



*Asian Pacific Counseling & Treatment Centers*

*Asian Pacific Counseling and Treatment Centers (APCTC) is a division of Special Service for Groups, Inc. (SSG), a legal entity contracted with Los Angeles County Department of Mental Health (LACDMH)*

## CONSENT FOR SERVICES

### INTRODUCTION TO SERVICES

Asian Pacific Counseling and Treatment Centers (APCTC) provides Specialty Mental Health Services (SMHS) for people who have mental illness or emotional problems that require treatment by a specialist. These illnesses or problems are severe enough that they get in the way of a person's ability to carry on with their daily activities. SMHS may include psychological testing, psychotherapy/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. For more information about these services, please refer to the Los Angeles County Mental Health Plan Beneficiary Handbook for Specialty Mental Health Services: <https://dmh.lacounty.gov/our-services/patients-rights/mhp-handbooks/> (see QR code on page 7). You may request a copy of this Handbook at any time.

All SMHS provided to a client within the LACDMH system will be coordinated by staff of a single agency. Services may be delivered at different locations if this will benefit the client's treatment. To find LACDMH directly operated and contracted provider sites throughout Los Angeles County, please refer to LACDMH's Provider Directory: <https://dmh.lacounty.gov/pd/> (see QR code on page 7).

### SERVICE DELIVERY

When providing SMHS, APCTC primarily utilizes in-person contact. Telehealth, telephone, limited text messaging and email are also utilized to best meet the needs of our clients.

**Telehealth services** incorporate the use of video teleconferencing along with audio, so practitioners and clients may visually see and communicate with each other, even though both parties are in a different physical location. **Telephone services** incorporate the use of a telephone so practitioners and clients may also communicate with each other, however there are no visual capabilities. For both telehealth and telephone services, practitioners will continue to provide the covered SMHS to the client as well as provide documentation that will be included in a client's clinical record for future reference.

**Text Messaging and Email Messaging** are additional ways in which our staff can quickly and efficiently communicate with clients regarding their services. Texts and emails will be limited to appointment and treatment reminders. Occasionally, consumer perception surveys and/or other helpful resources and information may be sent out via email. Staff will not use text or email messaging for diagnostic or therapy purposes and will not include protected health information (PHI).

The only exception would be in response to a client's specific request to receive electronic PHI over email. Any email containing a client's electronic PHI will be encrypted and secured. According to the Health Insurance Portability and Accountability Act (HIPAA), email security and privacy regulations are required to ensure the privacy and confidentiality of clients.

APCTC is a Division of Special Service for Groups

Alhambra Center

Cerritos Center

Main Center

San Fernando Valley Center

Riverside Center

West Covina Center

Wilshire Center



Without client consent for electronic messaging, APCTC staff will not initiate text or email messaging with clients or offer text and email messaging as modes of communication. If a client initiates text or email messaging with an APCTC staff despite not providing consent to do so at the start of treatment, staff will respond and consider the initiation as temporary consent. Staff will later clarify and receive written consent to receive electronic messaging if necessary. It is important for clients to keep their mental health provider(s) informed of their current contact information should it change at any time.

Clients have the right to access any covered services that can be delivered via telehealth or telephone through an in-person visit if they so choose. Medi-Cal coverage includes the availability of transportation services for in-person visits when other available resources have been reasonably exhausted. To access information about obtaining transportation, talk to your Managed Care Plan's Member Services Department or go to:

<https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx>.

### **PROTECTED HEALTH INFORMATION**

By law, APCTC is required to ensure that your Protected Health Information (PHI) is kept private. PHI constitutes information about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. All new clients are given a **Notice of Privacy Practices** that explains when, why, and how APCTC would use and/or disclose your PHI. With some exceptions, APCTC may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, APCTC is always legally required to follow the privacy practices. The Notice of Privacy Practice can be found at:

<https://dmh.lacounty.gov/our-services/consumer-and-family-affairs/privacy/> (see QR code on page 7).

### **CONFIDENTIALITY**

All information disclosed during sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission. There are exceptions where disclosure without your written permission is required or permitted by law. Such exceptions include but are not limited to: *1. Suspected abuse (physical, sexual, verbal, neglect, etc.) of children. 2. Suspected abuse (physical, sexual, financial, verbal, neglect, etc.) of any elderly and/or dependent persons. 3. Serious threat to your health and safety or the health and safety of others (i.e. a threat to harm oneself and/or someone else).* Most of the provisions explaining when the law requires disclosure are described in the Notice of Privacy Practices.

**Health Insurance & Confidentiality of Records:** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP to process the payment claims. Only the minimum necessary information will be communicated to the carrier. APCTC has no control or knowledge over what insurance companies do with the information.

**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf, will call on APCTC to testify in court or at any other proceeding.

## **ADVANCE HEALTH CARE DIRECTIVES FOR ADULT BENEFICIARIES**

An Advance Health Care Directive is a legal document that allows an individual to state in advance their wishes should they become unable to make healthcare decisions in the future. All Medi-Cal beneficiaries 18 years of age and older have the right to make decisions about their medical treatment unless they are conserved, or a third party has been granted the ability to make their health care decisions. Any person 18 years or older who has the “capacity” to make health care decisions can fill out an Advance Health Care Directive. “Capacity” means the person understands the nature and consequences of the proposed healthcare, including the risks and benefits.

An Advance Health Care Directive goes into effect when the person’s primary physician decides the person does not have the “capacity” to make their own healthcare decisions. This means the individual is unable to understand the nature and consequences of the proposed healthcare. The fact that a person has been admitted into a psychiatric facility does not mean the person lacks “capacity.”

In California, an Advance Directive consists of two parts: (1) appointment of an agent for healthcare; and (2) individual health care instructions. For a person with a psychiatric disability, an Advance Health Care Directive can:

- Allow you to make treatment choices now in the event you need mental health treatment in the future. You can tell your doctor, institution, provider, treatment facility, and judge what types of treatment you do and do not want.
- Select a friend or family member to make mental health care decisions, if you cannot make them for yourself.
- Improve communications between you and your physician.
- Reduce the need for long hospital stays.
- Become a part of your medical record.

In California, an Advance Health Care Directive is indefinite. You can change your mind at any time, as long as you have the “capacity” to make decisions. It is a good idea to review your Advance Health Care Directive yearly to make sure your wishes are stated. It is also important to keep track of who has a copy of your Advance Health Care Directive in case you make changes to the document. You, your agent (the person designated to make health care decisions if you are unable to do so), each of your health care providers, and each of your mental health providers should have a copy of your Advance Health Care Directive.

Advance Health Care Directive Forms can be obtained from your attorney and the internet. You can get legal advice about an Advance Health Care Directive from your attorney and/or the Protection and Advocacy, Inc. Complaints concerning non-compliance with the Advance Health Care Directive requirements may be filed with the California Department of Health Services (DHS) Licensing and Certification by calling 1-800-236- 9747 or by mailing to P.O. Box 997413, Sacramento, California 95899-7413.

## **THE PROCESS OF THERAPY/EVALUATION**

Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and difficult. There is no guarantee that therapy will yield positive or intended results.

**Discussion of Treatment Plan:** After the initial session(s) with a designated clinician who is tasked to assess your presenting problems/needs and functional impairments, the clinician will collaborate with you on a working understanding of the problem, treatment plan, therapeutic objectives, and our view of the possible outcomes of treatment. You have the right to ask about any of the procedures used during your therapy, APCTC's expertise in employing them, about the treatment plan, or other treatments for your condition and their possible risks and benefits. If you could benefit from any treatment that APCTC does not provide, we will refer you to other resources.

**Termination:** You have the right to terminate therapy at any time. If you choose to do so, APCTC will provide you with names of other agencies and/or qualified professionals whose services you might prefer. If at any point during treatment, APCTC assesses that we are not effective in helping you reach the treatment goals, we will discuss this with you and terminate treatment. APCTC reserves the right to terminate treatment in the event of threats or of actual violent acts against our staff or others.

**Dual Relationships:** Dual relationships refer to any relationships in addition to the therapeutic relationship between APCTC staff and the client. APCTC prohibits such dual relationships.

## **ATTENDANCE/CANCELLATION POLICY**

Regular and consistent attendance contributes to positive treatment outcomes. Failure to cancel in advance and missing appointments is a disruption to treatment. Also, last-minute cancellations and absences affect our ability to provide appointments to others who are in need of treatment.

**Cancellation:** Should you need to cancel your appointment, please provide a minimum of 24 hours' notice. If APCTC needs to cancel or remind you of your appointment, we will attempt to reach you by phone as soon as possible. Unless you indicate otherwise, we will leave you a phone message.

**Late Cancellations:** After two (2) late cancellations (cancelling less than 24 hours before your appointment), your preferred appointment time cannot be held or guaranteed. Multiple appointment cancellations within a 60-day period may result in the closing of your case with APCTC.

**No Shows:** If you miss your appointment without cancelling, that is considered a *NO SHOW*. After your first *NO SHOW*, any additional *NO SHOWS* will result in the cancellation of any future appointments you have scheduled with the staff member. After three (3) *NO SHOWS* with any staff member, your case may be closed with APCTC.

**PAYMENTS & INSURANCE REIMBURSEMENT**

You are responsible for the treatment fee. If you carry insurance (Medi-Cal, Medi-Care, etc.), it is your responsibility to show proof of coverage and inform us. We will bill your insurance company and furnish it with the minimum information required to process the payment claim.

**PAYER FINANCIAL INFORMATION (UMDAP):** You will also need to update and sign the PAYER FINANCIAL INFORMATION form on a yearly basis. Our business office staff will receive this information from you annually.

**OPEN PAYMENTS DATABASE:** The federal Physician Payments Sunshine Act requires that detailed information about payments worth over ten dollars (\$10) to physicians from manufacturers of drugs, medical devices, and biologics be made available to the public. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. The Open Payments database can be found at <http://openpaymentsdata.cms.gov>

**NOTICE TO CLIENTS/CONSUMERS/PATIENTS**

A complaint can be filed with the Board of Behavioral Sciences (BBS), where the practitioner is licensed/registered (i.e., marriage and family therapists or clinical social workers), regarding the services received by the practitioner. This notice complies with AB 630, Chapter 229, Statutes of 2019 to provide this information to clients who receive psychotherapy. Similarly, a complaint can be filed with the Board of Psychology, where the practitioner is a licensed/registered psychologist. Or, a complaint can be filed with the Medical Board of California, where the practitioner is a licensed medical doctor.

**HOW TO FILE A COMPLAINT:**

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](http://www.bbs.ca.gov) or by calling (916) 574-7830.

The **Department of Consumer Affairs' Board of Psychology** receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the Board by visiting [www.psychology.ca.gov](http://www.psychology.ca.gov), e-mailing [bopmail@dca.ca.gov](mailto:bopmail@dca.ca.gov), calling 1-866-503-3221, or writing to the following address: Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834.

The **Medical Board of California** regulates licensed medical doctors. To check up on a license or to file a complaint, go to [www.mbc.ca.gov](http://www.mbc.ca.gov), email: [licensecheck@mbc.ca.gov](mailto:licensecheck@mbc.ca.gov), or call (800) 633-2322.

Additional client's rights materials and grievance and appeals procedures and forms can be found at [dmh.lacounty.gov/our-services/patients-rights/](http://dmh.lacounty.gov/our-services/patients-rights/) (see QR code on page 7) and in the County of Los Angeles Beneficiary Handbook for Specialty Mental Health Services. LACDMH Patient's Rights Office can be contacted by calling (800) 700-9996. Complaints with APCTC can also be expressed by calling APCTC's director at (213) 252-2100 and/or through [www.apctc.org](http://www.apctc.org).

### **Clinical Practice Guidelines**

The Department of Mental Health develops and adopts clinical practice parameters that are based on valid and reliable clinical evidence and/or consensus of providers in mental health. The clinical practice parameters are reviewed and updated on a regular basis. The DMH Clinical Practice Parameters can be found at <https://secure2.compliancebridge.com/lacdmh/public/index.php?fuseaction=app.main&msg=> or by asking your provider.

### **EMERGENCY PROCEDURES**

In case of an emergency, please call the police (911), mental health emergency line (988), or the Los Angeles County Department of Mental Health ACCESS number: (800) 854-7771. You may also text the Crisis Text Line "HOME" to 741741.

### ***By consenting to APCTC services, you understand:***

1. You have a right to be informed of and participate in the selection of any of the Specialty Mental Health Services described in the County of Los Angeles Beneficiary Handbook for Specialty Mental Health Services.
2. You have a right to receive services without being required to receive other services from LACDMH system.
3. All services, including the use of telehealth, telephone, secure email and/or secure text messaging, are voluntary, and you have the right to request a change in service provider (agency or staff).
4. You have the option to withhold or withdraw consent for any service, mode of service, or method of communication at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. Mental health staff may also withdraw the ability to utilize specific modes of service or methods of communication at any point in which it is determined it is not the most appropriate means of service provision and/or communication.
5. All APCTC staff, as a condition of their employment, sign an oath of confidentiality which prohibits them from sharing client information except as allowed under federal, State, and Department confidentiality laws, policies, and procedures.
6. Any information disclosed to staff which is determined by them to be important to care will be recorded in the clinical record to ensure treatment staff have available to them the most complete information about you when deciding on treatment appropriate to your needs and for quality of care.
7. Your demographic and clinical information is entered into APCTC's electronic health record system and may be made available to staff within APCTC and other authorized individuals involved in your treatment as appropriate. Please refer to the Los Angeles County Health Agency Notice of Privacy Practices for more information.
8. The potential risk of telehealth and telephone services include partial or complete failure of the equipment being used which could result in mental health staff's temporary inability to provide mental health services.

9. By consenting to secure email and/or secure text messaging, you agree to allow APCTC staff to send information about your mental health condition and care to you via secure text and secure email.
10. Secure email and secure text messaging will never be used for emergency or urgent situations and/or diagnostic purposes. You should discuss with your provider how best to contact them after normal business hours or during an emergency or urgent situation. Any requests to be assessed through secure email or secure text messaging will not be honored

There are technical considerations for your personal device(s) when **Telehealth, Telephone, Secure Email** and/or **Secure Text Messaging** are utilized. ***By consenting, you understand the following:***

1. APCTC assumes no liability for your device if installation of approved APCTC telehealth / secure text messaging / secure email application causes any conflict, malfunction, or damage.
2. You are fully responsible for handling, operating, and maintaining your device and applications. Should your device be compromised, lost, or stolen, APCTC will not be held responsible for the disclosure of information, including but not limited to, Protected Health Information (PHI) residing on the device.
3. APCTC does not allow recording of sessions, including telephone and telehealth sessions, unless explicit consent is given by you and by your practitioner.
4. APCTC will not share your personal identifiable images or information from telehealth interactions to researchers or other entities without your consent.
5. There may be a delay between the time a secure text message and/or secure email are submitted and the point at which your treating provider reads and/or responds. You will not know if the information in the text/email has been seen, and APCTC cannot anticipate when you will receive a response.
6. The APCTC approved secure text messaging and secure email is the only option for sending and receiving text information with APCTC staff.
7. You are responsible for any data usage or texting messaging fees associated with using your personal device when you are using it for telehealth, telephone, and secure text messaging.
8. Information sent via secure text and secure email may assist mental health staff in providing treatment and scheduling.
9. Although email(s) and text message(s) will be sent through a secure means, there is a risk that an email or text intended for you may be inadvertently sent to the wrong email address or phone number.



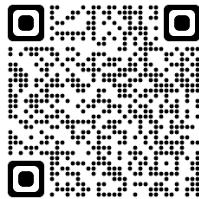
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### QR CODES

Please scan the below QR codes to access our APCTC Website and forms.

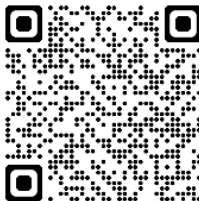
APCTC Website

[www.apctc.org](http://www.apctc.org)



APCTC Website-Forms

<https://www.apctc.org/forms.html>



APCTC Welcome Packet

[https://www.apctc.org/uploads/1/1/5/0/115018149/apctc\\_welcome\\_packet\\_english\\_5.15.23\\_final.pdf](https://www.apctc.org/uploads/1/1/5/0/115018149/apctc_welcome_packet_english_5.15.23_final.pdf)







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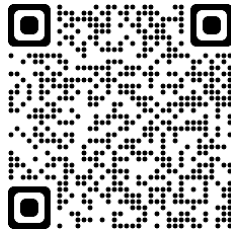
### QR CODES

Please scan the below QR codes to access resources from the LAC DMH website.

## Los Angeles County Department of Mental Health

Provider Directory

<https://dmh.lacounty.gov/pd/>



Consumer Resource Directory

[https://file.lacounty.gov/SDSInter/dmh/1059976\\_CONSUME\\_RRESOURCEDIRECTORY\\_07-19\\_.pdf](https://file.lacounty.gov/SDSInter/dmh/1059976_CONSUME_RRESOURCEDIRECTORY_07-19_.pdf)



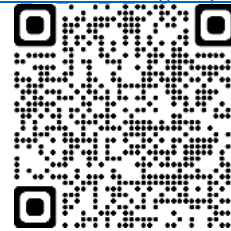
Notice of Privacy Practices

[https://file.lacounty.gov/SDSInter/dhs/1034641\\_rev218HA10\\_052017FinalHANPPHandoutEnglish.pdf](https://file.lacounty.gov/SDSInter/dhs/1034641_rev218HA10_052017FinalHANPPHandoutEnglish.pdf)



Request for Change of Provider Form

[https://file.lacounty.gov/SDSInter/dmh/1041262\\_200\\_05\\_Att\\_1\\_English.pdf](https://file.lacounty.gov/SDSInter/dmh/1041262_200_05_Att_1_English.pdf)



Mental Health Plan Beneficiary Handbook

<https://dmh.lacounty.gov/our-services/patients-rights/mhp-handbooks/>



Beneficiary / Client Grievance of Appeal and Authorization Forms

<https://dmh.lacounty.gov/our-services/patients-rights/>



\*Please scroll down and choose your language of choice





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### CONSENT FOR SERVICES AND ACKNOWLEDGMENTS FORM

I, \_\_\_\_\_, consent to receiving mental health services by **Asian Pacific Counseling and Treatment Centers (APCTC)**.

**I have read the information provided in this consent. I had the opportunity to ask questions about this information, and all my questions have been answered. I understand the written information provided.**

- *I consent to the use of Telehealth services* Yes      No
- *I consent to the use of Telephone services* Yes      No
- *I consent to the use of Text Messaging for communication* Yes      No

**Phone Number** for telephone and/or texting: \_\_\_\_\_

- *I consent to the use of Email for communication* Yes      No

**Email Address** for telehealth and/or email: \_\_\_\_\_

*Please initial to indicate understanding of the following items:*

- **Privacy, Confidentiality, and Limits to Confidentiality** \_\_\_\_\_
- **The Process of Therapy/Evaluation & Termination** \_\_\_\_\_
- **Attendance/Cancellation Policy** \_\_\_\_\_
- **Payments & Insurance Reimbursement** \_\_\_\_\_
- **Notice to Clients/Consumers/Patients** \_\_\_\_\_
- **Emergency Procedures** \_\_\_\_\_

#### *Advance Health Care Directives*

- **I have been provided information on Advance Health Care Directives** Yes      No
- **I have an Advance Health Care Directive currently in place** Yes      No

*If yes, please provide a copy for us to place in your clinical record*





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### CONSENT FOR SERVICES AND ACKNOWLEDGMENTS FORM (CONT.)

Client was offered the APCTC Welcome Packet and the following Patient’s Rights materials upon first receiving services. Copies of these materials can be requested anytime:

• <b>APCTC Welcome Packet</b>	QR code/links	Hard copies
• <b>Mental Health Plan Beneficiary Handbook</b>	QR code/links	Hard copies
• <b>LAC-DMH Grievance &amp; Appeal Procedures</b>	QR code/links	Hard copies
• <b>Provider Directory</b>	QR code/links	Hard copies
• <b>Consumer Resource Directory</b>	QR code/links	Hard copies
• <b>LACDMH Request for Change of Provider</b>	QR code/links	Hard copies
• <b>LACDMH Notice of Privacy Practices</b>	QR code/links	Hard copies

**By signing, I consent to receive services and acknowledge receiving the above documents at the intake appointment, being introduced to services at this agency, and being informed about my rights as a client.**

_____ Signature of Client *	_____ Date	_____ Client Name (Print)
_____ Signature of Responsible Adult **	_____ Date	_____ Relationship to Client
_____ Signature of Staff ***	_____ Date	_____ Language (if interpreted)

\*A minor client receiving services under his/her own signature must have the signed Consent of Minor form in the clinical record  
 \*\*Responsible Adult = Guardian, Conservator, or Parent of minor when required  
 \*\*\*Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language in which it was interpreted)

Client was given the above copies, but unwilling to sign the Consent to Services and Acknowledgments Form  
 Client and/or Responsible Adult is unavailable/unable to sign. Verbal/implied consent provided on \_\_\_\_\_  
 Due to intake conducted via telehealth/telephone, information discussed and client directed to [www.apctc.org](http://www.apctc.org) to view the documents. Hardcopies will be offered at in-person meeting.

This confidential information is provided to you in accord with State and Federal laws and regulations included but not limited to applicable Welfare and Institutions code, Civil Code, and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the state purpose of the original request is fulfilled.	<b>Name:</b>	<b>IS#:</b>
	<b>Agency:</b>	<b>Provider#:</b>

