

## Understanding Group Therapy and Consent to Treatment for Adolescents

The success of group therapy depends upon a high degree of trust between you, your group facilitators and fellow group members. This document has been prepared to fully inform you and your parents about what to expect from group therapy and from your group facilitators.

### **Understanding Group Therapy**

Group therapy is a process of understanding more about yourself and others in a safe environment. In group you will have the opportunity to explore patterns of thinking and behaving that are similar to how you relate to others in your life. Objectives of group therapy include, but are not limited to:

- Develop skills to assist you in reaching your goals
- Feel a sense of support from other group members
- Understand more about yourself and your family system
- Identify and explore thoughts, feelings and behaviors that hold you back
- Learn how to improve relationships with others

You are welcome to share as much or as little about yourself while in the group, however, the more open you are the better experience you will have. Please ask questions at any time. The more deeply you understand the process of therapy, the more effectively you will be able to incorporate positive change into your life.

### **Your Group Facilitators and the Therapeutic Relationship**

Your group facilitators are Karin Thebus, Psy.D. and Melissa Hansen, Psy.D. Both Dr. Thebus and Dr. Hansen are Registered Psychological Assistants in the state of California. Thus, they are pre-licensed clinicians who work under the supervision of Rochelle Perper, Ph.D., PSY23090. Psychological Assistants are registered by the California Board of Psychology and can perform all of the same duties as a licensed Psychologist.

The relationship between you and your group facilitators is special and unique. You will be sharing information in group that is sensitive and personal. With time, you may come to feel close to your facilitators and may wish to spend time with her in a more social environment. However, in order to protect your confidentiality and maintain professionalism, group facilitators and group members do not socialize together outside of group time. Under no circumstances is it ever okay for a therapist or group facilitator to be romantically or sexually engaged with you or another group member.

#### *The role of your group facilitators*

Our philosophy and approach to group therapy is the belief **that this is your group.** Each group member will have an equal say in what topics will be discussed and what format feels most beneficial. Your group facilitator's primary responsibility is to create an atmosphere of safety and support in order for you to get the most out of group. Your group facilitator will encourage each group member to be honest, vulnerable, and respectful about his or her feelings and observations in the group. If you are ever feeling unsafe in group, talk with your group facilitator. If for any reason you experience any negative reactions or blocks towards participation, please share this with the group. Your voice is your power and your right.

### **Potential Benefits of Group Therapy**

Participating in group therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improving personal relationships, and resolution of specific problems you are facing

in your life. It is important to recognize that therapy is not magic and change does not occur overnight. Your willingness to participate fully in group and your openness to take feedback from your facilitators and other group members will play a role in how much you gain in therapy. In particular, the extent to which you are open and honest about yourself will play a role in how quickly you can achieve your goals.

### **Knowing the Risks of Group Therapy**

There can be discomfort involved in participating in group therapy. You may remember unpleasant events, or experience feelings of anger, fear, anxiety, frustration, loneliness, helplessness, or other unpleasant feelings. If these distressful emotions arise during your therapy, please talk with your group and with your group facilitator.

During the process of group therapy, it is normal to have intense feelings and reactions to other group members or even towards your group facilitators. Again, these are understandable emotions that should be discussed and processed in the group setting. If you believe that group is not the most appropriate setting for you to heal and grow, you have several options available to you:

1. You can receive individual therapy as well as group therapy
2. You can consider just participating in individual therapy with one of the group facilitators, another member of the Therapy Changes team, or from an outside referral
3. Your group facilitator can assist you in finding another group that is a better fit for your needs

### **Confidentiality**

It is important that you feel comfortable in group to talk freely about whatever is bothering you. Sometimes you might want to discuss things that you do not want your parents or guardians to know about. **You have the expectation of privacy in group sessions.** As a general rule, group facilitators do not talk to your parents about what you discuss in group without your permission. However, there are some exceptions to this rule. In some situations, in accordance with professional ethics and California law, your facilitator may disclose information without your permission. Some of the circumstances where disclosure is required by California law are: 1) If you, another minor, a dependent person or an elder adult is being abused; 2) If you are in danger of hurting yourself, someone else or another person's property; 3) When a family member communicates to your facilitator that you present a danger to others

If you are doing things that could cause serious harm to you or someone else, your facilitator will use her professional judgment to decide whether a parent or guardian should be informed. In these situations, your facilitator will talk with you about her concerns and discuss the best way to include your family in order to get the support that you need.

#### *Group member's agreement for confidentiality*

All members of the group will be asked to agree to a high level of confidentiality in the group sessions. This means that each participant agrees not to share any other group member's identifying and personal information with others. It is appropriate to share your personal reaction and feelings about group with others, but **please do not share other people's stories with anyone outside of the group.**

### **Fees**

The fee for each group session is \$45.00. Payment is requested at the beginning of every group session. Some group members may choose to pay in advance for services rendered on a monthly basis. If you pay in advance and have an excused absence, then that payment will be held as a credit for future sessions.

Payment can be made by debit or credit card, cash or check payable to ‘Therapy Changes’. As the administrative costs of running a practice change, session fees may be adjusted accordingly. In such cases, your group facilitator will discuss the adjusted fee with you or your parent/guardian at least 30 days before a change will come into effect.

#### *Time spent on your behalf*

In addition to the time spent in group, time spent on your behalf outside of group may be charged at \$120.00 per hour. This time might include, but is not limited to: consultations with other treatment providers, reading or writing documents, family therapy or report writing. Typically, any time exceeding 20 minutes outside of the regularly scheduled group sessions is subject to additional charge.

#### **Electronic Communications**

It is important to be aware that electronic communication, such as e-mail, is not secure. It can be relatively easily accessed by unauthorized people and can compromise your privacy and confidentiality. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. A non-encrypted e-mail, such as your group facilitator’s email, is even more vulnerable to unauthorized access. Although your facilitator’s emails are not encrypted, her office computer is equipped with a firewall, a virus protection and a password.

E-mail is a helpful tool for asking general questions of your facilitator, confirming appointments, and conveying relevant information and updates. However, **e-mail should not be used as a substitute for therapy**. Your group facilitator will not conduct therapy via email, and in such cases that lengthy or disclosing emails are received; she will invite you to talk about it during group. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail. Otherwise, your therapist may communicate with you via e-mail when necessary or appropriate. Please do not use e-mail for emergencies and please note that e-mails, faxes, etc. are all part of the clinical records.

#### *Online reviews and social media*

We understand that the use of the internet, online reviews, and social media impact virtually all aspects of our lives – especially as teens. **Please be aware of the implications of posting information about your group therapy online!** If you post an online review, status update, tweet, or blog about your experience in therapy, you are publicly acknowledging a therapist-client relationship and have thus waived your right to privacy. Please consider any potential negative impact that this could have either today or in your future.

#### *Social networking & internet searches*

In order to protect your privacy, it is our policy not to follow you electronically. For example, your group facilitators will not Google you, view your Facebook page, ‘friend’ you on Facebook, or follow you on Twitter. Exceptions to this may include instances of safety or situations of acute crisis.

#### **Emergencies**

Your therapist can be reached during normal business hours Monday through Friday by calling Therapy Changes at 619-275-2286. Please note that she may not be immediately available to handle emergency situations. If you are in need of emergency assistance, call ‘911’ or the San Diego Crisis Line at 1-888-724-7240. Unless otherwise specified, phone messages will be returned by your therapist within 24 hours.

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**Consistent Attendance**

It is very important that you consistently attend scheduled group therapy sessions. Although illness, unexpected events or vacations may occasionally interrupt your therapy, consistent attendance plays a large role in helping you, and your fellow group members achieve your desired goals. Please be aware that your absences negatively influence the progress of yourself and the other group members. If for any reason you are not able to attend a group session, please inform your group facilitator.

**Conclusion of Group Therapy**

There are many different levels of care that therapists provide. Although group therapy is a very helpful tool for many people, the level of care offered at Therapy Changes and with this group may sometimes not be the best match to your needs. If at any point during therapy your facilitator assesses that she is not effective in helping you reach your goals in the group setting, she will provide you and your parent/guardian with a number of referrals that may be of help. We ask that you give the group a month’s notice when you are ready to leave in order to say goodbye fully.

In the event that I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a trusted licensed psychologist as my professional executor. My professional executor would be given access to my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services or to facilitate continued care with another qualified professional.

If you have any questions or concerns regarding this document, I will be glad to discuss them with you. Please sign below to indicate that you understand and agree to the above, and consent to group therapy treatment. You are encouraged to keep a copy of this form, and refer to it from time to time during your therapy.

\_\_\_\_\_  
 Signature of Adolescent Client

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Adolescent Client

*All legal guardians must sign below:*

\_\_\_\_\_  
 Signature of Client’s Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Legal Guardian

\_\_\_\_\_  
 Signature of Client’s Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Legal Guardian

## Acknowledgement of Receipt: Notice of Privacy Practices

I have read and understand Therapy Changes Notice of Privacy Practices outlined below.

\_\_\_\_\_  
Printed Name of Adolescent Client

\_\_\_\_\_  
Signature of Client's Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Guardian

*You may refuse to sign this acknowledgement*

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### Required HIPAA Notice of Privacy Practices

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.**

**II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

**III. HOW I MAY USE AND DISCLOSE YOUR PHI**

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

- i. **For Treatment.** I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care



providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

- ii. **To Obtain Payment for Treatment.** I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
- iii. **For Health Care Operations.** I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.
- iv. **For Patient Incapacitation or Emergency.** I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

- i. **When federal, state, or local laws require disclosure.** For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.
- ii. **When judicial or administrative proceedings require disclosure.** For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.
- iii. **When law enforcement requires disclosure.** For example, I may have to use or disclose your PHI in response to a search warrant.
- iv. **When public health activities require disclosure.** For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
- v. **When health oversight activities require disclosure.** For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.



- vi. **To avert a serious threat to health or safety.** For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
- vii. **For specialized government functions.** For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.
- viii. **To remind you about appointments and to inform you of health-related benefits or services.** For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.** Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

#### IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- A. **The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.
- B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
- C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written

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request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

- D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.
- E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.
- F. The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

**V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES:** Rochelle Perper, Ph.D., 5055 North Harbor Drive, Suite 320, San Diego, CA 92127, (619) 275-2286.

**VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on February 10, 2017.