Trust 2 Believe

Sogol Philipson, LCSW | California LCSW #66853

4199 Campus Drive, Suite 550 | Irvine, CA 92612 | Telehealth

Client Rights in Psychotherapy

You may ask questions about your treatment, discuss alternatives, decline a proposed intervention, seek a second opinion, and stop treatment at any time. You remain responsible for fees for services already provided and any lawful charges under the signed financial policy.

Your participation and treatment

Therapy is voluntary except where participation is required by a separate legal process. You and your therapist will collaborate on goals, treatment approaches, and referrals when appropriate. Benefits are not guaranteed; discussing difficult experiences may temporarily increase distress.

Confidentiality and its limits

Your treatment information is protected by applicable federal and California law. Disclosures may occur with valid authorization or when permitted or required by law, including certain mandated abuse reports, serious safety concerns, and legally valid processes. Psychotherapy records may receive special protections; not every subpoena automatically authorizes disclosure.

Records and recordings

You may request access to or copies of records subject to applicable exceptions, request corrections, and receive a copy of the privacy notice. Neither party should record sessions without appropriate prior permission; any clinician recording requires specific informed consent.

Questions and complaints

You may raise concerns without retaliation. California Board of Behavioral Sciences licensing and complaint information should be provided in the final approved version.

I acknowledge receiving information about my rights

☐ Acknowledged

Acknowledgment / signature

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

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Communication & Availability

Routine communication

Use the practice-approved scheduling and messaging channels for appointments, cancellations, and administrative questions. Ordinary email and text may be insecure; do not send sensitive clinical information unless the practice confirms a secure method. Communication preferences and risks will be discussed.

Response time

The therapist generally aims to respond within one business day, Monday through Friday, excluding holidays. This is a goal, not a guarantee. Messages are not monitored continuously and are not a crisis service.

Emergencies

For immediate danger, call 911 or go to the nearest emergency department. In the United States, call or text 988 for suicide and crisis support. Do not rely on voicemail, email, or portal messages for urgent assistance.

Telehealth logistics

If a session disconnects, attempt to reconnect using the agreed platform. If unsuccessful, use the designated backup contact method. At each session, the therapist may confirm your physical location and emergency contact information.

Permitted administrative contact methods (check all that apply)

☐ Phone ☐ Text ☐ Email

Preferred phone number / email

May a neutral voicemail be left?

☐ Yes ☐ No

Acknowledgment / signature

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Date

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Fees & Financial Agreement

Services and fees

Standard individual psychotherapy session: $150. Session length, any longer-session pricing, and fees for other services must be confirmed before scheduling. Telehealth services are provided to eligible clients located in California.

Payment

Payment is due at the time of service unless another arrangement is made in writing. Accepted payment methods and any returned-payment charges must be confirmed by the practice. No blanket promise is made that fees are tax deductible.

Cancellation and missed appointments

Please provide at least 24 hours notice to cancel or reschedule. A late-cancellation or missed-session fee may apply only if the amount and exceptions are separately disclosed and agreed upon, and only as permitted by law and applicable payer rules.

Late cancellation / no-show fee amount (practice to confirm before use)

Insurance and private pay

The practice must disclose whether it participates in insurance plans, whether superbills are available, and how out-of-network reimbursement works. Reimbursement is never guaranteed. Fees and payment responsibilities will be explained before services begin.

Good Faith Estimate

If you are uninsured or not using insurance, you may be entitled to a Good Faith Estimate of expected charges under federal law. A separate estimate and applicable dispute-resolution information should be provided when required.

I have reviewed the fees and cancellation terms

- [ ] Acknowledged

Acknowledgment / signature

Client full name



Fees & Financial Agreement

Client signature (type name if accepted by your secure e-signature workflow)

Date

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Notice of Privacy Practices - Draft

IMPORTANT: This is a proposed plain-language framework, not a finalized Notice of Privacy Practices. It requires a comprehensive review against HIPAA, California confidentiality law, and current federal requirements before publication.

Our duties

We protect your protected health information (PHI), provide notice of privacy practices, and notify affected individuals when required following a breach of unsecured PHI. We follow the notice currently in effect.

How information may be used

As permitted by law, PHI may be used for treatment, payment, healthcare operations, appointment reminders, and other legally authorized purposes. Additional restrictions may apply to psychotherapy notes, certain reproductive-health information, and substance-use-disorder records.

When permission is required

Uses or disclosures requiring written authorization will not occur without it. Authorizations may generally be revoked in writing, except to the extent already relied upon. Marketing, sale of PHI, and psychotherapy-note disclosures have special rules.

Your rights

You may request access, amendment, an accounting of certain disclosures, restrictions, confidential communications, and a paper copy of the notice. You may file a privacy complaint without retaliation.

Practice privacy contact

Privacy contact email / telephone - confirm

Notice effective date - confirm

Required full-notice content to finalize

A California healthcare privacy professional must review and expand the full notice, including all required uses, legal exceptions, patient rights, complaint procedures, contact details, and applicable 2026 regulatory changes.

I acknowledge receiving this notice (not consent to disclosure)

☐ Acknowledged

Acknowledgment / signature

Notice of Privacy Practices - Draft

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

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Confidentiality & Mandated Reporting

Child abuse and neglect

California law requires specified professionals to report known or reasonably suspected child abuse or neglect to designated agencies under applicable reporting rules. The therapist does not conduct a law-enforcement investigation.

Elder and dependent adult abuse

California law also requires reports of certain known or suspected abuse or neglect of elders and dependent adults. Reporting rules depend on the circumstances and setting.

Safety concerns

If serious threats or imminent safety concerns arise, the therapist may take steps permitted or required by law to protect the client or others. Not every mention of suicidal thoughts or harm automatically results in a report to police or hospitalization; decisions depend on clinical and legal circumstances.

Privacy

Only information required or permitted by law will be shared. Other confidentiality protections continue to apply.

I understand the limits of confidentiality explained above

☐ Acknowledged

Acknowledgment / signature

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

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New Client Questionnaire

Please complete what you can. You may leave a question blank and discuss it privately with your therapist. This information is collected for clinical care; use a secure intake system rather than ordinary website email.

Contact details

Full legal name

Preferred name / pronouns (optional)

Date of birth

Address / city / state / ZIP

Phone

Email

Emergency contact name / relationship / phone

Reason for seeking care

Main concerns (select any)

- [ ] Relationships
- [ ] Anxiety
- [ ] Depression

Additional concerns

- [ ] Life transitions
- [ ] Stress
- [ ] Grief

What would you most like help with?

What changes would tell you therapy is helping?

Previous care and current health

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New Client Questionnaire

Have you previously received mental health treatment?

☐ Yes ☐ No

Prior therapy / hospitalization (optional details)

Current medications and relevant health conditions

Current healthcare or psychiatric providers (optional)

Safety screening

If you are in immediate danger, do not use this form; call 911 or 988 as appropriate.

Are you currently concerned you may harm yourself or someone else?

☐ Yes ☐ No ☐ Prefer to discuss

Anything the therapist should know to help you feel safe?

Lifestyle and supports

Important relationships, family or living situation

Sleep, appetite, substance use or stress concerns (optional)

Strengths, coping skills, community or spiritual supports (optional)

Anything else you would like the therapist to know?

Acknowledgment / signature

Client full name



New Client Questionnaire

Client signature (type name if accepted by your secure e-signature workflow)

Date

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Authorization to Release Information

This authorization is separate from routine consent to treatment and is optional unless a specific lawful disclosure is needed. Complete all relevant fields before signing.

Client name and date of birth

Person / organization authorized to disclose information

Person / organization authorized to receive information

Address, phone or secure fax of recipient

Information to disclose (select all that apply)

- ☐ Dates of service
- ☐ Treatment summary
- ☐ Billing

Other specific records or information to disclose

Purpose of disclosure

Expiration date or specific expiration event

Authorization conditions

I understand I may revoke this authorization in writing, except where action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility generally will not be conditioned on signing except where law permits. Redisclosure may be possible depending on the recipient and applicable law.

Specially protected records, including psychotherapy notes and certain substance-use-disorder records, may require separate authorization and additional language. This general form does not authorize their disclosure unless reviewed and completed under applicable rules.

I authorize only the specifically identified disclosure above

- ☐ I authorize

Acknowledgment / signature

Authorization to Release Information

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

Electronic signatures should be collected through an approved system that records consent and audit details.

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Sogol Philipson, LCSW | California LCSW #66853

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Informed Consent for Telehealth

What telehealth means

I consent to psychotherapy using secure video or another mutually agreed remote communication method while I am physically located in a jurisdiction where the therapist may lawfully provide services. My therapist may verify my identity, physical location, and emergency contact at each session.

Benefits and limitations

Telehealth can improve access and convenience, but connection failures, unauthorized access, interruptions, or lack of privacy may occur despite reasonable safeguards. Remote care may not be appropriate for every condition or emergency; referral to in-person or higher-level care may be recommended.

Privacy and setting

I will make reasonable efforts to join from a private location using a secure connection and device. Neither the therapist nor client will record a session without prior appropriate written permission.

Technology and emergency plan

If the connection fails, we will use the agreed backup plan. I understand the therapist cannot provide immediate emergency response remotely. In emergencies, call 911 or go to the nearest emergency department; 988 is available for crisis support.

My current California city / usual telehealth location

Emergency contact name and phone

Backup phone number for disconnections

Choice and consent

I may ask questions, discuss alternatives, and withdraw consent to telehealth. Fees and confidentiality protections are addressed in separate practice documents.

I voluntarily consent to telehealth psychotherapy

- [ ] I consent

Acknowledgment / signature



Informed Consent for Telehealth

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

Electronic signatures should be collected through an approved system that records consent and audit details.

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Informed Consent for Adult Psycnotherapy

DRAFT — FOR CLINICIAN AND CALIFORNIA LEGAL/COMPLIANCE REVIEW

LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

Nature of services

I understand that psychotherapy is a collaborative professional service intended to address emotional, behavioral, relational, and mental health concerns. Treatment may include assessment, discussion of experiences and patterns, skill building, and mutually developed goals. Benefits are not guaranteed; discussing difficult experiences can cause temporary distress.

Voluntary participation

I may ask questions, discuss alternatives, decline a particular intervention, request referrals, or end treatment. The therapist may recommend additional evaluation or a different level of care when appropriate. Treatment is not an emergency service.

Confidentiality

Information is generally confidential, subject to applicable legal exceptions including mandated abuse reporting, serious safety concerns, court processes where disclosure is legally required, and permitted treatment, payment, and operations disclosures. The separate Notice of Privacy Practices describes privacy rights and practices.

Telehealth and practical policies

All appointments are provided remotely. I have received or will review the separate telehealth consent, fee policy, communication policy, and client rights document. Questions may be raised before signing.

Acknowledgment

By signing, I acknowledge an opportunity to ask questions and voluntarily consent to adult outpatient psychotherapy. This form does not replace separate authorizations for disclosures that require them.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Good Faith Estimate — Self-Pay / Uninsured

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LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

Patient and provider

Patient name: _____ Date of birth: _____. Provider: Sogol Philipson, LCSW #66853. Practice: Trust 2 Believe. Service delivery: telehealth.

Expected charges

Expected individual psychotherapy session charge: $150. Estimated number of sessions: _____. Expected total: $_____ (multiply the anticipated sessions by $150). This estimate covers the items and services reasonably expected to be provided by this practice, and does not include unrelated services from other providers.

Service details to complete

Expected service/CPT code: _____. Diagnosis code, if applicable and known: _____. Anticipated dates/frequency: _____. Estimate date: _____. Other anticipated services/charges: _____.

Important notice

This estimate is not a contract and does not obligate you to receive care. Actual services and costs may differ. You may have the right to initiate the federal patient-provider dispute resolution process if your bill is at least $400 more than the Good Faith Estimate from this provider. Visit cms.gov/nosurprises or call 1-800-985-3059 for more information.

Acknowledgment

I received this estimate. Receipt does not waive any rights under applicable law.

Client name: _____ Date: _____

Client signature: _____ Date: _____

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Telehealth Emergency Contact & Safety Plan

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Current location

Client full name: _____. Residential address: _____.
City/State/ZIP: _____. Preferred phone: _____.

Emergency contacts

Emergency contact name: _____. Relationship: _____. Phone: _____. Permission to contact in a safety emergency, consistent with applicable law: Yes / No.

Local resources

Nearest emergency department: _____. Local crisis team or emergency contact number: _____. Client county: _____.

During telehealth

At the start of each session, I will confirm my physical location and a callback number. If technology fails, my therapist may attempt to call the agreed number. In an immediate emergency, call 911 or go to an emergency department. In the U.S., call or text 988 for suicide and crisis support.

Emergency disclosures

If there is a serious safety concern, my therapist may take legally permitted or required steps to seek emergency assistance, including sharing the minimum information reasonably needed.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Payment Method & Card-on-File Authorization

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Payment method

I authorize Trust 2 Believe to charge my payment method held with its approved payment processor for services I receive and for applicable cancellation or no-show fees that have been disclosed to me in advance.

Fees and disputes

Standard individual session fee: $150. Cancellation notice: 24 hours. Specific late-cancellation/no-show charge: $_____ [PRACTICE MUST COMPLETE]. I may request a receipt and raise billing questions using the practice contact information.

Security

Do not write a complete card number or CVV on this form. Card details should be entered directly into a secure payment processor or approved client portal. This authorization does not authorize charges beyond the agreed fee policy.

Revocation

I may revoke authorization for future automatic charges by written notice, subject to payment obligations already incurred. The practice will provide an alternative payment arrangement where available.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Appointment Cancellation & No-Show Agreement

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LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

Notice period

Please provide at least 24 hours notice if you need to cancel or reschedule an appointment. Notify the practice through the approved scheduling or contact method.

Fees

Standard individual therapy session: $150. Late cancellation fee: $_____. Missed appointment fee: $_____. These amounts must be completed and disclosed before this agreement is used.

Exceptions and insurance

The practice may consider emergencies and exceptional circumstances individually. Insurance plans generally are not billed for sessions not provided; any client responsibility must comply with applicable payer agreements and law.

Acknowledgment

I understand the 24-hour cancellation policy and the charges stated above, once completed.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Electronic Communication Preferences & Consent

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Communication channels

I understand standard email, SMS, and voicemail may present privacy risks. They are intended primarily for scheduling and administrative matters; I should not send urgent or sensitive clinical details through unsecured channels.

Select preferences

Appointment reminders by: [ ] secure portal [ ] SMS [ ] email [ ] phone [ ] none. Voicemail allowed: [ ] yes [ ] no. Administrative SMS allowed: [ ] yes [ ] no. Administrative email allowed: [ ] yes [ ] no.

Limits

Messages may not be monitored continuously and are not for emergencies. I may change my preferences by notifying the practice. Communications involving protected health information will be handled under applicable privacy requirements and practice safeguards.

Emergency guidance

For an immediate emergency call 911; for U.S. mental health crisis support call or text 988.

Client name: _____ Date: _____

Client signature: _____ Date: _____

Couples Therapy Agreement — Conditional Use

DRAFT — FOR CLINICIAN AND CALIFORNIA LEGAL/COMPLIANCE REVIEW

LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

Scope

This optional document is for use only if the practice later offers couples therapy. It is not applicable to the currently confirmed adult individual telehealth-only service model.

Joint treatment

The therapist must explain who the client is, treatment goals, confidentiality boundaries between partners, records access, handling of individual disclosures, and whether any no-secrets policy applies before beginning couples therapy.

Required decisions

Couples therapy offered? [ ] yes [ ] no. Policy on secrets: _____. Records access policy: _____. Financial responsibility: _____. These decisions require clinician and legal review.

Acknowledgment

Both participating adults should sign a finalized version before conjoint treatment begins.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Coordination of Care — Limited Authorization

DRAFT — FOR CLINICIAN AND CALIFORNIA LEGAL/COMPLIANCE REVIEW

LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

People and purpose

I authorize Sogol Philipson, LCSW, to [ ] disclose to [ ] obtain from [ ] exchange with: _____ (provider / organization), contact information: _____.

Specific information

Information authorized: [ ] treatment dates [ ] diagnosis [ ] medications [ ] treatment summary [ ] other: _____. Purpose: [ ] coordinate treatment [ ] medication management [ ] other: _____.

Duration and revocation

Expiration date or event: _____. I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it. Redisclosure by a recipient may not be protected by the same privacy laws.

Choice

I understand treatment is generally not conditioned on signing this optional authorization. Special protections may apply to certain records; obtain separate legally sufficient authorization when required.

Client name: _____ Date: _____

Client signature: _____ Date: _____

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Treatment Completion, Termination & Referral Record

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Treatment summary

Client: _____. Last session: _____. Treatment start date: _____. Reason for termination: [ ] goals met [ ] client preference [ ] referral [ ] scheduling [ ] other: _____.

Clinical documentation

Progress toward goals: _____. Current clinical status and risk assessment: _____. Outstanding issues: _____.

Continuity of care

Referrals/resources provided: _____. Follow-up recommendations: _____. Emergency/crisis resources discussed: _____.

Documentation

Therapist signature: _____ Date: _____. Client acknowledgment (optional): _____ Date: _____. This is primarily an internal clinical record, not a required client consent.

Client name: _____ Date: _____

Client signature: _____ Date: _____

TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

California BBS Notice to Clients — Draft

DRAFT — FOR CLINICIAN AND CALIFORNIA LEGAL/COMPLIANCE REVIEW

LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

License information

Sogol Philipson, Licensed Clinical Social Worker (LCSW), California license number 66853. License expiration date: _____ [VERIFY AGAINST BBS RECORD].

Required state notice

INSERT THE EXACT CURRENT CALIFORNIA BOARD OF BEHAVIORAL SCIENCES STATUTORY NOTICE TEXT BEFORE DISTRIBUTION. Do not substitute this draft for the legally prescribed notice.

Board information

California Board of Behavioral Sciences. Website: www.bbs.ca.gov. Confirm the current complaint instructions, contact details, required wording, delivery method, and documentation requirements.

Acknowledgment

I acknowledge receipt of the finalized California BBS Notice to Clients. This signature records receipt, not agreement to waive any right.

Client name: _____ Date: _____

Client signature: _____ Date: _____