CMM Mental Health & Family Therapy, Inc.

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29995 Technology Dr., Suite 101A
Murrieta, CA 92563
Phone (951)249-7288 Fax (951) 654-3526

CLIENT POLICY STATEMENT AND CONSENT FOR TREATMENT

Appointments Times have been reserved for you. If you have to cancel an appointment, please give me at least **24 hours notice**, insurance companies do not pay for missed sessions.

THERE WILL BE A **$30.00** CHARGE IF APPOINTMENTS ARE CANCELLED LESS THAN 24 HOURS BEFORE AN APPOINTMENT. _____initials
If you have more than **3 missed appointments**, you will be dismissed/discharged from treatment as you will no longer benefiting from treatment anymore and you will be provided with referrals for the proper continuation of care.

Please choose a method of payment:
I would like to pay for psychotherapy services directly to **CMM Mental Health & Family Therapy, Inc.** _____
initials

I am using an insurance _____
Initials

Limitations of Confidentiality: I understand that all information between the therapist and client is held strictly confidential, UNLESS:

- Client authorizes release of information in writing with signature
- Client presents a physical danger to self or others
- Child or Elder, Dependent abuse or neglect is suspected

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

I have read, received and understand the HIPAA Notice of Privacy Practices for Health Information _____ Initials
I consent to correspond via **Text, Calls, Voicemail, and E-mail** for scheduling and confirmation purposes **only** the number provided. Initials _____
A) Yes phone #_____

B) E-mail _____

C)No. (initials)_____