INSTITUTE FOR CHILDREN'S AID
A Voice of HOPE for Children Worldwide

951-695-3336
info@4achild.org
www.instituteforchildrensaid.org
A Division of International Christian Adoptions

HEADQUARTERS:
41745 Rider Way #2
Temecula, CA 92590

BRANCH OFFICE:
6248 Birdcage Street
Citrus Heights, CA 95610

BRANCH OFFICE:
333 University Ave., Ste. 200
Sacramento, CA 95825

BRANCH OFFICE:
1800 Martin Luther King Pkwy,
Ste 200, Durham, NC 27707

ICA INTAKE FORM

Client Name		Date	

CLIENT INFORMATION

Child / Youth to Receive Treatment – General Information

Name: | Date of Birth: | Gender: ☐ Male ☐ Female

Client Address: ☐ Same as Parent/Guardian ☐ Different from Parent/Guardian (specify):

School Attending: | Grade:

Cell Phone: | Email Address:

How much contact per month does the child have with his/her biological mother/father: ☐ N/A

Extracurricular activities / interests:

LEGAL GUARDIAN INFORMATION

Parent/Guardian Name P(1):

Relationship to Child: ☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Other:

Street Address:
City: State: Zip:

Home Phone: | Work Phone:

Cell Phone: | Email Address:

May we send mail to you at this address?	P(1) ☐ Yes	☐ No	P(2) ☐ Yes	☐ No
May we call you and leave a message at work?	P(1) ☐ Yes	☐ No	P(2) ☐ Yes	☐ No
May we call you and leave a message at home?	P(1) ☐ Yes	☐ No	P(2) ☐ Yes	☐ No
May we send e-mails to you at this e-mail address?	P(1) ☐ Yes	☐ No	P(2) ☐ Yes	☐ No
May we call, text, leave you a message on your cell?	P(1) ☐ Yes	☐ No	P(2) ☐ Yes	☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse/Partner P(2):

☐ Same contact information as Spouse/Partner ☐ Different (If different, please specify below.)

CURRENT CAREGIVER INFORMATION (who the child resides with)

☐ Same as Legal Guardian (fill in only new information different from previously listed)

Name C(1):

Relationship to Child:

☐ Foster Parent(s) ☐ Biological Relative-Specify ☐ Group Home ☐ Other:

Street Address:
City: State: Zip:

Home Phone: | Work Phone:

Cell Phone: | Email Address:

May we send mail to you at this address?	C(1) ☐ Yes	☐ No	C(2) ☐ Yes	☐ No
May we call you and leave a message at work?	C(1) ☐ Yes	☐ No	C(2) ☐ Yes	☐ No
May we call you and leave a message at home?	C(1) ☐ Yes	☐ No	C(2) ☐ Yes	☐ No

May we send e-mails to you at this e-mail address? C(1) ☐ Yes ☐ No C(2) ☐ Yes ☐ No

May we call, text, leave you a message on your cell? C(1) ☐ Yes ☐ No C(2) ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse/Partner C(2):

☐ Same contact information as Spouse/Partner ☐ Different (If different, please specify below.)

HOUSEHOLD INFORMATION

Children in the home:

Name	DOB	Gender	Relationship to Child
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Caregiver Occupations:

Caregiver Highest Level of Education:

☐ Some High School ☐ High Schol Diploma ☐ Some College ☐ College Degree

☐ Some Graduate Work ☐ Master's Degree ☐ Doctoral Degree

EMERGENCY CONTACT INFORMATION

Name: Relationship to Child:

Street Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: Email Address:

REQUESTED SERVICES

Please check the corresponding box for the service(s) that you are requesting or for which you have been referred. (Upon the initial intake assessment, the counselor will evaluate and determine the best course of treatment based on the clinical need for each client, including but not limited to services being held in-office and/or in-home, etc.)

☐ Individual Therapy ☐ Group Counseling ☐ Family Therapy ☐ Therapeutic Assessment/Evaluations

☐ Social Skills Training ☐ Parenting Skills Training ☐ Coaching ☐ Behavior Management Therapy

☐ IEP/504 Advocating ☐ Respite Care ☐ Other (please describe):

REASON FOR SEEKING HELP

What concerns about the child/youth have brought you to counseling?

Where are these concerns causing the most problems for YOU? (Check all that apply.)

☐ Home ☐ Work ☐ Marriage/Relationship ☐ Other:

Where are these concerns causing the most problems for the CHILD/YOUTH? (Check all that apply.)

☐ Home ☐ Work ☐ Marriage/Relationship ☐ Other:

When did the present concerns begin to be a problem for the child?

What concerns about the child/youth have been identified by others?

Please indicate which of the following are currently problems the child experiences. (Check all that apply.)

☐ Crying spells	☐ Hyperactivity	☐ Excessive Fears/Anxieties
☐ Bullying/Picking Fights	☐ Difficulty Being Away from Specific Family Members	☐ Difficulty with Authority
☐ Hearing Voices	☐ Nightmares	☐ Getting into Trouble at School
☐ Temper Tantrums	☐ Obsession/Compulsions with Specific Specific Activities	☐ Lack of Motivation
☐ Difficulty Falling Asleep	☐ Unable to Sleep at Night	☐ Lack of Self Confidence
☐ Difficulty Making/Keeping Friends	☐ Decreased/Increased Appetite	☐ Loss of Interest in Usual Activities
☐ Other:		

TREATMENT & PSYCHIATRIC HISTORY

Has the child/youth received previous treatment? ☐ No ☐ Yes (complete the information below)

When: For how long: For what concern:

Has the child/youth ever been diagnosed with/or treated for *any* type of mental illness?

☐ No ☐ Yes (If yes, specify which type)

Has anyone in the child's/youth's family ever been diagnosed with/or treated for *any* type of mental illness?

☐ No ☐ Yes (If yes, specify which type)

Please list any psychiatric medications child/youth is currently taking:

Psychiatric Medication(s)	Dosage

MEDICAL HISTORY

How would you rate child/youth's current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is the child/youth currently complaining of any physical problems? (e.g. headaches, stomach aches, etc.)

☐ No ☐ Yes (If yes, specify which type)

Primary Care Physician			
Name:		Associated Hospital:	
Address:	City:	State:	Zip
Phone:		Notes:	

Previous Hospitalization for Medical Reason(s)	
Date:	Reason:
Date:	Reason:

Please list any medical conditions/disabilities:

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Please list any learning disabilities:

Please list any medications child/youth is currently taking:

Medication(s) – Over the counter & Prescription	Dosage

SIGNATURES

Your signature below indicates that at the INITIAL INTAKE appointment you have been advised of and agree to: Limits of Confidentiality, Risk and Benefits of Treatment, Attendance Policy, Fee Policies, After-hours emergency contact, Informed Concerns (2), Receipt of Privacy Practices, Release of Confidentiality, and received a copy of the HIPAA Privacy notice.

Signature of Client Date Print Name of Client

Signature of LEGAL Guardian (If Applicable) Date Print Name of LEGAL Guardian (If Applicable)

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1800 Martin Luther King Parkway
Ste. 200, 201, Durham, NC

ICA Child Trauma & Learning Center
INFORMED CONSENT

CLIENT INFORMATION

Client Name		**Client DOB**	

PROVIDER INFORMATION

Provider Name		**Provider License**	

SERVICES PROVIDED

ICA Child and Family Counseling Services (ICA) is a non-profit counseling program dedicated to serving children and their families. Services provided are based on Judeo-Christian principles. Families with children from all ethnicities and socioeconomic or religious backgrounds are welcome. Our services are unique, interactive and include evidence-based TF-CBT, CBT and other very effective modalities. Assessments, psychological evaluations, group and individual sessions, adoption and foster care supervision monitoring and reporting, psychoeducational sessions, parent education training, youth coaching and other services will be offered.

_____
Initial

WHAT TO EXPECT

Counseling and psychotherapy can have both risks and benefits. The counseling process may include discussions of your personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger, and frustration. However, counseling has also been shown to have numerous benefits, including better interpersonal relationships, improved work/academic performance, solutions to specific problems and reductions in your feelings of distress. However, there is no assurance of these benefits. Therapy is a collaborative process and you have the right to ask questions and are encouraged to discuss any concerns you may have about the process. At any time, you are free to leave therapy and/or can request a referral to another therapist.

_____
Initial

COUNSELING POLICIES

Many issues typically encountered by clients can be addressed in a short period of time (8-10 weeks). Your initial session is an intake session, devoted to defining your concerns, developing a treatment plan, and determining whether an ICA counselor can help meet your needs. If at any point, it is determined that other services are more suitable we will, whenever possible, help you obtain assistance. Should you require more in-depth counseling for a longer period, this may be arranged with your counselor, providing there is space on his/her schedule.

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Initial

SCHEDULING, ATTENDANCE & CANCELATION

Unless other arrangements have been made, therapy sessions are 50 minutes in duration. Please make every attempt to keep scheduled appointments and arrive on time. Missed appointments reduce your therapeutic benefits and our capacity to provide services to other clients.

If you are unable to keep your appointment, please contact your counselor by phone at the number they provide within

the amount of time they designate. If there has not been a reasonable attempt to cancel or reschedule an existing appointment, there is a high likelihood that you will lose your time slot on the counselor's schedule and be unable to reschedule with another therapist at the time you wish. Any appointments missed for any reason that is not rescheduled that same week, or the week immediately after, is considered an absence. Any absence defined above will be considered a no-show. You will be charged $40. If you must cancel the appointment, due to an illness or an emergency, please contact your therapist as soon as possible to reschedule a session. Rescheduled sessions are not considered a no-show. Two missed sessions within an 8-week period, or 2 consecutive weeks missed of therapy without notification will give therapist reason to release your appointment slot and close your case.

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Initial

FEES

Clients participate in counseling services in by one of the following means:

NO RATE PROGRAMS:
ICA is reimbursed by government, foundation or private donations OR counseling costs were already covered in programs and your counseling sessions are a non-expense to you.

MODIFIED RATES:
Some clients are experiencing extraordinary circumstances and there are legitimate reasons for reductions of fees. This is accomplished by request and an approved application process.

NORMAL RATES:
Our normal rates are explained below.

Rates for General Services	
Initial Intake	$80 for a 90-minute clinical session*
Individual Session	$50 per 50-60-minute clinical session
Group Session (per session)	$50 per 50-minute clinical session
Psychoeducational Session	$50 per 50-minute clinical session
Behavior Management Session	$50 per 50-minute clinical session
Attending IEP Meeting	$50 per 50-minute clinical session
Attending Child Family Team Meeting	$50 per 50-minute clinical session
Assessments & Psychological Evaluations	Discussed in detail before work begins
Multiple Siblings & Family Therapy	$50 per 50-minute clinical session ***If have multiple clients in sessions, might have multiple sessions back-to-back is possible, and as discussed prior to session.
Timely Rescheduled Appointments **(***Rescheduled before 24 hours of the original appointment day & time)**	Normal Rate of Session
Late To Appointment	Normal Rate of Session

"No Show" / Late Cancellations **(***Not showing up to session. And / Or cancelling WITHIN 24 hours of your scheduled appointment day and time.)**	$50.00

*Please note that a clinical session includes 10-minute note taking, making the session *not* a full hour.

_____
Initial

CONFIDENTIALITY

In keeping with ethical standards of the American Psychological Association and state and federal law, all services provided by the staff of ICA are kept confidential except as noted below. As required by psychological practice guidelines, we keep records of your counseling, kept in a locked filing cabinet, with access limited to ICA staff, or other onsite clinical staff.

All information shared with your therapist is confidential and is not to be revealed to anyone without your written permission, except where disclosure is required or permitted by law. The following are the primary exceptions to confidentiality:

- By law, any reasonable suspicion of child, elder, or dependent adult abuse must be reported to the appropriate protective agencies or law enforcement.
- If there is a concern that you are a harm to yourself, the appropriate measures must be taken to protect your well-being.
- If there is a serious threat of harm to another person, there is a legal requirement to inform the intended victim and law enforcement.
- Some legal proceedings - for instance, if mental status is at issue in a lawsuit or if legal action is taken against the therapist or counseling agency.
- During the legally required process of supervision between supervisors and trainees/associates.

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Initial

COACHES

ICA offers Coaches to youth who would benefit from such services. Coaching and therapy differ significantly. Coaching is NOT an alternative to therapy yet is fundamental in helping youth with decision -making, life skills, behavioral issues, anger management, communication and other issues. Please see our Coaching Packet for further details.

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Initial

ASSOCIATES & TRAINEES

In addition, if you see an associate or trainee, please be advised that they will be under supervision of a licensed therapist. Their supervisor will have access to your files and will assist the trainee or associate in providing you with the best care possible. If you have additional questions or concerns that have not been addressed by your therapist, please feel free to contact their supervisor directly.

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Initial

CONSENT TO TREAT A MINOR

The law defines a minor as anyone under the age of 18. For therapy to be effective, confidentiality must be maintained. This means that during therapy with anyone, including his or her parents or guardians, confidentiality must be maintained, unless there is an issue of safety. Safety includes but is not limited to, suspected abuse to a child, elder, or dependent adult and potential harm to self or others. If in Therapist/Associate/Trainee's opinion, a safety issue arises, Therapist/Associate/Trainee will attempt, but does not guarantee, to notify the minor that information will be shared with their parent or guardian prior to sharing the information with them. Therapist/Associate/Trainee will also disclose billing and scheduling information so that the parent/guardian knows what they are paying for.

By signing this consent, the minor agrees and understands that the Therapist/Associate/Trainee will contact your parent or guardian, and/or authorities, to prevent harm to self or others, or to report suspected abuse to a child, elder, or dependent adult.

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Initial

CONSENT TO USE ARTWORK

I authorize my artwork to be release for the below purpose(s) to the Art / Play Therapist and ICA Staff. I understand that I may revoke this specific portion of my informed consent only (CONSENT TO ARTWORK, DIGITAL ARTWORK, SAND PLAY / SAND TRAY, PLAY THERAPY WORK, ETC.) at any time, but my revocation is not effective until delivered in writing to ICA Staff responsible for my collected art work, and is not effective to artwork already disclosed under this authorization. The client authorizes the use or disclosure of his/her artwork for the following purposes:

- Educational purposes (local university classroom presentation and/or supervision) for research purposes; for publication; for professional presentation; for training purposes.

Any identifying information about me (such as name) will be concealed or changed to protect my identity.

A description of the artwork for which I am authorizing disclosure is:

☐ Original ☐ Photocopies/Graphs of Artwork ☐ Other: _____

I understand this authorization will expire within two (2) years from the date of discharge from therapy, unless revoked earlier by me in writing, as previously stated.

As the person signing this authorization, I understand that I am giving my permission to the above named individual(s) or entity(ies) for disclosure of my artwork. I understand that such individual(s) or entity(ies) may not condition therapy on my willingness to sign this authorization unless such conditions are set forth in this authorization. I understand that my artwork disclosed pursuant to this authorization might be re-disclosed by a recipient.

This authorization expires on 2 years after discharge.

_____

Initial

COUNSELING POLICIES

Your therapist/counselor will take reasonable precautions to insure your confidentiality when using electronic media such as Faxes, E-mail, texting and voice mail communications. However, you should be aware that such communications might not be completely confidential. In addition, most forms of electronic communication do not lend themselves to immediate response.

Therefore, it is important to never use these forms of communication in the case of an emergency or when there is an urgent concern. Electronic communication should not be used to discuss therapeutic issues or concerns unless a telemedicine consent has been signed. (Please see the attached ADDENDUM for further clarification).

I authorize phone calls and messages to my cell phone and home phone.

_____
Initial

EMERGENCY PROCEDURES

If a situation should arise between sessions, please leave a message for your counselor at our office line at (951) 695-3336 and your call will be returned as quickly as possible. When calling, please clearly state the issue and provide a phone number where you can be reached. If you are experiencing an emergency and need to talk to someone right away, please refer to the numbers provided below:

- Emergency Services 911
- Suicide Prevention Center (877) 727-4747
- National Certified Crisis Hotline 1-800-784-2433
- California Youth Crisis Line 1-800-843-5200

_____
Initial

ADDITIONAL FORMS RECEIVED

☐ ICA Intake Form ☐ Informed Consent for Electronics ☐ HIPAA Privacy Notice
☐ Privacy Practices Notice ☐ Notice To Clients (BBS Contact) ☐ Release of Confidential Info.
☐ Good Faith Estimate Notice ☐ Good Faith Estimate (Good Up To 12 Months)

_____
Initial

SIGNATURES

By signing, this means that I have read and understand the above information and agree to the terms of treatment in the INFORMED CONSENT.

Client Signature	Client Name (Print Name)	Date

Parent / Guardian Signature	Parent / Guardian Name (Print Name)	Date

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ELECTRONIC INFORMED CONSENT:
Telephone, Email, Electronics, Etc.

Client Name _____ Date _____

ELECTRONIC CONSENT

Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with your therapist constitutes implied consent for reciprocal use of electronic and mail communication as well.

It is the consensus of mental health professionals that reliable and valid psychotherapy and supervision are always conducted in a face-to-face setting, so that nonverbal communications can be taken into consideration. Body language, voice tone, pacing, emotional overtones, eye contact, and other variables are an important part of counseling or psychotherapeutically oriented professional services. However, there may be times or circumstances under which telephone, text, electronic, video-conferencing, e-mail, postal or other kinds of communication may have a limited value, such as:

1. Brief, between-session contact calls, e-mail, or mail messages.
2. In some cases, using video-conferencing with specific HIPAA compliant software (Ex: ZOOM, etc.) may be an option when deemed appropriate by the clinical team. The best option for therapy is in-person contact in order to avoid misunderstandings in body language, voice tone, pacing, emotional overtones, and other variables that can be missed in video-conferencing. Confidentiality will be maintained to the best of the ability of the clinical staff. It is expected the client(s) is to have a quiet, private, and confidential meeting space, free from distractions during session time. It is vital to maintain the integrity of therapy that no one else be able to overhear the session, in order to maintain the confidentiality of this type of session. It is expected that no recordings will be taken of any kind by client(s) or others for the safety of the client(s). If ICA staff is to record session for training and supervision purposes, it will be discussed and consented to prior to recording session.
3. Long distances communication when either party is out of town or otherwise unavailable.
4. Long distance communication for a limited period when therapy seems near its natural termination and either party relocates, making regular standard sessions impossible. Electronic communication is always incomplete without agreed-upon and periodic face-to-face contact.
5. Limited long-distance consultation, supervision, tutoring, or assessment may be appropriate when specialty or expertise is an issue. However, considerations of reliability and validity without regular face-to-face contact necessarily limit the kinds of interventions the consultant or tutor can make to (1) general questions about the client's concerns, (2) general theoretical considerations or advice, and (3) recommendations as to what kinds of professional consultation to seek locally.

I am aware of the limited validity and reliability of telephone, text, electronic, video-conferencing, e-mail, postal or other kinds of communication as suggested above. I am further aware that I am not guaranteed confidentiality when I contact or receive such contacts from my therapist (E-mail or text messages for appointments, etc.). I understand that the purposes for engaging in telephone, electronic, or mail communication must be limited in scope and time and that the validity and reliability of information given and received is thus limited.

Client Signature _____ Date _____

Professional Signature _____ Date _____

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INTERNATIONAL CHRISTIAN ADOPTIONS / INSTITUTE FOR CHILDREN'S AID
HIPAA PRIVACY NOTICE

Client Name		Date	
Counselor Name		Counselor License or Registration #	

HIPAA NOTICE

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

International Christian Adoptions ("ICA") has always highly valued and respected the privacy of the consumers that receive our services. ICA complies with the Health Insurance Portability And Accountability Act of 1996 ("HIPAA") and its rules, as well as the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and the HITECH Act Final Rule of 2013 which amended HIPAA.

Due to changes in Federal Regulations and our desire to continue our commitment to your privacy, we are providing you with this Notice of Privacy Practices ("Notice") regarding your privacy of health information. ICA is required by law to maintain the privacy of your protected health information ("PHI") and to provide you with a notice of its legal duties and privacy practices. State and federal laws require ICA to: maintain the privacy of your health information; provide you with this Notice about our legal duties and privacy practices and your legal rights pertaining to health information we collect and maintain about you; to notify you following a breach of unsecured protected health information; follow the privacy practices described in this Notice while it is in effect; notify you if we are unable to agree to a requested restriction pertaining to your health information; and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

WHO WILL FOLLOW THIS NOTICE

This notice describes ICA practices and that of:

- All ICA board, employees, staff, interns, and other professionals
- All departments and programs of ICA
- Any member of volunteer services who works with you while you are a client of ICA
- Business Associates and Consultants

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We understand that PHI about you is personal. We are committed to protecting information about you. We create a record of the services that you receive at ICA. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of information.

ICA will, to the best of its ability, work to mitigate the negative effects of any disclosure it makes. ICA will abide by the terms of the Notice currently in effect. ICA reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, the revised Notice will be posted in our facilities, offices, and on our website (www.4achild.org), or a copy of the revised Notice will be sent to you.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose information. For each category of use or disclosure we will explain what we mean and try to give some examples. We use and disclose health information

about you for treatment, to obtain payment, for healthcare operations, and for other purposes. For example:

For Treatment:

We may use PHI about you to provide you with mental health treatment or services. Additionally, we may use information about you to develop an effective treatment plan, for purposes of assessment and to enhance all services rendered. We may disclose this information to the persons involved in providing service at ICA, which may include consultants, respite workers, clinicians, childcare workers, interns, supervisors, administrators, foster parents, volunteers, nurses or other ICA personnel who are involved in providing services to you during your involvement with ICA.

We may ask you for authorization to disclose information about you to people outside of ICA who are involved in your treatment, such as, clergy, medical professionals, family members, educators or others. However, information would be disclosed only with your authorization and only for the purposes that you authorize. For example, a clinician treating a client for depression may need to know if the client is in need of or currently taking medication. Therefore, the clinician will need to share information with the client's doctor (psychiatrist) in order to coordinate treatment.

Other Financial Areas:

ICA receives regular financial audits, COA audits and intercountry audits. Your PHI may be shared with auditors and inspectors.

For Payment:

We may use and disclose PHI about you so that the treatment and services that you receive at ICA may be billed and collected from you, an insurance company, or a third party. For example, we may need to disclose your PHI about treatment that you received at ICA to your health plan so they can pay us or reimburse you for the treatment.

For Quality Assurance and Utilization Review:

We may use and disclose PHI about you for our health care operations. These uses and disclosures are necessary to run ICA and ensure that all our clients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in treating you. We may also combine PHI about many ICA clients to determine what additional services ICA should offer, what services are not needed, and whether certain new services are effective. Information used in this way is de-identified in order to protect your privacy. We may also disclose information to clinicians, interns, and other ICA personnel for review and learning purposes.

For Adopting a Child:

ICA assists your family in the adoption process. When adopting internationally, your PHI is shared with multiple sources including the countries Central Authority, Foreign Authority adoption agency, attorney, or delegate, orphanage, courts, other adoption agencies that may handle a portion of your adoption and other sources. In domestic adoptions your PHI is often shared with social services supervisors and workers, interstate compact, sometimes birthparents, attorneys, mental health counselors, courts and other sources.

For Foster Care:

Your PHI may be shared with numerous county social services staff including child and birth parent social workers and supervisors. Your PHI may also be shared with licensing authorities and auditors.

Treatment Options:

We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Fundraising Activities:

We may use your demographic information to contact you to raise funds for the organization. You have a right to opt out of receiving fundraising communications. If you choose not to receive these fundraising communications, we must provide you with a clear and conspicuous opportunity to elect not to receive any further fundraising communications and we may not condition treatment or payment on your choice with respect to the receipt of fundraising communications. We may not make fundraising communications to you if you have elected to opt out of receiving these communications, but we may provide you with a method to opt back in to receive these communications. We would release information about you and services you received at ICA only with your permission. We may use and disclose your PHI to the media only with your authorization.

Research:

Under certain circumstances (e.g., only with your express authorization or in a format that preserves your anonymity), we may use and disclose PHI about you for research purposes. Some research projects are subject to a special approval process. This process evaluates a proposed research project and its use of information, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, we may have the research project approved through an Institutional Review Board.

As Required by Law:

We will disclose PHI about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety:

We may use and disclose PHI about you when necessary to prevent a serious threat to you or another person. Any disclosure would only be to someone able to help prevent the threat.

Workers' Compensation:

In situations when worker's compensation pays for services or treatment, we may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks:

We may disclose PHI about you for public health activities. These activities generally include the following:
-To prevent or control disease, injury, or disability
-To report child abuse or neglect
-To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
-To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities:

We may disclose PHI to a health oversight organization for activities required to maintain ICA licensure and certification. These activities include, but are not limited to audits, site visits, and inspections. These activities are necessary to monitor ICA performance and compliance with civil rights laws and child welfare requirements.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a valid subpoena, or a court or administrative order. We may also disclose PHI about you in response to an order by a court, but only if good faith efforts have been made to notify you of the request and you do not object.

Law Enforcement:

We may release PHI if required to do so by law:

- In response to a court order
- In response to laws that may require that we disclose information, for example, in a case where child abuse is indicated
- In response to a governmental agency request, for example, if you make a complaint against us.

Medical Examiners and Funeral Directors:

We may release PHI to a medical examiner or funeral director. This may be necessary to allow a medical examiner or funeral director to identify a deceased person or determine the cause of death, as necessary, to expedite necessary arrangements.

National Security and Intelligence Activities:

We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities that are required by law.

To Individuals Involved in Your Care or Payment for Your Care:

During times of treatment, we disclose your PHI only to you, a family member, personal representative, or another person responsible for your care. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

To Provide You Notice of Breaches of Unsecured PHI:

We may contact you to provide you with any notice of any breach of your unsecured PHI.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to ICA will be made only with your written permission. For example, a specific authorization will be required for use or disclosure of your PHI 1) if it involves certain psychotherapy notes, 2) for marketing (except if the communication is face-to-face or is for a promotional gift of nominal value) or for any marketing that involves financial remuneration; or 3) for any sale of your PHI. In these situations,
you may withdraw your authorization at any time and must do so in writing to ICA. Your withdrawal may not be effective in certain situations where we have already taken action in reliance on your authorization.
If you provide ICA with permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, ICA will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that ICA is unable to take back any disclosures that have already been made with your permission, and that ICA is required to retain records of the treatment that has been provided to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Inspect and Copy:

You have the right to inspect and copy PHI that may be used to make decisions about your treatment. This includes billing and case records but does not include clinicians' personal notes. To inspect and copy PHI, you must submit your request in writing to your primary clinician. If you request a copy of the information, we may charge a fee for costs incurred for copying, mailing, or other work associated with your request. You also have a right to receive an electronic copy of your records, if available.
We may deny your request to inspect and copy PHI in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed. Another professional chosen by ICA will review your request and the denial. The person conducting the review will not be the person who denied your request and we will comply with

the outcome of the review.

Right to Amend:

If you feel that PHI we have about you is incorrect or incomplete, you may ask for the information to be amended. You have the right to request an amendment for as long as the information is kept by or for ICA. To request an amendment, your request must be made in writing and submitted to your primary clinician or the program supervisor. In addition, you must provide a reason that supports your request.
ICA may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, ICA may deny your request if you ask for information to be amended that:
-Was not created by ICA
-Is not part of the case record information kept by ICA
-Is not part of the information that you would be permitted to inspect or copy
-Is already accurate and complete

Right to an Accounting of Disclosures:

You have the right to request an "accounting of disclosures." This is a list of the disclosures ICA made of PHI about you. To request this list or accounting of disclosures, you must submit your request in writing to your primary clinician or the program supervisor. The time period of your request may not be longer than six years. Your request should indicate in what form you want the list (electronically or paper copy). The first list requested within a 12-month period will be free. For additional lists, ICA may charge you for the costs of providing the list. ICA will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions:

You have the right to request a restriction or limitation on the PHI ICA uses or discloses about your for treatment, payment, or healthcare operations. ICA is not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency services.
If you request, we must agree to restrict disclosures to health plans if you pay out of pocket in full for any service we provide.

To request restrictions, you must make your request in writing to your primary clinician or the program supervisor. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit ICA's use, disclosure or both; (3) to whom you want the limits to apply.

Right to Request Confidential Communications:

You have the right to request that ICA communicates with you about treatment matters in a certain way or at a certain location. For example, you can ask that we can contact you at work or by mail.
To request confidential communications, you must make your request in writing to your primary clinician. ICA will not ask you the reason for your request. ICA will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice:

You have the right to a paper copy of this notice. You may ask ICA to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you may contact the Privacy Officer listed below, your primary clinician, or the program supervisor. You may also obtain a copy of this notice at our website, www.4achild.org.

CHANGES TO THIS NOTICE

951-695-3336
info@4achild.org
www.instituteforchildrensaid.org
A Division of International Christian Adoptions

HEADQUARTERS:
41745 Rider Way #2
Temecula, CA 92590

BRANCH OFFICE:
6248 Birdcage Street
Citrus Heights, CA 95610

BRANCH OFFICE:
333 University Ave., Ste. 200
Sacramento, CA 95825

BRANCH OFFICE:
1800 Martin Luther King Pkwy,
Ste 200, Durham, NC 27707

ICA reserves the right to change this Notice. ICA reserves the right to make the revised or changed Notice effective for PHI that ICA already has about you, as well as any information ICA receives in the future. ICA will post a copy of the current notice in all ICA sites with the effective date noted in the top right-hand corner. In addition, at your first intake appointment, ICA will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with ICA or with the Secretary of the U.S. Department of Health and Human Services ("DHHS"). All complaints must be submitted in writing. To file a complaint with ICA, contact the Executive Director at:
Charlotte Paulsen 41745 Rider Way #2
Temecula, CA 92590
You also may file a complaint with DHHS, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.
We support your right to protect the privacy of your medical information. You will not face any retaliation if you file a complaint.
If you request additional information regarding our Notice please contact our Executive Director at 951-695-3336.
-- Implemented 2016

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HIPAA ACKNOWLEDGEMENT

I have read this Notice and understand ways in which ICA discloses PHI about myself. I am also comfortable with the release of our PHI as explained.

_____ _____

Parent/Adoptive/Foster Parent/Guardian Signature Date

_____

Printed Name

_____ _____

Parent/Adoptive/Foster Parent/Guardian Signature Date

_____

Printed Name

_____ _____

Client Signature (If applicable - client is 12 yrs. or older) Date

_____

Client Printed Name

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NOTICE OF PRIVACY PRACTICES

Client Name		Effective Date	

PRIVACY PRACTICES NOTICE

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, ICA will disclose no information about you, or the fact that you are our client, without your written consent. **ICA does not routinely disclose information in such circumstances, so will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission, in writing, at any time, by contacting ICA.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by ICA's own choice, some because of policies in this office/agency, and some required by law. If you wish to receive services from ICA, you must sign the attached form indicating that you understand and accept ICA's policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

ICA may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency If you are involved in a life-threatening emergency and ICA cannot ask your permission, ICA will share information if believed that you would have wanted ICA to do so, or if believed that it will be helpful to you.

· Child Abuse Reporting: If ICA staff have reason to suspect that a child is abused or neglected, they are required by California law to report the matter immediately to the California Department of Social Services.

· Adult Abuse Reporting: If ICA staff have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, they are required by California law to immediately make a report and provide relevant information to the California Department of Welfare or Social Services.

· Health Oversight: California law requires that licensed social workers report misconduct by a provider of their own profession. By policy, ICA staff also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by a mental health provider of any profession, ICA is required to explain to you how to make such a report. If you are yourself a health care provider, California Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for your records, such information is privileged under state law, and ICA will not release information unless you provide written authorization or a judge issues a court order. If ICA receives a subpoena for records or testimony, ICA staff will notify you so that you (or your

attorney or ICA) can file a motion to quash (block) the subpoena and can give reasons why I think your records should be protected from disclosure. However, while awaiting the judge's decision, ICA is required to place said records in a sealed envelope and provide them to the Clerk of Court. In California, parents' records may not be used as evidence (i.e., are privileged) in child custody cases, but a child's records do not have that same protection.

· Serious Threat to Health or Safety: Under California law, if ICA staff are engaged in their professional duties and you communicate to them a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and ICA staff believe you have the intent and ability to carry out that threat immediately or imminently, they are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By ICA's own policy, ICA may also use and disclose information about you when necessary to prevent an immediate, serious threat to your own health and safety.

· Workers Compensation: If you file a worker's compensation claim, ICA is required by law, upon request, to submit your relevant information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: California has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to records without notification or consent of parents or child.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Client's Rights and Agency's Duties:

· Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected information about you. You also have the right to request a limit on the information ICA discloses about you to someone who is involved in your services or the payment for services you use. If you ask ICA to disclose information to another party, you may request that ICA limit the information disclosed. However, ICA is not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell ICA: 1) what information you want to limit; 2) whether you want to limit use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications by alternative means and at alternative locations. (For example, you may not want a family member to know that you are using our services. Upon your request, ICA will send your bills to another address. You may also request that ICA contact you only at work, or that ICA staff not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of information for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, ICA staff will discuss with you the details of the accounting process.

· Right to Inspect and Copy: In most cases, you have the right to inspect and copy your billing records. To do this, you must submit your request in writing. If you request a copy of the information, ICA may charge a fee for costs of copying and mailing. ICA may deny your request to inspect and copy in some circumstances. ICA may refuse to provide you access to certain information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend: If you feel that protected information ICA has about you is incorrect or incomplete, you may ask ICA to amend the information. To request an amendment, your request must be made in writing, and submitted to ICA. In addition, you must provide a reason that supports your request. ICA may deny your request if you ask ICA to

951-695-3336
info@4achild.org
www.instituteforchildrensaid.org
A Division of International Christian Adoptions

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amend information that: 1) was not created by ICA; ICA will add your request to the information record; 2) is not part of the information kept by ICA; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right To A Copy of This Notice: You have the right to a paper copy of this notice. You may ask ICA to give you a copy of this notice at any time. Changes to this notice: ICA reserves the right to change policies and/or to change this notice, and to make the changed notice effective for information about you already in the possession of ICA as well as any information ICA may receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the office of ICA. ICA will have copies of the current notice available on request.

· Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to the office of ICA. You may also send a written complaint to the U.S. Department of Health and Human Services.

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ACKNOWLEGEMENT OF PRIVACY PRACTICES: NOTICE OF RECEIPT

Client Name		Date	

ACKNOWLEDGEMENT OF RECEIPT

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Client (or Parent/Guardian) Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Parent/Guardian Name: _____

Relationship to Client: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please be specific):

_____

_____

_____

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BBS NOTICE TO CLIENTS

Client Name		Date	
Counselor Name		Counselor License or Registration #	

ACKNOWLEDGEMENT OF NOTICE

Regarding complaints of Licensed or Registered counselor.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

I _____, acknowledge the above information was provided to me.
(Client Name)

_____ _____

Client Signature Date Client Name (Print Name)

_____

Parent / Guardian Signature Date

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RELEASE OF CONFIDENTIAL INFORMATION

Client Name		Effective Date	

GENERAL INFORMATION

Completion of this form authorizes release of information described in the section below called "Specific Description of Record Authorized for Release." The person whose records are to be released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances.

CLIENT INFORMATION

Name of person whose records will be released:		
Street Address:		
City:	State:	Zip:
Date of Birth:		

Please complete the chart below with all Agencies or Parties who you wish to authorize to share information to or with ICA.

Agency Information: Name, Contact Person, Address, Phone	ICA may Release Information TO this Agency	THIS Agency may Release Information TO ICA
Name: Institute for Children's Aid **Contact Person:** **Address:** 41745 Rider Way, Temecula, CA 92590 **Phone:** 951-695-3336	N/A	N/A
Name: **Contact Person:** **Address:** **Phone:**	☐	☐
Name: **Contact Person:** **Address:** **Phone:**	☐	☐
Name: **Contact Person:** **Address:** **Phone:**	☐	☐

**Specific Terms of Release and Signature(s) on Next Page.*

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TERMS OF RELEASE

Specific description of records authorized to be released (Include dates of records if applicable):

Purpose or need for Release of Information (be specific):

Understandings:

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefit eligibility except for:
  - ☐ No Exceptions ☐ Exceptions
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the disclosed information may be controlled by different laws.
- I may revoke this information, in writing, at any time for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release the information.
- Unless revoked, this authorization will remain in effect until the authorization time listed below:

  Choose one:

  ☐ Authorization expires as of: _____ (Date).

  ☐ Authorization expires _____ month(s) from the date I signed this authorization.

  ☐ Authorization expires after the following action takes place: _____.

SIGNATURES

As evidenced by my signatures, I hereby authorized disclosure of my records to the person(s) or agency(ies) specified above for the RELEASE OF CONFIDENTIAL INFORMATION.

Signature of Person's Records Being Released	Date	Print Name

Print Name of LEGAL Guardian (If Applicable)	Relationship or Title (If Applicable)

Signature of LEGAL Guardian (If Applicable)	Date	Print Name of LEGAL Guardian (If Applicable)

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GOOD FAITH NOTICE

THE LAW

Due to the "No Surprises Act," it requires health care providers (including mental health providers), to inform their uninsured and private pay clients that they have a right to a "Good Faith Estimate" to help clients estimate their expected charges the may be billed for.

NOTICE TO CLIENTS

NO RATE PROGRAMS
ICA is reimbursed by government, foundation or private donations OR counseling costs were already covered in programs and your counseling sessions are a non-expense to you.

MODIFIED RATES
Some clients are experiencing extraordinary circumstances and there are legitimate reasons for reductions of fees. This is accomplished by request and an approved application process.

NORMAL RATES
Our normal rates are listed in the Informed Consent, and the Good Faith Estimate specifically.

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.
Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.
You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

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GOOD FAITH ESTIMATE

CLIENT INFORMATION

Client Name		Client DOB	
Client Address			
Client Diagnosis		Date of Initial Assessment	
Service Requested		Date of GFE	

PROVIDER INFORMATION

Provider Name		Provider License	
Provider Address			
Provider Phone			
Provider Tax ID		Provider NPI	

WHAT IS THE GOOD FAITH ESTIMATE

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

DISCLAIMERS

Clients participate in counseling services in by one of the following means:

NO RATE PROGRAMS:
ICA is reimbursed by government, foundation or private donations OR counseling costs were already covered in programs and your counseling sessions are a non-expense to you.

MODIFIED RATES:
Some clients are experiencing extraordinary circumstances and there are legitimate reasons for reductions of fees. This is accomplished by request and an approved application process.

NORMAL RATES:
Our normal rates are explained below.
There may be additional items or services the provider (counselor/clinician) may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400.00 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

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GOOD FAITH ESTIMATE

The fee for a 50-minute psychotherapy visit (in person or via telehealth) is $50.00. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. (This includes individual sessions, family sessions, group therapy, psychoeducational sessions, behavioral sessions, etc. Additional services and fees beyond that will be discussed at the time of service, and a new GFE can be produced for the additional services beyond the regular services discussed.) Based on a fee of $50.00 per visit, the following are expected charges of psychotherapy services:

Number of Weeks	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per week
1 Week of Service	$50	$100
13 Weeks of Service (Approx. 3 Months)	$650	$1300
26 Weeks of Service (Approx. 6 months)	$1300	$2600
39 Weeks of Service (Approx. 9 months)	$1950	$3900
52 Weeks of Service (Approx. 12 Months)	$2600	$5200

ADDITIONAL INFORMATION

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

DATE

Date of this Good Faith Estimate: _____

SIGNATURES

By signing, this means that I agree that the above information is an accurate representation of what was discussed in the GOOD FAITH ESTIMATE.

Client Signature	Client Name	Date	Parent / Guardian Signature	Parent / Guardian Name	Date

ICA Provider Signature	ICA Provider Name / Title	Date	Supervisor Signature (If Applicable)	Supervisor Name / Title	Date