



**CMM Mental Health & Family Therapy, Inc.**

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) \_\_\_\_\_

