



Address: 5 Governors Ln. Suite 150  
Phone: 530-228-6301  
Fax: 530-898-9008  
Email: lisa@lisajellisonlcsw.com

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## Office Policies & Consent to Psychotherapy Services

Welcome and thank you for choosing Lisa Jellison, LCSW & Associates. The purpose of the Office Policies and Consent to Psychotherapy Services is to inform you of office policies, state and federal laws, and your rights. If you have any questions, please contact Lisa Jellison, LCSW & Associates at 530-228-6301.

**THE PROCESS AND SCOPE OF THERAPY:** Participation in psychotherapy can result in a number of benefits to you, including improvement in the areas of concern that led you to seek therapy. Psychotherapy provides the most benefit with your consistent involvement and active participation. There is no guarantee that psychotherapy will result in desired changes. Lisa Jellison, LCSW & Associates does not provide custody evaluation recommendation nor legal advice, as these do not fall within Lisa Jellison, LCSW & Associates scope of practice.

**CHILDREN OF SEPARATED PARENTS:** In such cases where the parents of a minor are separated or divorced, court rulings regarding custody may limit the rights of either parent to participate in psychotherapy without the consent of the other parent. Signing this consent for psychotherapy services indicates that you either a) have the consent of the other parent to have your child participate in psychotherapy services, or b) that you have the sole legal right to bring your child to psychotherapy.

**CONFIDENTIALITY:** The information disclosed in psychotherapy sessions, and the written records related to those sessions, are confidential and may not be shared with anyone without your written permission. Exceptions to this are where disclosure is required by law, which is further detailed on pg. 5 (*HIPAA: Health Insurance Portability and Accountability Act*). In order to process claims, disclosure of confidential information may be required by your health insurance or third party payer of psychotherapy services (e.g., EAP). . Lisa Jellison, LCSW & Associates has no control over what your insurance company or third party payer does with this information.

**RECORDS AND YOUR RIGHT TO REVIEW THEM:** Lisa Jellison, LCSW & Associates retains clinical records only as long as is mandated by law. You have the right to request your records at any time, with the exception of legal or emergency circumstances, or if your therapist assesses that releasing such information would be harmful in any way. If more than one client is involved in treatment – such as in cases of couples/marital/family therapy – your therapist will release records only after obtaining signed consent from all involved parties involved in the treatment.



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**PAYMENT:** The current standard fee is \$120.00 per 53-60-MINUTE SESSION. Payment/co-payment/co-insurance is collected at each session. Please note that Lisa Jellison, LCSW & Associates reassesses session fees every 12 months. If you are using your insurance benefits, by signing this agreement, you agree to pay for any outstanding costs of psychotherapy in the event that services are not covered by your insurance. Please inform your therapist if any problems arise regarding your ability to make payments. If for any reason your account is overdue, Lisa Jellison, LCSW & Associates may use legal or other means to obtain payment. Prior to using these means, Lisa Jellison, LCSW & Associates will make reasonable attempts to communicate with you to collect payment.

**HEALTH INSURANCE:** It is your responsibility to contact your health insurance company and fully understand your benefits prior to scheduling therapy. Please be aware that not all issues addressed in psychotherapy are reimbursed by insurance companies.

**LITIGATION AND COURT APPEARANCES:** Client records are generally kept confidential and private in nature. In circumstances where you become involved in litigation, it is possible for you or attorneys to request psychotherapy records. The client-therapist relationship is built on trust and confidentiality, and it can be damaging to the therapeutic relationship for the therapist to be asked to present records to the court, or to testify, whether factual or in an expert nature, in court or in a deposition. It should be noted that consequences may result from disclosing information to the legal system and may negatively affect the outcome of custody disputes or other legal matters. In order to protect the therapeutic relationship, it is asked that you request a court appearance only in extreme cases. In the event where the therapist is requested to testify, whether the testimony is factual or expert, or to present records pertaining to the therapy relationship, you agree to pay the fees for these services at a rate of \$150.00 per hour, rounded to the nearest half hour. Fees for court and legal-related matters include appearances and preparation, which includes but is not limited to, travel, phone calls, copies, meals, and other necessary expenditures.

**PREPARATION OF FORMS AND REPORTS:** Should you request forms or reports to be completed on your behalf, your therapist will assist you in the process, if appropriate. This requires that your therapist reviews your chart and the process often requires further discussion and collaboration with you. By requesting your therapist to assist you with forms or reports to be completed on your behalf, you agree to pay the fees for these services at a rate of \$150.00 per hour, rounded to the nearest half hour.

**CONSULTATION:** In order to provide quality care, your therapist may consult with other professionals regarding your treatment. Client identity remains anonymous and confidentiality is fully maintained.



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**ELECTRONIC COMMUNICATION:** Due to the nature of technology, emails, texts, phone calls, voicemails, and faxes can be accessed by unauthorized persons. Please inform your therapist if you do not wish to communicate via these means. If you provide your contact information and use these means to communicate with your therapist, Lisa Jellison, LCSW & Associates assumes that you have made the informed decision to communicate in this form.

**SOCIAL MEDIA:** The following policies are to help ensure the privacy of clients and protect the relationship between client and therapist.

*Liking and Following:* Lisa Jellison, LCSW & Associates currently does not have a social media presence on any social media platforms. Please be informed that Lisa Jellison, LCSW & Associates will not follow you back on any social media sites in order to protect your confidentiality.

*Friend Requesting:* Accepting friend requests via social media sites can compromise your confidentiality and may blur the boundaries of the professional relationship. Friend requests from current clients on any social networking sites are not accepted.

*Location-Based Services:* Please be aware that “checking in” to location-based sites from the therapy office may jeopardize your privacy.

*Business Review Sites:* You may find Lisa Jellison, LCSW & Associates on business review sites (e.g., Google, Healthgrades, Yelp). You have the right to express yourself on any site you wish. To protect your confidentiality, Lisa Jellison, LCSW & Associates is limited in its ability to respond and is unable to see all comments in a timely fashion. If you have concerns regarding your experience or care with Lisa Jellison, LCSW & Associates, you are encouraged to bring this up with your therapist.

**AUDIO / VIDEO RECORDING:** Unless otherwise agreed upon by all participating parties beforehand, audio or video recording of therapy sessions, phone calls, or any other services provided by Lisa Jellison, LCSW & Associates is not allowed.

**EMERGENCY PROCEDURES:** If you need to contact your therapist between sessions for non-emergencies, please leave a message at the Lisa Jellison, LCSW & Associates business line, 530-228-6301 or email at [lisajellisonlcsw@sbcglobal.net](mailto:lisajellisonlcsw@sbcglobal.net). Your message will be returned as soon as possible. If an emergency situation arises, you may contact the 24-hour National Suicide Prevention Lifeline at 800-273-8255 or Enloe Behavioral Health at 530-332-5250. In the event of an immediate emergency, call 911 or go to your nearest emergency room.



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**TERMINATION:** Throughout the course of psychotherapy, your therapist will continuously assess if psychotherapy is of benefit to you. If at any point during therapy your therapist determines that therapy is not effective, your therapist may discuss termination of therapy. You have the right to terminate therapy at any time.

*Your signature below indicates that you agree to the above terms, that you have the legal authority to make medical and legal decisions for this client, and that you consent to psychotherapy services with Lisa Jellison, LCSW & Associates.*

\_\_\_\_\_  
Client / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client / Legal Guardian Printed Name

\_\_\_\_\_  
Child Printed Name (if applicable)

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

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## Health Insurance Portability & Accountability Act (HIPAA)

### *Client Rights & Therapist Duties*

This document contains important information about federal law and the Health Insurance Portability and Accountability Act (HIPAA), which provides privacy protections and reviews patient rights regarding the use and disclosure of Protected Health Information (PHI). PHI constitutes information that can be used to identify you, and is used by Lisa Jellison, LCSW & Associates for treatment, payment, and healthcare provisions.

Lisa Jellison, LCSW & Associates is legally required to safeguard your PHI and provide you with a Notice of Privacy Practices. This Notice describes how, when, and why your information may be used and disclosed, and explains how you can obtain access to this information. The law requires that Lisa Jellison, LCSW & Associates obtains your signature as an acknowledgement that you have received this Notice. If you have any questions or concerns, it is your right and responsibility to ask your therapist so that this can be addressed prior to you signing this document. Signing this document represents an agreement between you and Lisa Jellison, LCSW & Associates. You may revoke this agreement in writing at any time.

While it is Lisa Jellison, LCSW & Associates legal obligation to protect your PHI, there are certain circumstances where Lisa Jellison, LCSW & Associates is either permitted or obligated to use or disclose your PHI without your authorization. An explanation of privacy practices and your rights are detailed below. Please review it carefully.

- I. Use and disclosure of your PHI relating to treatment, payment, or operations do not require your prior written consent:
  - a. *Treatment*: your health information will be used and disclosed internally for the purposes of providing and managing your treatment. For external communication regarding coordination of your healthcare, your therapist will have you sign an Authorization for Release of Information.
  - b. *Payment*: your health information may be used and disclosed to bill and collect payment for treatment services. For example, this may include communication with insurance companies, third party payers (e.g., EAPs), and payment services.
  - c. *Healthcare operations*: your health information may be used and disclosed for necessary operations or services within this practice. For example, this may include quality assessment, case consultation, and care coordination.

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- II. Use and disclosure of your PHI not requiring your consent in which Lisa Jellison, LCSW & Associates is either permitted or required to disclose information:
- d. *Public health activities*
  - e. *Health oversight activities*
  - f. *Research purposes*
  - g. *Workers' compensation*
  - h. *Court and legal proceedings*
  - i. *Other legal proceedings involving Lisa Jellison, LCSW & Associates*
  - j. *When required by federal, state, or local law:*
    - i. *If your therapist has reason to suspect, or become aware, that you may be a danger to yourself or a reasonably identifiable other; your therapist is required by law to report this to the appropriate authorities.*
    - ii. *If your therapist has reason to suspect, or become aware of, child abuse or neglect; your therapist is required by law to report this to the appropriate authorities.*
    - iii. *If your therapist has reason to suspect, or become aware of, neglect of a vulnerable adult; your therapist is required by law to report this to the appropriate authorities.*
- III. PATIENT RIGHTS
- You have:
- a. *The right to treatment.* You have the right to ethical treatment without discrimination regarding gender, ethnicity, race, religion, sexual orientation, disability status, age, or any other protected category.
  - b. *The right to request limits on the use and disclosure of your PHI.* You do not have the right to request restrictions regarding the uses and disclosures that your therapist is legally required, or permitted, to make.
    - i. If you receive psychotherapy services out-of-pocket, you may ask that your therapist not share PHI with your health insurer, and this request will be granted, unless otherwise required by law.
  - c. *The right to choose someone to act on your behalf.* You have the right to have your legal guardian exercise your rights and make choices regarding your health information.
  - d. *The right to request and obtain copies of your PHI.* You must make this request in writing and allow your therapist reasonable time to respond to your request. Under certain circumstances, your therapist may deny your request, which would be discussed with you. In some cases, you have the right to review this decision.



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- e. *The right to request how you receive your PHI.* You have the right to receive your PHI by alternative means and at alternative locations, provided the request can be completed without undue convenience.
- f. *The right to receive a copy of this notice.* You have the right to obtain a copy of this notice via paper or electronic form.
- g. *The right to amend.* If you believe that the information in your records is incorrect, or that important information has been omitted, you have the right to request that your therapist make certain changes. This request must be in writing and you must provide the reason for the requested changes. Your therapist has the right to determine if the requested changes are appropriate.
- h. *The right to receive notice of breach.* You have the right to be notified in the event of a breach involving your PHI.
- i. *The right to terminate.* You have the right to terminate therapy at any time.

IV. THERAPIST DUTIES

- V. Your therapist is legally required to protect your PHI and provide you with a Notice of Privacy Practices. Your therapist reserves the right to change the terms described in this notice. In the event that your therapist makes revisions, you will be provided with an updated Notice of Privacy Practices. Your therapist is required to abide by the most current terms in effect.

VI.

- V. WHOM TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO MAKE A COMPLAINT ABOUT Lisa Jellison, LCSW & Associates PRIVACY PRACTICES  
If you have any questions or complaints about this notice, you may contact me by phone at 530-898-9008 or email lisajellisonlcsw@sbcglobal.net. You may also contact the California Department of Health or the Secretary of the U.S. Department of Health and Human Services.

*Your signature below serves as an acknowledgement that you have received the above HIPAA notice form, that you have read this agreement, and that you agree to its terms.*

\_\_\_\_\_  
Client / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client / Legal Guardian Printed Name



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## Child Intake Questionnaire

Today's Date: \_\_\_\_\_

### Child Information

Child Name (full): \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Gender: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Client Address: \_\_\_\_\_

Phone (if applicable): \_\_\_\_\_ Email (if applicable): \_\_\_\_\_

### Family Information

1. Legal Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Ok to leave a message (circle one)? Yes No

Email: \_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_

2. Legal Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Ok to leave a message (circle one)? Yes No

Email: \_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_

Do both parents have legal custody (circle one)? Yes No

If no, please describe custody arrangement: \_\_\_\_\_

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*Other caregiver(s), guardian(s), stepparent(s):* \_\_\_\_\_

\_\_\_\_\_  
*Please describe child's current living situation:* \_\_\_\_\_

\_\_\_\_\_  
*Siblings/other children living in the household (names/ages/relationship):* \_\_\_\_\_

\_\_\_\_\_  
**Education and Extracurricular Activities**

*Current school:* \_\_\_\_\_

*Current grade:* \_\_\_\_\_

*Previous school(s):* \_\_\_\_\_

\_\_\_\_\_  
*General school performance (grades, teacher feedback):* \_\_\_\_\_

\_\_\_\_\_  
*Education services in place (504 / IEP Plan):* \_\_\_\_\_

\_\_\_\_\_  
*Extracurricular activities:* \_\_\_\_\_

\_\_\_\_\_  
**Social / Cultural**

*Please describe any spiritual, religious, and/or cultural practices, customs, or beliefs:* \_\_\_\_\_

\_\_\_\_\_  
*Please note any concerns or recent changes regarding your child's social relationships  
(friendships, romantic relationships, etc.):* \_\_\_\_\_



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## Medical History

Primary care physician: \_\_\_\_\_

Name of hospital/clinic: \_\_\_\_\_ Last exam: \_\_\_\_\_

Past/present medical care (major medical issues, accidents, hospitalizations): \_\_\_\_\_

\_\_\_\_\_

Identified Disabilities: \_\_\_\_\_

Is your child currently taking medication? If so, please list the name, dose, prescriber, and date prescribed: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

## Mental Health History

Past or present counseling/mental health services/mental health hospitalizations:

1. Therapist/Location: \_\_\_\_\_ (dates) From \_\_\_\_\_ To \_\_\_\_\_

Initial concern: \_\_\_\_\_

Outcome of care: \_\_\_\_\_

2. Therapist/Location: \_\_\_\_\_ (dates) From \_\_\_\_\_ To \_\_\_\_\_

Initial concern: \_\_\_\_\_

Outcome of care: \_\_\_\_\_

Previous mental health concerns and/or mental health diagnoses (please include name of diagnosing provider and child's age of diagnosis): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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### **Additional Questions**

*1. Has your child experienced significant loss or trauma? Please explain below:*

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*2. Does your child have current, or a past history, of self-harm or suicidal ideation? Please explain below:*

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*3. Does your child have current, or a past history, of substance use? Please explain below:*

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*4. Are there current significant family stressors at this time? Please explain below:*

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*5. Is there a history of mental health/substance use in your child's family? Please explain below:*

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*6. What is prompting you or your child to seek therapy at this time? Please explain below:*

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*7. Is there anything else your child's therapist should know at this time?*

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*How did you hear about Lisa Jellison, LCSW & Associates?*

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## Payment Authorization Form

In adherence with Lisa Jellison, LCSW & Associates payment and late cancellation/no-show policy, clients are asked to keep their credit card information on file. Lisa Jellison, LCSW & Associates uses a HIPAA secure, PCI-protected card-on-file payment service. It is your responsibility to inform Lisa Jellison, LCSW & Associates of any payment changes you need to make prior to session. To ensure continuity of services, the cardholder must agree not to dispute fee charges. This authorization applies to session fees, late cancellation charges, and current and future outstanding charges.

I, \_\_\_\_\_ (name as it appears on card), authorize Lisa Jellison, LCSW & Associates to submit charges for services that are rendered to \_\_\_\_\_  
(client name).

*Your signature below indicates your agreement and consent that the card on file will be charged.*

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Credit Card Authorization Form

In adherence with Lisa Jellison, LCSW & Associates payment and late cancellation/no-show policy, clients are asked to keep their credit card information on file. It is your responsibility to inform Lisa Jellison, LCSW & Associates of any payment changes you need to make prior to session. To ensure continuity of services, the cardholder must agree not to dispute fee charges. This authorization applies to session fees, late cancellation charges, and current and future outstanding charges. Please be aware most HSA cards may not be able to be processed.

I, \_\_\_\_\_ (name as it appears on card), authorize Lisa Jellison, LCSW & Associates to submit charges for services that are rendered to \_\_\_\_\_  
(client name).

Cardholder's Name: \_\_\_\_\_

Cardholder's Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email/text receipt to: \_\_\_\_\_

- ☐ VISA
- ☐ Master Card
- ☐ Discover

Account number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ CVV: \_\_\_\_\_

*Your signature below indicates your agreement and consent that the card on file will be charged plus an additional \$5.00 transaction fee, as described above.*

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Late Cancellation & No-Show Policy**

A 24-hour notice must be provided when canceling or rescheduling an appointment. There are exceptions to the 24-hour notice, such as medical emergencies and illness. For other non-emergency/non-illness late cancellations, you will be billed for the entire cost of session. The charge will apply to the credit/debit card on file, unless there is an otherwise written agreed upon form of payment. After 3 late cancellations/no-shows, Lisa Jellison, LCSW & Associates holds the right to terminate therapy.

In order to protect you from accruing an unpaid balance, the late cancellation fee must be paid prior to the next scheduled session. You also have the option to mail a check to the address listed below:

Attn:  
Lisa Jellison, LCSW & Associates  
5 Governors Ln Suite 150  
Chico, CA, 95926

*By signing below, you agree to provide a 24-hour notice of session cancellation/reschedule request. If a 24-hour notice is not provided (unless in an exempt circumstance as described above), you consent to the late cancellation fee.*

\_\_\_\_\_  
Client / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client / Legal Guardian Printed Name



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## Authorization Consenting To Release Of Information

I, \_\_\_\_\_, authorize Lisa Jellison, LCSW & Associates to discuss and exchange, in verbal or written form, any relevant information to my child's treatment with the person, or any person(s) or staff of the institution, named below.

\_\_\_\_\_  
Name / Institution Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number / Fax Number

For the following reason(s):

\_\_\_\_ Psychological Assessment

\_\_\_\_ Medical Records

\_\_\_\_ Coordination of Care

\_\_\_\_ Other: \_\_\_\_\_

*You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for one year from the date of the last session. This consent is subject to the conditions outlined in the Office Policies & Consent to Psychotherapy Services.*

\_\_\_\_\_  
Client / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client / Legal Guardian Printed Name