Clinical Services Intake Packet

Psychotherapy and Case Management

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www.sanmateopride.org

SAN MATEO COUNTY PRIDE CENTER

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Clinical Policies and Procedures

Welcome to the San Mateo County Pride Center, and congratulations on taking steps toward transforming your life! We look forward to supporting you in gaining the skills and tools to create positive change. We are an innovative and ongoing collaboration between three local nonprofit organizations and San Mateo County Behavioral Health and Recovery Services (BHRS). Together, these four organizations created the Pride Center to provide a safer space in which the LGBTQ+ community can truly thrive with faster, easier access to direct services.

We want to be sure that you understand the nature of the services you will be receiving, so we ask that you please carefully read through this *Clinical Policies and Procedures* document. By signing and dating the accompanying documents, you acknowledge that you have received, understand, and consent to the services offered. If at any time you have questions, comments, or concerns, please direct them to your assigned clinician and/or case manager, or any member of our Pride Center team.

Mission: *The mission of the San Mateo County Pride Center is to create a welcoming, safe, inclusive, and affirming community climate that fosters personal growth, health, and opportunities to thrive for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support.*

Vision: *The vision of the San Mateo County Pride Center is to create an innovative, respectful, and equitable community of all ages, ethnicities, cultures, sexual orientations, and gender identities that supports complete inclusion, is free of discrimination, strives for knowledge, challenges barriers, and seeks to empower agents of social change.*

Programs

We provide a broad range of services to LGBTQ+ individuals, partners, and families of all ages, with specialized programming for youth and older adults. The Pride Center is unique in that it combines direct mental health and support services with social and educational programming both at the Pride Center and in the community, which can be summarized in three categories: Clinical, Community, and Resources.

Clinical Services*:

- For individuals, groups, families, and couples/multiples (Medi-Cal and self-pay are accepted)
- Bilingual peer support groups
- Case management, crisis intervention, and referral services

Community Space*:

- Regular drop-in hours
- Social, cultural, and arts events
- Educational workshops and film screenings
- Gathering space for LGBTQ+ groups to support one another and create together

Resource Hub*:

- Computer lab
- LGBTQ+ library
- Web-based media center
- Resource database and service referrals
- Training program for local health providers and school

* - Our programs, including clinical services, are on a hybrid (either in-person or online) platform. Please check with staff to confirm how a particular meeting/event is taking place.

Services Offered

Our clinical team is comprised of Psychologists, Marriage and Family Therapists, Social Workers, Interns, Trainees, Associates, and Case Managers.

Members of our team possess expertise in the following areas:

- Coming Out
- Depression and Anxiety
- PTSD and trauma
- Domestic violence (both perpetrators and survivors)
- Self-harm and suicidal ideation
- Working with siblings and blended families
- Couple and relationship counseling
- Gender identity & transitioning
- Sex and sexuality
- Polyamory and non-monogamy
- Anger management
- BDSM/kink
- Working with survivors of violent crime
- Working with LGBTQ+ adults, families, and youth

Counseling/Therapy: The San Mateo County Pride Center provides high quality mental health services to community members living throughout San Mateo County. Our multi-modal lens includes evidence-based and strength-based practices as well as cross-cultural therapy modalities. Our work is trauma-informed and engages natural supports and the whole family whenever possible. We accept Medi-Cal insurance and fee-for-service payments. Sliding scale (with proof of income) is available, if needed.

Counseling/therapy services may include:

- Individual counseling
- Group therapy
- Relationship therapy
- Family therapy
- Community based services
- Assessment
- Crisis intervention
- Collaborative treatment planning

Case Management: Case management is a collaborative process that involves the coordination of community-based services and resources to provide support to individuals, couples/multiples, and families in need. The goal of the case management program is to enhance participants' abilities to resolve issues, overcome obstacles, and lead fulfilling, productive lives. Our case manager works closely with participants to create a customized service plan that considers each person's unique strengths, needs, and circumstances.

Case management services may include the following areas:

- Housing search
- Employment assistance
- Health and well-being support
- Financial empowerment
- Academic/school support
- Legal aid referrals
- Mental health referrals
- Social skills and peer support
- Community participation
- Transportation
- Legal Name and Gender change
- Resources and information

Peer Support Groups: A Peer Group is a space for members of a specific identity and/or community to come together, build friendships, and find social and emotional support in a private and affirming environment. Groups are run by community members and consist of a check-in and topic-based discussion or activity brought forward by different participants. These are not therapy groups, meaning facilitators are not licensed therapists; instead, facilitators are community members providing supportive spaces for their peers to find connection. *Please see our calendar at sanmateopride.org/events and/or website at sanmateopride.org/peer-groups for types of groups, meeting times, and more information.*

Training Site: The San Mateo County Pride Center is a member of the Bay Area Practicum Information Collaborative (BAPIC), and is a training site for Psychologists, Marriage and Family Therapists, Clinical Social Workers, and Professional Clinical Counselors. Thus, the counseling you receive may be from a Practicum Student (MFT/CSW/PCC/Psychology trainee), a pre/post-doctoral Psychology Intern/Psychological Assistant, an Associate MFT/CSW/PCC, or a Licensed MFT/CSW/PCC. All clinicians and therapists in training will inform you of their trainee status or credentials as well as the name of their clinical supervisor who can be contacted. Your counseling sessions may be recorded or observed for training purposes, with your signed permission. Your clinician will discuss this in more detail during your intake appointment.

Risks, Benefits, and Your Rights

It is important to note that counseling 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 been shown to have many benefits. It can lead to better interpersonal relationships, improved academic performance, solutions to specific problems, and reductions in your feelings of distress.

Consenting to services does not waive your civil rights. You reserve the right to decline treatment at any time. You also have the right to request a change of clinician without being subject to discrimination or any penalty.

Minor Consent

Under California law there are certain subjects and situations that permit minors, 12 years of age or older, to receive counseling without parental permission. In such instances, the clinician will consult with their supervisor to determine the best way to provide support and assistance. For minors to consent to their own mental health treatment, the following criteria, as outlined in the ***California State Health and Safety Code 124260***, must be met: the minor is 12 years of age or older, ***and***, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services.

Confidentiality

In keeping with the ethical standards of the American Psychological Association (APA), and both state and federal law, all services provided by staff of the San Mateo County Pride Center are kept confidential – except as noted below and in the

accompanying *Notice of Policies and Privacy Practices*. As required by current standards of care, we keep records of your counseling and clinical services received for 10 years. These records are stored securely in accordance with federal and state security standards for medical records. Neither the fact that you seek clinical services, nor any information disclosed in your sessions, will appear in any other records unless you specifically direct us to communicate with other organizations/individuals or unless we are directed to by law. Per your signed request, you will be given access to your electronic health records within the legally mandated timeframe without charge.

Please note that here at the San Mateo County Pride Center we are *mandated reporters* and have a legal responsibility to disclose protected participant information without prior consent when:

- A participant is likely to harm themselves or another person(s), unless sufficient protective measures are taken.
- There is known or reasonable suspicion of abuse of children, dependent adults, or the elderly.
- The participant lacks the capacity to care for themselves.
- Child pornography has been witnessed.
- There is a valid court order for the disclosure of participant files.

We must also inform you that we may consult as needed with the staff and partners of the San Mateo County Pride Center regarding the best way to provide the assistance you might need. Please speak with your assigned clinician and/or case manager if you have any questions or concerns regarding your protected health information and confidentiality.

Counseling Sessions

Individual counseling sessions are between 45-50 minutes long and begin once payment is collected. Relationship and family counseling sessions may last longer. Case management sessions are generally 45 minutes long. The length of sessions may also vary according to your needs.

The duration of services (e.g., number of sessions) is determined by a number of factors including but not limited to your: goals, strengths, needs, progress outcomes, and insurance provider (i.e., Medi-Cal). Length of treatment may be discussed during the development of your individualized support plan during your intake meetings.

It is very important that you arrive to session on time. If you arrive more than 15 minutes late, it is at your clinician's discretion whether to cancel your session or see you for the remaining time.

If you are requesting services through your Medi-Cal insurance, the length of treatment may be determined by Health Plan of San Mateo (HPSM) or San Mateo County Behavioral Health and Recovery Services (BHRS). All Medi-Cal participants must meet the criteria outlined by Medi-Cal and must keep their Medi-Cal insurance active to remain eligible for services. If your Medi-Cal insurance is discontinued during the course of services, we may need to close your case until your Medi-Cal coverage is reactivated.

If your clinician and/or case manager determines that more sessions are needed at the end of treatment, staff must first gain approval from their Clinical Supervisor or Administrative Coordinator. Upon continuing, a new support plan and *Acknowledgement of Informed Consent* may need to be completed. You may request additional services by discussing options with your assigned clinician and/or case manager.

What to Expect in the First 1-2 Sessions

- **Session #1 (Intake, Assessment, Planning):** The first session is considered an intake session. During this session, your clinician and/or case manager will explain our services, complete the required paperwork, and begin an assessment with some potential goal setting. If possible, we highly recommend that you review intake paperwork ahead of time.

- **Session #2 - #4 (Review of Treatment Plan, Goals, and Objectives):** During the 2nd through 4th session, you and your clinician will begin to develop a treatment plan based on your identified needs and strengths and your clinician's recommendations. The treatment plan will consist of mutually agreed upon goals, objectives, and interventions to assist you in achieving your overall goals. During the development of your treatment plan, you and your clinician and/or case manager may discuss how many sessions will be needed to meet your goals. Both you and your clinician will sign the treatment plan, which will serve as our service agreement.

Waiting/Reception Area and Counseling Rooms

During in-person services, if you arrive early to your appointment and no one is present to greet you, we ask that you ring our bell and take a seat in the waiting area.

Your clinician and/or case manager will come to greet you at the time of your appointment.

In the waiting area, children under the age of 12 must be accompanied by an adult at all times. Parents with children under 12 must arrange for their children to be accompanied by a trusted adult while in the waiting area.

While in the waiting area, we also ask that noise levels be kept to a minimum and that cell phone conversations be held outside. This helps us maintain a quiet and therapeutic environment for all community members and staff.

Please also keep in mind that at the Pride Center we share our space with other StarVista Programs, staff, and administrators. Counseling rooms are scheduled based on availability, and therefore, you may not be in the same room every week.

Service Fees and Payment Options

Service fees and payment options *must* be agreed upon before the start of treatment. This amount will be noted on the *Acknowledgement of Informed Consent* form and serves as a contract between the identified participant(s) and the Pride Center, stating the agreed upon fee for services received. Please note that if your financial situation changes, if you transfer clinicians, or if you return to treatment after termination of services, a new fee may be negotiated.

Standard Rate: Our standard counseling/therapy fee is **$140.00 per session** for individual therapy and **$160.00 per session** for couples/multiples, family, and group therapy. Some health insurance plans may cover at least part of your counseling fees. Please contact your insurance company to see what they will cover and arrange for personal reimbursement. It is your responsibility to collect reimbursements, if applicable. Case management and/or peer support services are currently provided at no cost to the participant.

Sliding Scale: If you do not have health insurance, and/or cannot afford our standard fee, you may be eligible for our sliding scale rate. Sliding scale needs are assessed during your phone screening/consultation and may be based on your combined gross monthly income, number of dependents, and city of residence. You will be asked to provide proof of income prior to your first appointment (e.g., pay stubs, bank statements, tax returns, etc.) to qualify for this reduced rate. Sliding scale fees are subject to change periodically during treatment.

Payment: All payments are required at the time of session with payment instructions given by your clinician. You will receive a receipt after payment is collected. If you

are utilizing insurance, your regular fee is to be paid for each visit and it is your responsibility to collect reimbursement from your insurance company.

Fees can be paid by check or Visa, MasterCard, or Debit with a credit card logo. **If more than two sessions are unpaid, all future sessions will be cancelled until the balance is paid in full.** If paying by check, please make checks payable to the "*Pride Center*" and put the name of your therapist and date of service in the memo line of your check. Your clinician will let you know where to mail the check. If your check bounces, you will be responsible for the amount of that check and a $10.00 administrative fee. If this happens, arrangements may be made for you to pay by credit card for your balance and all future charges.

Cancellations, Missed Appointments, and Attendance

The San Mateo County Pride Center has a **24-hour cancellation policy**. This means that if you cancel within less than 24 hours of your scheduled appointment, or do not show up for your session, **you will be charged your regular session fee.**

- Cancellations for Monday appointments must be made no later than 6:30pm on Friday the week before.
- It is strongly encouraged that you attempt to reschedule any missed appointments; however, this is at the clinician's discretion and is dependent upon availability.

To help you achieve your goals, build consistency, and foster strong working relationships with your clinician and/or case manager, it is important that you regularly attend your scheduled appointments.

  - **Participants** receiving counseling/therapy should miss no more than four (4) sessions within a 6-month period (due to vacation, sickness, or important engagements). If you must cancel a session and are able to reschedule within the same week, it will not count toward your number of missed sessions.

- Clients who miss more than the above-mentioned number of sessions will be asked to meet with their clinician, by phone/virtually or in person, to discuss barriers to attendance and the effects of missed sessions on the ability to meet treatment goals. Every attempt will be made to decrease barriers and support your success in achieving treatment plan goals. If we are unable to find a way to support you in attending regular sessions, you and your

therapist may decide to take a break from clinical services at the Pride Center.

- If you do not show up for appointments, do not call, and do not return calls when your clinician and/or case manager attempts to contact you, it will be assumed that you no longer wish to continue services and services will be terminated. For participants who decide to discontinue services at the Pride Center, we are happy to make referrals on your behalf to other service providers if needed.

Appointment Reminders

The Pride Center utilizes software to remind participants of their upcoming appointments. We encourage all participants to opt-in to this service. If you are interested in receiving appointment reminders, please specify this on the *Acknowledgement of Informed Consent* form so that we may know how to best contact you. On this form, you may also indicate special instructions for us to follow when contacting you so that we may best protect your confidentiality (e.g., "please call my cell phone only," "please do not mention 'Pride Center' when calling," etc.). If you have any questions or concerns, please discuss them with your assigned clinician and/or case manager.

Hours of Operation, Electronic Mail, & Communication

Please be aware that e-mail and/or any communication sent via electronic device(s) may not be private or confidential. E-mail may not be read or received by the recipient in a timely fashion, so contacting your clinician and/or case manager by phone is strongly encouraged. The Pride Center's normal hours of operation* and general contact information are as follows:

- **Tuesday-Thursday***
  11:30am – 6:30pm
  (Note: closed Tues 1-3:00pm)
- Front Desk: 650-591-0133

**Hours are subject to change depending on holidays and/or special events.*

- Pride Center's Program Director:
  Francisco Sapp (he/him)
  650-579-5441
  francisco.sapp@sanmateopride.org
- Pride Center Manager
  Alex Golding (he/him)
  650-465-6795
  alex.golding@sanmateopride.org

Your assigned clinician and/or case manager will discuss their availability for contact during your first session. As 24-hour on-call services are not currently available at the Pride Center, it is at the discretion of your assigned clinician and/or case manager whether they respond when contacted outside of the normal business hours (e.g., outside of their scheduled shifts). If you are in need support after hours, please refer to the listing of local and nationwide crisis intervention resources at the end of this document.

Good Faith Estimate

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost. Under the law, healthcare 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 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. Please visit www.cms.gov/nosurprises for questions or more information about your right to a Good Faith Estimate.

Grievance Policy

If at any point you feel that your assigned service provider is not the right fit for you, you have the right to request another clinician and/or case manager. We encourage you to discuss this directly with your assigned service provider. If you are dissatisfied with our services, or would like to make a complaint, please contact the Pride Center's Clinical Administrative Coordinator at clinical@sanmateopride.org or (650) 650-275-5553 ext. 838. You may also contact the Pride Center's Program Director Francisco Sapp (he/him) at francisco.sapp@sanmateopride.org or (650) 579-5441.

SAN MATEO COUNTY PRIDE CENTER

Local & National Hotlines

These phone lines are for anyone who is looking for someone to discuss their daily struggles. The call lines are usually staffed with peers who have lived experience of mental health struggles and other challenges. Anyone can call these lines (for free) to talk about their day, learn more about resources in their area, and/or receive peer support if they are experiencing a crisis themselves, or if they are caring for a family member or loved one in need:

650-579-0350 – StarVista Crisis Hotline (San Mateo County) 

Call 988 or **1-800-273-8255** – Suicide and Crisis Lifeline* (press 1 for Veteran's Line) 

**Please note: calls to both will be routed to the local hotline based on your phone's area code.*

1-888-628-9454 – Nacional de Prevención del Suicidio (en Español)

1-877-565-8860 – Trans Lifeline 

1-866-488-7386 – Trevor Lifeline for LGBTQ youth (ages 24 and under) 

1-888-843-4564 – LGBTQ+ National Hotline* 

1-888-234-7243 – LGBT National Senior Hotline (Ages 50+) 

1-800-300-1080 – Relationship & Intimate Partner Abuse (CORA) 

650-692-7273 – Rape and Trauma Services "RTS" (San Mateo County) 

1-888-220-7575 – Parent Support Line

1-800-367-2437 – HIV/AIDS Referral Line* (English & Spanish)

415-200-2920 – HIV/AIDS Text line

650-573-3950 – Alcohol and Drug Helpline (San Mateo County)

1-800-931-2237 – Eating Disorder Helpline (Referrals and Information)*

1-800-366-8288 – Self Harm Hotline (S.A.F.E. Alternatives)*

1-800-786-2929 – Runaway Safeline

1-855-845-7415 – Peer-Run Warmline (SF Bay Area)

Text "START" to 741741 – Crisis Text Line (free & confidential)

For additional crisis support visit: https://sanmateocrisis.org

Updated February 2023

Asterisks (*) indicate hotlines that may not be available 24 hours a day.

SAN MATEO COUNTY PRIDE CENTER

Local & National Hotlines

Dial 2-1-1 to receive personalized assistance and connections to local community resources (shelters, transportation, basic needs, & more) *Free and available 24/7 in over 150 languages!*

In need of food? Call 1-800-984-3663* for referrals to local food banks, hot meal sites, Food Stamps assistance and more.

1-800-686-0101*, TDD: 1-800-943-2833* – ACCESS Call Center for San Mateo County Behavioral Health and Recovery Services:

The ACCESS Call Center is the gateway that can guide you through all the different and appropriate services in San Mateo County. Initial appointments are evaluations from which treatment plans and next steps are determined.

1-800-662-4357 – Substance Abuse & Mental Health Services Administration (SAMHSA) Treatment Referral Routing Service:

SAMHSA's National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) is a confidential, free, 24-hour-a-day, 365-day-a-year information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations.

Psychiatric Emergency Services are available 24/7 at:

San Mateo Medical Center
222 West 39th Ave., San Mateo, CA, 94403
Phone: (650) 573-2662 – Call 911 for immediate help

Mills-Peninsula Medical Center
1501 Trousdale Drive, Burlingame, CA 94010
Phone: (650) 696-5915 – Call 911 for immediate help

Updated February 2023

Asterisks (*) indicate hotlines that may not be available 24 hours a day.

NOTICE OF POLICIES AND PRIVACY PRACTICES

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

StarVista is required, by law, to maintain the privacy and confidentiality of your protected health information (PHI) and to provide our clients with notice of our legal duties and privacy practices with respect to your protected health information, including notifying you of a breach of your PHI StarVista is required to follow the terms of this notice that is currently in effect.

Disclosure of Your Health Care Information

Treatment

StarVista will access your record and use your mental health information to assist in the continuity of your treatment and services. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, clinicians, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. This information will be shared with other health professional or outside agencies unless you specifically request it not to be, in writing and sign a consent form to that effect, or for reasons in which there are limitations to PHI according to professional ethics or California law. (See limits to PHI below).

Payment

StarVista can use and disclose your PHI to bill and collect payment for the treatment and services provided to you. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

Individuals Who May be Involved in Your Care or Payment for Your Care.
When appropriate, StarVista may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a caregiver. We also may notify your family or your caregiver about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

For Health Care Operations
StarVista may share basic identifying information with agency personnel to assist in Health Care Operating procedures. These uses and disclosures are necessary to make sure that all of our clients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the health care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities, such as performance improvement programs.

Health Oversight Activities.
StarVista may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings
We may disclose your health information in the course of an administrative or judicial proceeding if one of the following applies:

1. We have your written permission to disclose the information.
2. A judge issues an administrative court order or orders us to release the information.

In the absence of either of these instances, and if you are receiving services from a social worker, marriage and family therapist, or psychologist, we will claim therapist-patient privilege on your behalf.

Lawsuits and Disputes.
If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement.
StarVista may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners
We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities.
StarVista may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others.
We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.

StarVista may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you as part of our case management and referral.

Research.
Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of clients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify clients who may be

included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information and do not individually identify participants, but report their findings in aggregate form.

Limits to PHI

We may disclose your health information for purposes such that professional ethics or California law requires, specifically if it will prevent or lessen a serious and imminent threat to the health or safety of another person or the general public. These instances include, but are not limited to: if you are assessed to be a danger to yourself, others or gravely disabled; there is known or suspected child, elder, or dependent adult abuse; to prevent a crime or damage to property; or to comply with a court order issued by a judge. We will talk with you about our need to release information in each instance and will limit information to only that necessary to comply with the legal/ethical requirement.

Emergencies

StarVista may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists.

Data Breach Notification Purposes.

StarVista may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Business Associates.

StarVista may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing or auditing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes. For Example, we may disclose your health information to the Federal Government if you are applying for Social Security Disability benefits.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO AGREE OR OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever it is practicable to do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our StarVista Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Marketing

We are a nonprofit institution and we sometimes seek donations to support our programs. We may contact you for marketing purposes or fundraising activities. In the general course of business you may receive marketing information; however it is not our policy to utilize any client list for the aforementioned reason. It is not our policy to disclose any personal health information about your condition for the purposes of StarVista sponsored fund raising events.

Change of Ownership

In the event that StarVista is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that StarVista is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information except in some instances. A written release of information is required and you must make the request through the Program Manager supervising the program from which you are receiving services. Psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

You have a right to request that StarVista amend your protected health information. Please be advised, however, that StarVista is not required to agree to amend your

protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by StarVista. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a
health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. Health plans may request additional information in order to accommodate your request. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Change to this Notice of Privacy Practices

StarVista reserves the right to amend this Notice of Privacy at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, StarVista is required by law to comply with this Notice.

StarVista is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Shareen Leland, Chief Clinical Officer, by calling StarVista at (650) 591-9623 ext.116. If Clarise Blanchard is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how StarVista has handled your health information should be directed to Shareen Leland by calling StarVista at (650) 591-9623 ext.116. If Shareen Leland is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. All complaints must be made in writing. You will not be penalized for filing a complaint.

If you are not satisfied with the manner in which this office handles your complaints, you may submit a formal complaint to:

DHHS, Office of Civil
Rights 200 Independence
Avenue, S.W.
Room 509F HHH
Building
Washington, DC 20201

STAR VISTA

Consent for Telehealth Services

Definition of Services

Telehealth is a method for providing health care services, using information and communication technologies to facilitate diagnosis, consultation, treatment, and care management, while the client and service provider are not in the same physical location. This service is provided via internet technology using a computer or mobile device and may include the use of interactive audio, video, or data communications. No additional costs are affiliated with this service.

Electronic systems used will incorporate network and software security protocols to protect confidentiality and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

The laws and professional standards that apply to in-person services also apply to telehealth services. Additionally, the same laws that protect confidentiality and personal health information also apply to telehealth services. As such, any disclosed information is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the consent form received and signed at the start of services.

This document does not replace other agreements, contracts, or documentation of informed consent.

Benefits & Limitations

- Telehealth services have the same intended purpose and associated benefits as in-person services but may be experienced differently than face-to-face services.
- Some services or information that would ordinarily be available during in-person meetings, may not be available using telehealth services.
- Telehealth services rely on technology, which allows for greater access and convenience in service delivery.
- There are risks in transmitting information over technology that include but are not limited to, breaches of confidentiality, theft of personal information, and disruption or distortion of service due to unforeseen technical difficulties.

Client Rights & Responsibilities

- The client has the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The client and service provider will regularly reassess the appropriateness of service delivery using technology and will modify services as needed and appropriate.
- The client will need access to, and familiarity with, the appropriate technology to participate in the service provided.
- The client is responsible for taking the necessary precautions to maintain privacy at the end of the communication.

Payment

I agree to be responsible for full payment of my bill. Any delays in payment will be discussed with my therapist and the payment process completed as soon as circumstances surrounding the delay are remedied.

I understand that StarVista service providers will not be physically in my presence, instead, we will communicate electronically. This involves oral and visual communication of personal health information.

I understand that both my service provider and I, the client, must be located in the state of California at the time services are delivered.

I, _____, hereby consent to engage in telehealth

services with _____.

I am authorized to consent to treatment. I have read the above and I agree to accept treatment for my child or myself, and I further agree to all conditions set forth herein.

Client Signature: _____ Date: _____
☐ Consent provided electronically or by phone.

Caregiver Signature: _____ Date: _____
☐ Consent provided electronically or by phone.

☐ A copy of this document has been provided to the client/caregiver.

SAN MATEO COUNTY PRIDE CENTER

1021 S. El Camino Real
San Mateo, CA 94402
Phone: 650-591-0133 / Fax: 650-412-1986
www.sanmateopride.org

Authorization for Release of Information: EMERGENCY CONTACT

Signing this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information.

Participant Name: _____

Date of Birth: _____ **Age:** _____

In the event of an emergency, I hereby give my permission for the San Mateo County Pride Center and any of its employees to use or disclose my personally identifying information to the following person(s) or entity(s):

Name: _____

Relationship: _____

Phone 1: _____ Type: _____

Phone 2: _____ Type: _____

Please note this authorization applies ONLY to identifying information.

Effective Dates for this authorization: _____ **through** _____
This authorization will expire at the end of the above period. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Refuse to sign this authorization.
2. Inspect or obtain a copy of the protected health information that I am being asked to disclose.
3. Receive a copy of this authorization.
4. Restrict what is disclosed with this authorization.
5. Revoke this authorization at any time by sending written notice, signed by me or on my behalf, to this office. Revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

I also understand that treatment, payment, enrollment, and/or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

_____

Signature (Participant/Authorized Representative 1) Print Name 1 Date

☐ Consent provided electronically or by phone.

_____

Signature (Participant/Authorized Representative 2) Print Name 2 (if applicable) Date

☐ Consent provided electronically or by phone.

_____

Signature (Witness/Clinical Staff) Print Name Date

☐ Consent provided electronically or by phone.

Office Use: ☐ Copy offered to client/accepted ☐ Copy offered to client/declined *Updated 12.2022*

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Phone: 650-591-0133 / Fax: 650-412-1986
www.sanmateopride.org

Authorization for Release of Information: PRIMARY CARE PHYSICIAN

Signing this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information.

Participant Name: _____

Date of Birth: _____ **Age:** _____

I hereby give my permission for the San Mateo County Pride Center and any of its employees to use or disclose my health information to the following person(s) or entity(s) associated with this office:

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

This Authorization applies to the following information (select only one of the following):

☐ All health information pertaining to any medical history, mental or physical condition, and treatment received, including drug/alcohol, and/or HIV/AIDS, housing status, education, and/or employment.
☐ Only the following records or types of health information (including any dates):

_____
_____

For the specific purpose of (describe in detail):

_____
_____

Effective Dates for this authorization: _____ **through** _____
This authorization will expire at the end of the above period. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Refuse to sign this authorization.
2. Inspect or obtain a copy of the protected health information that I am being asked to disclose.
3. Receive a copy of this authorization.
4. Restrict what is disclosed with this authorization.
5. Revoke this authorization at any time by sending written notice, signed by me or on my behalf, to this office. Revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

I also understand that treatment, payment, enrollment, and/or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

_____
Signature (Participant/Authorized Representative 1) **Print Name 1** **Date**
☐ Consent provided electronically or by phone.

_____
Signature (Participant/Authorized Representative 2) **Print Name 2 (if applicable)** **Date**
☐ Consent provided electronically or by phone.

_____
Signature (Witness/Clinical Staff) **Print Name** **Date**
☐ Consent provided electronically or by phone.

Office Use: ☐ Copy offered to client/accepted ☐ Copy offered to client/declined *Updated 12.2022*

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Authorization for Release of Information

Signing this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information.

Participant Name: _____

Date of Birth: _____ **Age:** _____

I hereby give my permission for the San Mateo County Pride Center and any of its employees to use or disclose my health information to the following person(s) or entity(s) associated with this office:

San Mateo County: ☐ Health Department, ☐ Behavioral Health & Recovery Services, ☐ Human Services Agency
Pride Center partners: ☐ Adolescent Counseling Services (including Outlet), ☐ Peninsula Family Service, ☐ StarVista

Other (name, contact information, relation): ☐ _____

This Authorization applies to the following information (select only one of the following):

☐ All health information pertaining to any medical history, mental or physical condition, and treatment received, including drug/alcohol, and/or HIV/AIDS, housing status, education, and/or employment.

☐ Only the following records or types of health information (including any dates):

_____

_____

For the specific purpose of (describe in detail):

_____

_____

Effective Dates for this authorization: _____ **through** _____

This authorization will expire at the end of the above period. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Refuse to sign this authorization.
2. Inspect or obtain a copy of the protected health information that I am being asked to disclose.
3. Receive a copy of this authorization.
4. Restrict what is disclosed with this authorization.
5. Revoke this authorization at any time by sending written notice, signed by me or on my behalf, to this office. Revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

I also understand that treatment, payment, enrollment, and/or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

_____

Signature (Participant/Authorized Representative 1) **Print Name 1** **Date**

☐ Consent provided electronically or by phone.

_____

Signature (Participant/Authorized Representative 2) **Print Name 2 (if applicable)** **Date**

☐ Consent provided electronically or by phone.

_____

Signature (Witness/Clinical Staff) **Print Name** **Date**

☐ Consent provided electronically or by phone.

Office Use: ☐ Copy offered to client/accepted ☐ Copy offered to client/declined *Updated 12.2022*

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Acknowledgment of Informed Consent

I ,**_____**(print name), *hereby make a request for services voluntarily from the San Mateo County Pride Center for* ☐ *myself and/or* ☐ *my minor child(ren):

_____

***I acknowledge that I received the following documents*:**

☒ Pride Center Clinical Policies and Procedures ☒ Notice of Policies and Privacy Practices

***I have been informed that I/we will be receiving services from*:**

☐ Case Manager: _____

☐ Licensed Clinician: _____, Lic. # _____

☐ Clinician: _____, working toward licensure, and supervised by:

Licensed Clinician: _____, Lic. # _____

Phone: _____ Email: _____

Although electronic communication may not be confidential, I consent to receive appointment reminders via:

☐ Text Message (Cell): _____ Network (required): _____

☐ Email: _____

☐ I decline to receive appointment reminders and reserve the right to reconsider later.

I agree to pay the amount listed below for ongoing treatment:

☐ $ _____ per session, with expected revision date (if known): _____.

☐ N/A – Services will be paid through Medi-Cal ☐ N/A – Case management (No Charge)

* ☐ ***I am authorized to consent to treatment for myself and/or my minor child(ren).***

OR* ☐ *I am a minor and I consent to treatment for myself following California's Minor Consent laws (California State Health and Safety Code 124260).

I have read the above and I agree to accept treatment for myself / my child(ren), and I further agree to all conditions set forth herein.

_____ _____ _____

Participant or parent/guardian - signature 1 Print Name 1 Date

☐ Consent provided electronically or verbally/by phone.

_____ _____ _____

Minor Signature (optional, unless minor consent) Print Name Date

☐ Consent provided electronically or verbally/by phone.

_____ _____ _____

Clinical Staff/Witness - signature Print Name Date

☐ Consent provided electronically or verbally/by phone.

Office Use: ☐Copy offered to client/accepted ☐ Copy offered to client/declined

Updated 7.2023

610 Elm Street, Suite 212, San Carlos, CA 94070
(650) 591-9623

Credit Card Authorization Form

Please complete all fields.

Card Type: ☐ VISA ☐ MasterCard

Cardholder Name (as shown on card): _____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: (MM/YY): _____

Security Code: _____

Numeric portion of Street Address: _____

Cardholder Zip Code (from credit card billing address): _____

Cardholder email (for signature requests and receipts): _____

I,_____, authorize StarVista to charge my credit card after each therapy session. I understand that my information will be saved for future charges.

_____ _____

Signature Date

☐ Consent obtained electronically or by phone.

Internal:

Program: San Mateo County Pride Center

Clinician Name: _____

Client Name: _____

ETO# _____

CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328

San Mateo County Health System
Behavioral Health & Recovery Services

AUTHORIZATION for SESSION RECORDING and/or 1-WAY MIRROR OBSERVATION

Client Name _____ **MH Number** _____

I do hereby give my consent to have counseling sessions observed and/or recorded.

I understand that this taping will be treated with complete confidentiality and will be discussed only with the clinical staff within this agency and, in the case of clinical trainees, with the immediate clinical supervisor of the trainee. If the taping is discussed in an educational setting no clients or families will ever be identified by name.

This authorization shall be valid until _____. In all circumstances, the consent must be renewed annually.

I consent to the following conditions:

1. Audio Recording
2. Audio/Video Recording
3. One-Way Mirror Observation
4. Other (specify) _____

I understand that my consent is voluntary and may be withdrawn at any time.

Signature _____ **Date** _____
Client/Legal Representative

If signed by someone other than the client, state legal relationship to the client:

_____

Original to Client Chart

cc: Client
Authorized Clinician