Consent for Treatment

Acknowledgment of Participation in Assessment

I acknowledge that I, and/or my legal guardian (if applicable), have actively participated in the initial mental health assessment conducted by a licensed provider or a provide supervised by a licensed provider at Confianza Health. This assessment included a review of presenting concerns, relevant history, and clinical observations. I understand that the information gathered during this process will inform the development of an individualized treatment plan.

Purpose of Treatment:

I understand that I am consenting to receive mental health services, which may include:

- Psychological assessment and diagnosis
- Individual, group, couples, or family therapy
- Psychoeducation and behavioral interventions
- Crisis intervention and referrals as needed

These services are provided by licensed professionals under the Arizona Board of Behavioral Health Examiners or by a provider receiving supervision from a licensed professional.

Nature of Psychotherapy:

Psychotherapy is a collaborative process that may involve discussing difficult emotional experiences. While many clients experience relief and personal growth, I understand that:

- There are no guaranteed outcomes.
- Therapy may involve emotional discomfort.
- Progress depends on my active participation.

Confidentiality and Limits:

All information shared in therapy is confidential **except** under the following circumstances:

- Threats of harm to self or others
- Suspected abuse of children, elderly, or vulnerable adults
- Court orders or subpoenas
- Insurance billing requirements (diagnosis, dates of service)

I understand that electronic communication (email, phone, video) may carry risks of unintended disclosure despite reasonable safeguards.

Consent for Minors (if applicable):

If the patient is a minor, I confirm that I am the legal guardian and authorize mental health treatment. I understand that:

- Minors may be seen in family therapy settings.
- Confidentiality with minors may be limited based on age and clinical judgment.
- I may be involved in treatment planning and progress reviews.

Communication:

·I authorize Confianza Health (staff, volunteers, interns, contractors) to contact me via phone, email, or other secure means for the purpose of scheduling appointments, discussing treatment progress, and addressing urgent matters related to my mental healthcare.:

- In the event of a mental health emergency, I authorize Confianza Health to contact me or my emergency contacts promptly.
- I understand that communication may include voicemail messages, emails, or text messages.

Observations:

I understand that:

- I understand my therapist may be an associate provider and require supervision
- I understand my therapist may be required to have their supervisor observe sessions in person, virtually, or audible and I have the right to decline observation.
- I consent to supervised observation unless otherwise noted.

Consent and Acknowledgment

I acknowledge that:

- I have read and understood this consent form.
- I have had the opportunity to ask questions.
- I voluntarily consent to treatment.
- I may withdraw consent at any time, understanding the potential consequences.

Initial: * ×

Signature: * ×

Date:

Therapy Expectations

1. Purpose of Therapy

Mental health therapy is a collaborative process between a client and a licensed therapist aimed at improving emotional, psychological, and behavioral well-being. Therapy may involve discussing personal issues, exploring thoughts and feelings, identifying patterns, and developing coping strategies. The goal is to support clients in achieving greater self-awareness, emotional resilience, and personal growth.

2. What to Expect

Therapy sessions are confidential and conducted in a safe, nonjudgmental environment. During sessions, clients may experience a range of emotions as they explore personal challenges. Progress may be gradual and vary depending on individual circumstances. Clients are encouraged to actively participate and communicate openly with their therapist.

Therapy may include:

- Individual talk therapy
- Cognitive-behavioral techniques
- Mindfulness and stress-reduction strategies
- Goal setting and progress review

When appropriate, therapy may include family-based approaches to address relational dynamics and improve communication among family members. Family therapy modalities may include:

- Structural Family Therapy – focusing on family organization and boundaries
- Strategic Family Therapy – addressing specific problems with goal-oriented strategies
- Systemic Therapy – exploring patterns and roles within the family system
- Emotionally Focused Therapy (EFT) – enhancing emotional bonds and attachment
- Narrative Therapy – helping families reframe and rewrite their shared stories

3. Frequency and Duration

Sessions are typically held **once per week**, unless otherwise agreed upon. Each session lasts approximately **53 minutes**. The frequency and duration of therapy may be adjusted based on the client's needs and therapeutic goals.

4. Hours of Operation

Therapy services are available during the following hours: **(After hour and weekend appointments available)**

Monday – Friday: 8:30 AM – 5:00 PM

Saturday: By appointment only

Sunday: Close

5. Contact Information

Phoenix Office: 11225 N 28th Dr.

Suite C-206

Phoenix AZ, 85029

Avondale Office: 919 N Dysart rd.

Suite F

Avondale AZ, 85323

6. Confidentiality

All information shared in therapy is confidential and will not be disclosed without written consent, except in cases where disclosure is required by law (e.g., risk of harm to self or others, abuse, court orders).

7. Minor Clients

If the client is a minor (under the age of 18), parental or guardian involvement is **EXPECTED**. This may include participation in sessions, collaboration in treatment planning, and communication with the therapist regarding the minor's progress and needs. The therapist will work to balance the minor's confidentiality with appropriate parental involvement.

8. Assessment Acknowledgment

I acknowledge that I have participated in an initial mental health assessment conducted by my therapist. I understand that the purpose of this assessment was to evaluate my current emotional and psychological state, identify areas of concern, and help guide the development of an appropriate treatment plan.

9. Rights to Services

Patients have the right to an array of qualified providers and clinically appropriate services, and—consistent with Arizona's *Voice and Choice* standard—they may request covered services, choose where to receive those services within their network, and actively participate in all service-planning decisions.

AHCCCS Statewide Provider Directory

- **AHCCCS Online Provider Directory** – Search statewide for behavioral health and physical health providers.
- https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/ProviderListings/

10. Consent

I understand the nature and purpose of therapy as described above. I acknowledge that I have the right to ask questions and withdraw from therapy at any time. I voluntarily consent to participate in mental health therapy services.

Person Signing the Document *

Signature: * ×

Date:

Telehealth Consent

Telehealth Informed Consent for Mental Health Services

Purpose of Telehealth Services

Telehealth involves the use of electronic communications technology to provide mental health services remotely. This may include video conferencing, telephone sessions, secure messaging, and electronic sharing of clinical information. Telehealth allows clients to receive services without being physically present at the agency.

Nature of Telehealth Services

I understand that telehealth services will be provided using secure, HIPAA-compliant platforms when available. These services may be similar to in-person therapy; however, there may be limitations related to technology, privacy, or the ability to respond to emergencies.

Benefits and Risks

I understand that the potential benefits of telehealth include increased access to care, convenience, and continuity of services. I also understand there are potential risks, including but not limited to interruptions, technical difficulties, unauthorized access, or misunderstandings due to the lack of in-person interaction. I acknowledge that no technology is completely secure, and confidentiality cannot be absolutely guaranteed.

Confidentiality and Privacy

I understand that my therapist will take reasonable steps to protect my privacy and confidentiality during telehealth sessions. I am responsible for participating in sessions from a private location and ensuring that my environment is free from distractions and unauthorized listeners. Telehealth services are subject to the same confidentiality and legal requirements as in-person services, including mandatory reporting laws.

Emergency and Crisis Situations

I understand that telehealth is not appropriate for emergency situations. In the event of a mental health crisis or emergency, I agree to call 911 or go to the nearest emergency room. I agree to provide my current physical location at the start of each telehealth session to ensure appropriate emergency response if needed.

Technology Requirements and Responsibilities

I understand that I am responsible for having access to a reliable internet connection, a compatible device, and a private setting for telehealth sessions. I agree to notify my provider immediately if technical issues interfere with the session.

Consent and Right to Withdraw

I understand that participation in telehealth services is voluntary and that I may withdraw my consent at any time without affecting my right to receive future services. I understand that I may request in-person services if available.

Client Responsibility for Confidentiality

I understand that maintaining confidentiality during telehealth services requires shared responsibility. I agree to make every reasonable effort to participate in telehealth sessions from a private, secure location and to prevent unauthorized individuals from overhearing, observing, or participating in my services. I acknowledge that I am responsible for ensuring my environment supports confidentiality, including the use of headphones or other privacy measures when appropriate.

I understand that the agency and provider are not responsible for breaches of confidentiality that occur due to my failure to maintain a private environment or due to the presence or involvement of others in my location during telehealth services without the provider's knowledge or consent.

Acknowledgment and Consent

By signing below, I acknowledge that I have read and understand this Telehealth Informed Consent. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I voluntarily consent to receive mental health services via telehealth.

Person Signing the Document *

Signature: * ×

Date:

Attendance, Cancellation Policy

Attendance and Cancellation Policy

Appointment Commitment

Mental health treatment is most effective when appointments are attended consistently. By scheduling an appointment, you are reserving time specifically for your care. We ask that you make every effort to attend all scheduled sessions.

Cancellation and Rescheduling

If you need to cancel or reschedule an appointment, please notify our office **at least 24 hours in advance**. You may do so by:

- Calling the office directly
- Leaving a voicemail (if after hours)
- Using the secure client portal (if available)

This allows us to offer the time slot to another client in need.

Late Cancellations and No-Shows

A **late cancellation** is defined as canceling an appointment **less than 24 hours before** the scheduled time. A **no-show** is when a client fails to attend a scheduled appointment without any prior notice.

- **Late cancellations** may incur a fee of **up to $40**.
- **No-shows** may incur a fee of **up to the full session rate**.
- These fees are not billable to insurance and must be paid by the client.
- Medicaid and Medicare patients may not be billed for No-Show fees.

Repeated late cancellations or no-shows may result in:

- A review of your treatment plan
- Placement on a waitlist
- Discharge from services

Arriving Late

If you arrive late to your session, your appointment will still end at the scheduled time to respect the next client's time. If you are more than **15 minutes late**, the session may be considered a no-show and subject to the associated fee.

Emergencies and Exceptions

We understand that emergencies and unforeseen circumstances happen. If you experience a medical emergency, family crisis, or other unavoidable event, please contact us as soon as possible. Exceptions to the cancellation policy may be made at the clinician's discretion.

Consistent Attendance

Clients who attend therapy regularly tend to experience better outcomes. If you miss multiple appointments without communication, your provider may reach out to discuss your engagement in treatment. In some cases, services may be paused or discontinued until consistent attendance can be re-established.

Initial: * ×

Signature: * ×

Date:

Appointment Policy

We strive to provide timely and efficient care to all our patients. To ensure this, we have implemented a policy regarding charges for late arrivals to scheduled appointments. By signing this consent form, you acknowledge and agree to the following terms:

No show fee will be assessed if rescheduled within 24 hours of scheduled appointment

No show fee is only for commercial clients. Medicaid clients will not be charged a No show fee

- No Show Fee: **$40.00**
- Grace Period: **15 minutes**
- Effective Date: **05/01/2025**

Terms and Conditions

1. Patients arriving later than the grace period can have their appointment cancelled and rescheduled.

2. After three late arrivals you may be placed on the waiting list and reassigned.

3. The fee compensates for the time reserved and the disruption caused to the schedule.

4. Patients are encouraged to arrive on time to avoid any charges and ensure they receive the full duration of their appointment.

Please sign below to indicate your understanding and acceptance of these terms.

We appreciate your cooperation and understanding. If you have any questions or concerns, please contact us below.

Sincerely,

Confianza Administration

Confianza Health

(623) 439-7472

Initial: * ×

Signature: * ×

Date:

Incident Agreement

At Confianza Health, we are committed to providing a safe and supportive environment for all participants. Such as behavioral disruptions to property or other staff or peers. Substances are also prohibited to include the use, possession, distribution, or paraphernalia of substance abuse whether on or off program premises.

Confianza Health staff will redirect identified disruptive behaviors verbally and will verbally explain the expectations and consequences of those behaviors and will use all means to de-escalate situation prior to contacting legal guardian. Confianza Health staff **WILL NOT** use any means of force or contact with a minor for **ANY** circumstances.

De-escalation process

1. De-escalation techniques will be utilized as a first attempt.
2. If unsuccessful the legal guardian will be required to pick up the minor.
3. If unable to contact the legal guardian Confianza Health staff will contact emergency contact person.
4. If all other associated contact persons are unavailable, emergency services will be notified.

Rules & Regulations

1. Participants may not use, possess, or be under the influence of illegal drugs or controlled substances without a valid prescription.
2. Drug-related items, including paraphernalia, are not permitted at any time.
3. All participants are expected to comply with routine safety checks and policies, including drug testing if deemed necessary.
4. Any physical and/or verbal altercations will not be tolerated.
5. All participants are required to be presentable and hygienic to participate in services.
6. Any behaviors that cause a risk to self or others is strictly prohibited.

Consequences for violations

1. **First Incident:** Immediate suspension from the program pending parent/guardian conference and a formal behavioral plan.
2. **Second Incident:** Termination from the program. Re-enrollment may be considered after a formal review and documentation of completed.
3. **Third Incident:** Member will be terminated from the program for a period of six months.

Examples of Behavioral Concerns include:

- Aggressive or violentbehavior

- Bullying or harassment (verbal, physical, or cyber)
- Theft or vandalism
- Repeated defiance of staff instructions
- Inappropriate language or gestures
- Disruptive conduct during group activities

We ask all parents and guardians to review this agreement carefully and discuss its importance with their child. By signing below, you acknowledge your understanding of the above policy and agree to support the program in enforcing these standards.

Initial: * ×

Signature: * ×

Date:

Advanced Directives Acknowledgement

Purpose of This Consent

This document provides information about **Advance Directives** and obtains your consent for receiving education, support, and assistance from our agency in completing or updating an Advance Directive.

What Are Advance Directives?

Advance Directives are **legal documents** that allow you to make decisions about your future healthcare in the event that you are unable to communicate your wishes.

These may include:

- **Living Will** – Specifies the types of medical treatments you do or do not want.
- **Healthcare Power of Attorney (Healthcare Proxy)** – Designates a person to make healthcare decisions on your behalf.
- **Mental Health Advance Directive (if applicable)** – Specifies preferences for mental health treatment in crisis situations.

Information You Will Receive

As part of this service, our staff will provide:

- Education about the purpose and types of Advance Directives
- Information about your **rights under state law**
- Guidance on how to complete Advance Directive documents
- Assistance identifying a healthcare decision-maker (if desired)
- Information on how to store and share your Advance Directive

Your Rights

You have the right to:

- Accept or decline information and assistance at any time
- Complete an Advance Directive or choose not to
- Change or revoke your Advance Directive at any time
- Ask questions and receive clear explanations
- Receive copies of any documents you complete

Important Considerations

- Completing an Advance Directive is **voluntary**
- Your care will **not be affected** if you choose not to complete one
- Our staff **do not provide legal advice** but can guide you through general processes
- You are encouraged to discuss your decisions with family, trusted individuals, or legal advisors

Confidentiality

All discussions and documents related to Advance Directives will be handled in accordance with:

- HIPAA regulations
- Agency confidentiality policies

Your information will only be shared with individuals or providers you authorize.

Agency Role and Limitations

Our agency may:

- Provide education and guidance
- Assist with form completion
- Help coordinate documentation within your care plan

Our agency does **not**:

- Act as a legal authority or substitute decision-maker
- Determine your medical decisions

Consent for Services

By signing below, you acknowledge that:

- You have received information about Advance Directives
- You understand your rights
- You have had the opportunity to ask questions
- You consent to receive assistance and support related to Advance Directives

Initial: * ×

Signature: * ×

Date: