



NEW PATIENT INFORMATION: ADULT

Patient Last Name: _____ Patient First Name: _____ Patient Middle Name: _____

DOB: _____ Biological Sex: M F SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

First & Last Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

SSN: _____ Employer: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Social Security Number: _____ Employer: _____

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT & I CONSENT TO TREATMENT.

Patient Signature: _____ Date: _____

OFFICE USE ONLY:

Appointment Date:	Appointment Time:	Name of Clinician:
-------------------	-------------------	--------------------

DX: _____



ATTENDANCE AND FINANCIAL POLICIES

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers, but each patient may be responsible for an annual deductible or co-payment, depending on their insurance provider. It is the patient's responsibility to keep track of their appointments and to keep their financial accounts current including copays, deductibles, and service fees.

By initialing each paragraph below, you are stating that you understand our attendance and financial policies.

_____ (initial here) I agree to notify my clinician when canceling an appointment at least 24 hours in advance.

_____ (initial here) I understand that if I miss my initial appointment, I will incur a \$140.00 fee and services will be terminated.

_____ (initial here) I understand that KaraLee & Associates, P.C. has the right to charge me \$140.00 for missed appointments and cancellations with less than a 24-hour notification. Missed appointments or cancellations fees cannot be billed to my insurance company.

_____ (initial here) I understand that if I have good attendance, I may be allowed one missed appointment with documentation from a physician.

_____ (initial here) I agree that if for any reason a check is returned on my account, I will be responsible for a \$35 returned check fee in addition to the original fee(s) for service(s).

_____ (initial here) I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

_____ (initial here) I understand that if my balance remains unpaid for more than 90 days and/or exceeds \$200, KaraLee & Associates, P.C. may refer my account to a collection agency, and future services may be withheld.

_____ (initial here) I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

_____ (initial here) I acknowledge that I have the right to receive a "Good Faith Estimate" if I am not using insurance to pay for my service.



ATTENDANCE AND FINANCIAL POLICIES CONTINUED

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: \$28.92 plus:
	Pages 1-20: \$1.45 per page
	Pages 21-50: \$0.72 per page
	Pages 51+: \$0.29 per page
Records Request (continuation of care, records faxed to another medical office only)	Free of Charge
Paperwork/Forms to be Completed by Clinician or Psychiatrist (short/long-term disability, FMLA, worker's compensation) Fees determined by time needed to complete: Letters to be Written by Clinician or Psychiatrist (disability, probation, for school, for lawyer)	Fee determined by time needed to complete: 15 minutes: \$62.50 30 minutes: \$125.00 45 minutes: \$187.50 60 minutes: \$250.00 \$60.00
Cancellation of Appointment with Clinician or Psychiatrist (less than 24 hour notice given)	\$140.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: \$210.00
	Clinicians - Subsequent Appointments: \$140.00
	Psychiatrist - Initial Appointment: \$250.00
	Psychiatrist - Medication Reviews: \$85.00

PATIENT/GUARDIAN SIGNATURE

DATE



ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

Patient Name: _____ DOB: _____

Insurance: _____ ID# _____

I, _____ agree to arrange a payment plan with my provider
(print name here)
to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out prior to continuing services.

**REASON FOR ADVANCED BENEFICIARY NOTICE
(Patient/Guardian is responsible for any or all of the following reasons)**

1. Maximum visits per insurance contract have been reached.
2. Client is insured by straight Medicaid.
3. Deductible, copay, coinsurance not eligible for secondary insurance payment.
4. No-show or Late Cancel with therapist / psychiatrist / nurse practitioner.

Amount of Payment Responsibility

Doctor/Nurse Practitioner Evaluation = \$250; Medication Review = \$85; Clinician Initial Session = \$210;
Clinician Subsequent Sessions = \$140; No-Show / Late Cancel = \$140

I agree that I am the responsible party and KaraLee & Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for mental health services, I agree to pay the amount due for services.

Patient/ Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Revised 7/2023

PATIENT NAME: _____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request.

PATIENT/GUARDIAN SIGNATURE

DATE

CONSENT FOR TREATMENT

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, PC.

PATIENT/GUARDIAN SIGNATURE

DATE

COMPLIANCE WITH CLINIC REQUIREMENTS

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist.

PATIENT/GUARDIAN SIGNATURE

DATE

UNDERSTANDING OF LEGAL PARTICIPATION

I hereby acknowledge the legal participation limits of KaraLee and Associates, PC. Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

PATIENT/GUARDIAN SIGNATURE

DATE

OFFICE USE ONLY:

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (please explain):



**COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN
NOT A REQUEST FOR RECORDS**

Patient Name: _____ DOB: _____

Authorize Do Not Authorize

The release of any information to my physician by KaraLee & Associates, PC and...

Physician Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C. and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C. or upon my written request.

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Date Admitted/Assessed: _____

Diagnosis: _____

TYPE OF TREATMENT

Individual Family Group Testing Only Referred out

FREQUENCY

Weekly Bi-weekly Monthly

Referral provided to: _____

Medical Concerns (if any): _____

Signature of Clinician: _____ Date: _____

PATIENT NAME: _____ DOB: _____

PERSONAL HISTORY

Presenting Symptoms

- | | |
|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decreased concentration | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Homicidal Ideations | <input type="checkbox"/> Suicidal Feelings |

Presenting Concerns

- Academic Issues
- Behavior Issues
- Health Issues
- Legal Issues
- Relationship Issues
- Sexual Issues

Why have you come into treatment?
Explain:

What would you like to accomplish by coming to KaraLee & Associates, P.C.?
Explain:

SUICIDE & SELF-HARM

		(circle or check yes or no)	
Have they ever thought about suicide or harming themselves? <small>(If yes, describe when and how in the space provided below...)</small>	yes	no	
Do they have a history of suicide attempts or self-harm? <small>(If yes, describe when and how in the space provided below...)</small>	yes	no	
Do they currently feel suicidal? <small>(If yes, please explain in the space provided below...)</small>	yes	no	

Explain:

HOMICIDAL ISSUES

		(circle or check yes or no)	
Have you ever thought about killing or harming others? <small>(If yes, describe when and how in the space provided below...)</small>	yes	no	
Do you have a history of committing murder or harming others? <small>(If yes, describe when and how in the space provided below...)</small>	yes	no	
Do you currently feel homicidal? <small>(If yes, please explain in the space provided below...)</small>	yes	no	

Explain:

TRAUMA HISTORY

Have you experienced any of the following...

(If answered yes to any, please explain in the space provided below...)

(circle or check yes or no)

emotional abuse	yes	no
physical abuse	yes	no
sexual abuse	yes	no
emotional neglect	yes	no
physical neglect	yes	no
physical assault	yes	no
sexual assault	yes	no
crime-related events	yes	no
general disaster	yes	no

Explain:

SOCIAL INFORMATION

Do you usually spend leisure time: Alone With family With friends

Describe your strengths:

Describe your hobbies:



EDUCATION & EMPLOYMENT

EDUCATION LEVEL:

Circle or check one....

Did not complete high school	GED	High School Diploma	Vocational Training
Associate Degree	Bachelor's Degree	Master's Degree	Doctorate

Have you experienced academic difficulties? No Yes (explain):

Have you experience behavior difficulties? No Yes (explain):

OCCUPATION:

If employed, name of employer: _____ Job Title: _____

If a student, name of school: _____ Major: _____

Circle or check one.... Homemaker Retired Unemployed

What are your primary means of financial support?

Self-Employed Full/Part Time Job Parents Spouse Retirement Disability

Have you ever served in the military? No Yes

If so, what branch? Army Air Force Coast Guard Navy Marines

Enlistment Date: _____ Discharge Date: _____

FAMILY INFORMATION

Marital status: Single Married Partnered Separated Divorced Widowed

Spouse/Partner name: _____ Age: _____ Living with you? Yes No

Number of Siblings:

I do not have children



Child Name	Age	Biological/Step/Adopted	Lives with you? (circle or check one)
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe your relationship with your family:

(circle or check one)

At Childhood: Poor Strained Good Excellent

At Adulthood: Poor Strained Good Excellent

At Present: Poor Strained Good Excellent

(OPTIONAL)

(circle or check one)

Were you raised in a home that practiced religion? No Yes

Are you currently practicing religion? No Yes

Catholic Christian Hindu Jewish Protestant Muslim Other:

Which ethnic group do you identify with?

African American/Black Asian Caucasian Hispanic Native American Other: _____



LEGAL HISTORY

Are you currently involved in: Probation DUI/OWI Divorce Custody

Explain:

SUBSTANCE USE

ALCOHOL USE:

Do you currently drink? No Yes: What is your weekly consumption? _____

Have you ever been told you should cut down on drinking? No Yes

Have you ever felt bad about your drinking habits? No Yes

Have you ever attended an AA/SMART group? No Yes: When? _____

Have you ever received a DWI, OWI, or DUI? No Yes: When? _____

Have you ever been treated for alcohol use? No Yes: When? _____

DRUG USE:

Do you use illegal drugs or drugs not prescribed to you? No Yes

Drugs used: Amphetamines Benzodiazepines Barbiturates Crack Cocaine Heroin

Opiates Medical Marijuana Other: _____

Have you ever attended a NA group? No Yes: When? _____

Have you ever been treated for drug use? No Yes: When?

CAFFEINE USE:

NOT APPLICABLE

(Cups per day)

Coffee: 1 2 3 4+

Tea: 1 2 3 4+

Pop: 1 2 3 4+

Energy Drinks: 1 2 3 4+



SMOKING: Please check below the response that best summarizes your CIGARETTE smoking status

- Never smoked
- Former smoker: Month/Year Quit: _____
- Current smoker: Average number of cigarettes smoked per day: _____

MEDICAL HISTORY

Describe your current health
 Poor Fair Good Very good

Are you experiencing any physical pain at this time?

- No Yes

Where? _____

Check all that apply to yourself or an immediate family member...

	Myself				
	Current	Past			
Abuse: Emotional/Physical/Sexual			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Alcohol Abuse			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
ADD/ADHD			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Anxiety			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Asthma			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Appendicitis			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Bed wetting			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Birth defects			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Cancer			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Chest pain			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Chicken pox			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Diabetes			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Diarrhea			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Exploitation			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Fainting			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Hearing			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
High blood pressure			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Migraines			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Nausea			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Psychiatric hospitalization			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Other:			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling



MEDICATION LOG

List prescribed or over-the-counter medication(s),herbal supplements, medical marijuana you **currently** take below...

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects:

Pharmacy Name:

Phone Number:

MEDICAL HISTORY (CONTINUED)

List any major accidents or surgeries: Not Applicable

Surgeries...

Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____



Accidents/Injuries...

Type: _____ Date: _____

Type: _____ Date: _____

Do you have any diet or nutritional concerns: No Yes:
If yes, please explain:

Have you gained weight in the last 60 days: No Yes

Have you lost weight in the last 60 days: No Yes

Do you ever... (circle or check an item)

- Over-eat Induce vomiting Use laxatives Exercise to get rid of calories Skip meals

THERAPY GOALS

Please list what you hope to accomplish during therapy.

1.

2.

3.

4.



DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
 In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN , that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
--	--

Generalized Anxiety Disorder Screener (GAD-7)

Over the <i>last 2 weeks</i> , how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

PATIENT/GUARDIAN SIGNATURE **DATE**

PATIENT/GUARDIAN SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

MEDICAL DIRECTOR SIGNATURE **DATE**



Tariq Abbasi, MD: Medical Director
Andrea Nowak, MD: Consulting Psychiatrist
Karen J. Maier, PhD, LP: Owner/Consultant
John Kenner, LMSW, LMFT, DCSW: CEO/Clinical Director

Clinical Policy for Medication Management

Effective Immediately

Please be advised of our Clinic Policy for Medication Management patients. This Policy, while not new, will be strictly enforced, effective immediately.

--You will be **required** to continue therapy sessions, not less than two times a month (within 30 days of the scheduled psychiatry appointment) with **NO EXCEPTIONS.**

--If you are unable, or unwilling to commit to our policy, you will be dismissed from our Medication Management program.

Your welfare as a patient at KaraLee and Associates is of utmost importance. We value your safety during medication management, and the best way is to do that is to stay in communication with your therapist on a regular basis.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

1307 South Main Street Plymouth MI 48170
1308 South Main Street Plymouth MI 48170
1365 South Main Street Plymouth MI 48170
OFC: (734) 451-3440 FAX: (734) 451-8720
www.karaleeandassociates.com
Accredited by the Joint Commission





Tariq Abbasi, MD: Medical Director
Andrea Nowak, MD: Consulting Psychiatrist
Karen J. Maier, PhD, LP: Owner/Consultant
John Kenner, LMSW, LMFT, DCSW: CEO

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call KaraLee & Associates, PC at (734) 451-3440, so that the office staff can help you connect with me.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, **you will be solely responsible for the entire fee of the session.** Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Patient/Guardian Signature

Date

Therapist Signature

Date