denial. Reasons for a denial may include lack of information, if we did not create the information, if the person who created the information is no longer available to make the amendment or if the information is accurate and complete as is. Our clients also have the right to request that we add to their record a statement of up to 250 words concerning any statement or item they believe to be incomplete or incorrect.

Right to an accounting of disclosures – Our clients have a right to receive an account of disclosures of their information made by this psychotherapy practice with their written authorization. This practice does not have to account for disclosures for the following: disclosures for purposes of research or public health which exclude direct patient identifiers, disclosures permitted or authorized by law, or disclosures to a health oversight agency or law enforcement official by written notice or subpoena without which would be reasonably likely to impede their activities.

Right to a paper copy of notice of privacy practices – Our clients have a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email.

Minimum necessary use and disclosure of Protected Mental Health Information (PMHI)

It is the policy of this psychotherapy practice that all routine and recurring uses and disclosures of PMHI (except for treatment purpose, to or as authorized by the client or as required by law for HIPAA compliance) must be limited to the minimum amount of information needed to accomplish the purpose of use or disclosure.

Verification of identity – It is the policy of this psychotherapy practice that the identity of all persons who request access to PMHI be verified before such access is granted.

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that I have received a copy of Notice of Privacy Practices. The information contained in the document has been explained to me, and I understand that I may ask questions about it, and my rights, at any time.

_____ _____

Client's Signature (parent/guardian if client is a minor) Date

_____ _____

Printed name of person signing above Relationship to Client

_____ _____

Social Skills Development Center Signature Date

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