ELIZABETH RONA L.M.F.T. S.E.P.
Licensed Individual Marriage and Family Therapist
SOMATIC EXPERIENCING® and EMDR

Disclosure Statement & Agreement for Services

Greetings. I have been a licensed (No. M13521) Marriage and Family Therapist since 1981. I received my Masters in Counseling Psychology from Loyola Marymount University. I am a Somatic Experiencing Practitioner (SEP), Interpersonal Neurobiology (IPNB) specialist, as well as a Certified EMDR Therapist. I am fluent in English, Spanish and German. I work with individuals, couples and families.

My profession requires that I make you aware of specific policies. If you have any questions after reading this form, please address them with me.

ABOUT THE PSYCHOTHERAPY PROCESS

My approach to therapy is rooted in neurobiology and integrates Somatic Experiencing® and EMDR into "talking therapy." I focus on how both suffering and a sense of well being influence the Mind-Body-Spirit connection. I will help you identify, regulate and manage feelings that overwhelm you and negatively affect your thoughts, moods, and attitudes, and that, in turn, lead to unwanted behavior.

During the course of therapy, I will draw on various psychological approaches according, in part, to the issue that is being treated and my assessment of what will best benefit you. These approaches may include Somatic Experiencing, EMDR, Interpersonal Neurobiology (IPNB), developmental attachment, cognitive-behavioral, existential, system/family, family constellation, meditation, ego states and Dialectical Behavioral Therapy (DBT).

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

Most of the provisions explaining when the law requires disclosure are described to you in the *Notice of Privacy Practices* starting on page one. Generally, there are four situations in which confidentiality does not exist: (1) if you sign a consent to release the information, (2) if you become a danger to yourself, (3) if you become a danger to others, and/or (4) during cases of child, elder, or dependent adult neglect or abuse.

Professional Records

The laws and standards of my profession require that I keep treatment records. If you wish to see records, please make an appointment to go over them together.

Marriage/Couples Counseling

If you are participating in marriage or couples counseling with me, your relationship is what I am focusing on. Anything you say to me in one-to-one conversations will not be considered confidential from your partner. Anything you say in a one-on-one session is for the benefit of your processing your own experience so that you can bring that clarity into your partner work.

If you are coming for marriage or couples counseling, I encourage you to include your partner in all correspondences with me. I can meet with you individually, however it is important to remember that it is part of our group therapy and not considered confidential from your partner.

If a legal case emerges, both parties must sign an *Authorization for Release of Information* form for release of records. It am not available to testify or provide forensic evidence on behalf of one or the other counseling participants.

Minors and Confidentiality

Communications between clients who are minors (under the age of 18) and myself are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in such treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment progress of a minor client with the parent or guardian. Clients who are minors and their parents are urged to discuss any questions or concerns that they may have on this topic with me.

Initial _____

Telephone conversations with other professionals, site visits, report writing and reading, release of information, longer sessions, travel time, etc. will be charged at the same rate.

Initial _____

Videoconferencing AKA Telehealth or Remote Individual and Group Sessions

If our session is interrupted for technical reasons, we will continue our session via online video through https://signal.org/. You must sign-up for this service in order for us to confidentially communicate. Signal https://signal.org/ is an encrypted app that is HIPPA compliant and confidential. Look for **+1 (818) 445-8255** under my name: Elizabeth Rona.

Emergencies

If you urgently need to set up an appointment, please call or text me. **Your call or text will be returned within 48-hours. If it cannot wait please call 9-1-1 or go to your nearest emergency room or 877-7CRISIS.**

Initial _____

Appointment Scheduling and Cancellation Policies

Appointments are arranged at pre-scheduled times and, unless otherwise arranged, last fifty (50) or ninety (90) minutes depending what we arrange. Since the appointment reserves a time specifically for you, **a minimum of 24-hours notice is required for rescheduling or canceling an appointment**. **Monday appointments require 72-hours notice. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.** Insurance companies do not reimburse for missed sessions.

Initial _____

The best way to reschedule or cancel an appointment is via email, phone call or text https://signal.org/**. If you are canceling with greater than 48-hour notice, you may email me with the subject line "cancellation" or "reschedule."** If you do not receive acknowledgment from me, assume I did not receive your email and follow-up with a text.

Initial _____

Payments

Payment for all services are due prior to each session, you have the option to five or ten sessions at a time. We will establish a fee for your sessions, prior to our first meeting.

Payment for tele-sessions or in-person appointments are due PRIOR to each session, you will receive an email confirming your appointment and a meeting link along with an invoice. I do not take insurance directly, however, I can provide a statement for your insurance purposes. Upon payment you will receive a paid statement for your insurance purposes.

Failure to make prior payment, will waive your guaranteed appointment time. Failure to make payment for services is subject to a break in confidentiality by having to report a client's account to a collections agency.

Initial _____

Email and Texting Guidelines

1. TEXTS ARE FOR: Scheduling, canceling, or modifying an appointment or to notify me if you are running late only.
2. CELL CALLS: if your running late to your appointment and cannot text, or to set-up an appointment, or any situation requiring my immediate assistance.
3. EMAILS ARE FOR: Accounting inquiries and/or requesting an appointment 48-hours in advance. Emails are not for emergency or time-sensitive situations.
4. I do my best to respond to texts and emails in timely fashion. It is understood that if you do not hear from me within 48-hours, please attempt to reach me again. If it is an emergency, call 9-1-1 or go to your nearest emergency room.
5. With your written authorization, emails may be forwarded to other members of your health care team and becomes part of your patient electronic chart.
6. I use a secure server, however, it is understood that email and regular cell phones are unencrypted may be intercepted. Internet may be intercepted. By signing below, you request and agree to such digital communication.

Initial _____

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF MY COMMUNICATIONS FOR TREATMENT ON MY OWN ELECTRONIC DEVICES AND IN MY OWN PRIVATE LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services.

I agree to receive on-line therapy services and authorize Elizabeth Rona, LMFT, to provide such care. I understand that I am free to withdraw consent for such services at any time.

By signing this Informed Consent "I" the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____

Signature Date Signature Date

_____

Name Parent/Guardian/Legal Representative

_____

Signature (if minor or needed otherwise)

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. We will discuss a plan for termination as you approach the completion of your treatment goals. If either one of us determines that you are not benefitting from the treatment, either of us may elect to initiate a discussion of treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Mediation and Arbitration

Any dispute arising in relation to our working relationship shall first be discussed as a precondition to initiatiating arbitration. The mediator shall be a neutral third party chosen by agreement of you and myself. In the event that mediation is unsuccessful, any unresolved controversy related to our working relationship should be submitted to and settled by **binding** arbitration in Los Angeles County, in accordance with the rules of the American Arbitration Association. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine the sum.

***Your signature indicates that you have read this full agreement for services carefully and agree to its contents. Please ask me to address any questions or concerns that you have about this information before you sign.**

Name(s) of Client or Guardian

*Name(s) of Responsible Parties for Payment

1. Signature DOB Date

Client Home Address Email Address

Home Phone Cell

Emergency Contact Name

2. Signature DOB Date

Client Home Address Email Address

Home Phone Cell

Emergency Contact Phone

**Please circle your preferred number and means of communication.*

ELIZABETH RONA L.M.F.T. S.E.P.
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HIPAA - Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

I am legally required to inform you in writing of how I will protect the privacy of your Protected Health Information (PHI), which includes information that I have created or received about your past that can be used to identify: present, or future health condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I 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. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it on my website at www.elizabethrona.com.

III. HOW I MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

For some of the uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care 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 physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are 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.
2. **To obtain payment for treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services

that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

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 the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I am complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to:

1. Government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** E.g., I may have to report information about you to the county coroner.
3. **For health oversight activities.** E.g., I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
5. **For specific government functions.** I may disclose the PHI of military personnel and veterans in certain situations. I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
6. **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** It may be necessary to disclose a part of your PHI if you indicate that a family member/friend or other is involved in your care or in the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III - A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING 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 that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so 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. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $1.00 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the 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 will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list rendered will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the 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 based fee for each 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 request that I correct the existing information or add the missing information. You must provide the request and your 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 if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, and/or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that 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 of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES .

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint in writing and send the complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

Your signature indicates that you have read this full agreement for services carefully and agree to its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge **receipt** of the Notice of Privacy Practices that I provided. The Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

If you have any questions about my Notice of Privacy Practices, please contact me at +1 (818) 445-8255 through https://signal.org/.

I acknowledge receipt of the Notice of Privacy Practices of Elizabeth Rona, LMFT, SEP.

Name

Signature Date

Name of Client

Signature Date

EFFECTIVE DATE OF THIS NOTICE FEBRUARY 03, 2022.

ELIZABETH RONA L.M.F.T. S.E.P.
Licensed Individual Marriage and Family Therapist
SOMATIC EXPERIENCING® and EMDR

Patient Information

Name_____ DOB_____

Address_____

Phone Number_____ Prefered Phone Number_____

Email Address _____

Occupation/Employment Status _____

Spouse/Guardian_____

Name Phone Number

Emergency Contact_____

Name Phone Number

Primary Physician_____

Name Phone Number

How were you referred?_____

Person Financially Responsible _____

Relationship

Address_____ Phone_____

Patient/Guardian _____

Signature_____

What issues/concerns have resulted in your seeking therapy at this time?_____

_____

Goal for psychotherapy?_____

Have you ever had the same or similar condition? ____Yes ____No

If yes, when and describe_____

_____

What attempts have previously been made to resolve this issue?_____

_____

Family history of mental health or substance abuse? ____Yes ____No If yes, when and describe

_____

Regular Physical Activity/Body Work_____

Signature_____Today's Date_____

Signature_____Today's Date_____

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