NEW PATIENT INFORMATION CHILD/ADOLESCENT

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: SSN:

Relationship: Employer:

Secondary Insurance: Policy #: Group #:

OFFICE USE ONLY

Policy Effective Date: ☐ Calendar Year Plan ☐ Monthly Plan

Copay: Deductible: Deductible Remaining:

Authorization #:

Visit Limit:

Appointment Date: Appointment Time: Clinician:

DX:

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT

Patient/Guardian Signature: Date:

Revised 11/2020

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 copayment, depending on their insurance provider. It is the patient's responsibility to keep financial accounts current including copays, deductibles, and service fees.

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

_____ (initial here) I understand that KaraLee & Associates, P.C. has the right to charge me $60 for missed appointments and cancellations with less than 24 hours notification. Missed appointments or cancellations fees *cannot* be billed to my insurance company.

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

FINANCIAL POLICIES (CONTINUED)

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: $23.23 plus: Pages 1-20: $1.16 per page Pages 21-50: $0.58 per page Pages 51+: $0.23 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)	$250.00 Charge (psychiatrists to be booked for an hour-long appointment)
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
Cancellation of Appointment with Clinician or Psychiatrist (less than 24 hour notice given)	$60.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: $150.00 Clinicians - Subsequent Appointments: $90.00 Psychiatrist - Initial Appointment: $200.00 Psychiatrist - Medication Reviews: $60.00

PATIENT/GUARDIAN SIGNATURE **DATE**

Revised 11/2020

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 BENIFICIARY NOTICE
(Patient/Guardian is responsible for any or all of the following reasons)

1. Maximum visits allowed per insurance contract have been reached.
2. Patient is insured by straight Medicaid.
3. Deductible, copay, co-insurance not eligible for secondary insurance payment.
4. MD No-Show/ Late Cancel.
5. Therapist No-Show / Late Cancel.
6. Other: _____

Amount of Payment Responsibility

MD Evaluation: $200.00

MD Medication Review: $60.00

No-Show/ Late Cancel: $60.00

I agree that I am the responsible party and KaraLee and 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 my mental health services, I agree to pay the amount due for services.

Patient/ Guardian Signature: _____Date: _____

Clinician Signature: _____Date: _____

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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):

Revised 11/2020

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, P.C.

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	FREQUENCY
☐ Individual ☐ Family ☐ Group ☐ Testing Only ☐ Referred out	☐ Weekly ☐ Bi-weekly ☐ Monthly
☐ Referral provided to: Medical Concerns (if any):	

Signature of Clinician: Date:

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Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____Age: _____ Biological Sex: ☐ Male ☐ Female

Relationship with the child: _____**Date:**_____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during **THE PAST TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	☐	☐	☐	☐	☐	
	2.	Said he/she was worried about his/her health or about getting sick?	☐	☐	☐	☐	☐	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	☐	☐	☐	☐	☐	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	☐	☐	☐	☐	☐	
IV.	5.	Had less fun doing things than he/she used to?	☐	☐	☐	☐	☐	
	6.	Seemed sad or depressed for several hours?	☐	☐	☐	☐	☐	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	☐	☐	☐	☐	☐	
	8.	Seemed angry or lost his/her temper?	☐	☐	☐	☐	☐	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	☐	☐	☐	☐	☐	
	10.	Slept less than usual for him/her, but still had lots of energy?	☐	☐	☐	☐	☐	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	☐	☐	☐	☐	☐	
	12.	Not been able to stop worrying?	☐	☐	☐	☐	☐	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	☐	☐	☐	☐	☐	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	☐	☐	☐	☐	☐	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	☐	☐	☐	☐	☐	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	☐	☐	☐	☐	☐	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	☐	☐	☐	☐	☐	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	☐	☐	☐	☐	☐	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	☐	☐	☐	☐	☐	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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PERSONAL HISTORY

Why has child/adolescent come into treatment?

What would the child/adolescent like to accomplish by coming to KaraLee & Associates, P.C.?

SUICIDE & SELF-HARM

(circle or check yes or no)

Have they ever thought about suicide or harming themselves? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of suicide attempts or self-harm? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel suicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

HOMICIDAL ISSUES

(circle or check yes or no)

Have they ever thought about killing or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of committing murder or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel homicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

TRAUMA HISTORY

Have you experienced any of the following…

(If answered yes to any, please explain in the space provided on the next page…) (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 (Trauma History):

SCHOOL ADJUSTMENT

School District: School Name:

Has the child ever been afraid to go to school? ☐ Yes ☐ No

Explain:

Present Grade: Has the child repeated any grades? ☐ Yes ☐ No

Has he/she ever had problems with the following: ☐ Math ☐ Reading ☐ Language ☐ Speech

Has the child ever had any special education services? ☐ Yes ☐ No

Has the child received complaints from school regarding behavior or achievement? ☐ Yes ☐ No

SOCIAL INFORMATION

Social time is usually spent: ☐ Alone ☐ Immediate Family ☐ Peers

Please describe:

Does the child isolate him/herself from other people? ☐ Yes ☐ No

Please explain:

Does the child have a job? ☐ Yes ☐ No Hours a week: Position & Type of Work:

ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical (or historical) of the child's behavior.

☐ Feels Lonely	☐ Overactive	☐ Defiant	☐ Stealing from home	☐ Prefers to be alone
☐ Shy with children	☐ Lacks motivation	☐ Daydreams	☐ Stealing from peers	☐ Preoccupied with sex
☐ Shy with adults	☐ Sexual acting out	☐ Aggressive with…	☐ Will not admit blame	☐ Compulsive behavior
☐ Worries	☐ Poorly organized	☐ Peers	☐ Short attention span	☐ Ritualistic behavior
☐ Moody	☐ Tics or twitches	☐ Siblings	☐ Bedwetting - present	☐ Talks impulsively
☐ Sad	☐ Feelings of guilt	☐ Adults		☐ Unusual behavior
☐ Cries easily	☐ Clumsy	☐ Jealousy	☐ Bedwetting - past	☐ Unusual thinking
☐ Expects failure	☐ Sets fires	☐ Fails to understand consequences	☐ Soils self	☐ Violent behavior
☐ Does not share	☐ Destructive		☐ Not always truthful	☐ Exploitation

BIRTH & DEVELOPMENT

Normal Pregnancy? ☐ Yes ☐ No Complications? ☐ Yes ☐ No

Length of Labor: Premature? ☐ Yes ☐ No Weeks/Weight:

Newborn's Health:

Please check all that apply…

☐ Colic	☐ Overactive	☐ Constipation
☐ Eating Issues	☐ Underactive	☐ Chronic Illness
☐ Sleeping Issues	☐ Infections	☐ High fevers
☐ Milk or food allergies	☐ Fussy	☐ Hospitalization

EARLY CHILDHOOD

Indicate age started…

Single words: _____ months Sentences: _____ months

Walking: _____ months Began Toilet Training: _____ months

Ending Toilet Training: _____ months Knew colors: _____ months

CURRENT GENERAL HEALTH STATUS

Name of Physician: Phone Number:

Are the child's immunizations up to date? ☐ Yes ☐ No
Did the child ever have an eye exam? ☐ Yes ☐ No Glasses? ☐ Yes ☐ No
Did the child ever have a hearing exam? ☐ Yes ☐ No Hearing deficiency? ☐ Yes ☐ No
Date of last physical exam: Results:

What is the present health of the child? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

NUTRITIONAL SCREENING

Has the child gained weight in the last 30-60 days? ☐ Yes ☐ No If yes, how many pounds?

Has the child lost weight in the last 30-60 days? ☐ Yes ☐ No If yes, how many pounds?

Does the child have any diet or nutritional concerns? ☐ Yes ☐ No

MEDICATION LOG

List prescribed or over-the-counter medication(s) or herbal supplements your child **currently** takes.

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects:

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FAMILY INFORMATION

Family Member Name	Age	Relationship to Child	Lives with child?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

RELIGION

Mother: ☐ Catholic ☐ Protestant ☐ Jewish ☐ Muslim ☐ Other:

Father: ☐ Catholic ☐ Protestant ☐ Jewish ☐ Muslim ☐ Other:

Does the family practice one of the parent's religions? ☐ Yes ☐ No

Does the child participate with this religion? ☐ Yes ☐ No

How important are the child's religious beliefs? ☐ Very Important ☐ Somewhat Important ☐ Not Important

ETHNIC GROUP (OPTIONAL)

☐ Caucasian ☐ African American/Black ☐ Native American ☐ Hispanic ☐ Asian-American ☐ Other _____

LEGAL HISTORY

Is the child currently facing any pending charges or convictions? ☐ No ☐ Yes
Explain:

Is the child currently on probation? ☐ No ☐ Yes
Explain:

Has the child been on probation in the past? ☐ No ☐ Yes
Explain:

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Has the child ever been arrested or spent time in a corrections facility? ☐ No ☐ Yes
Explain:

Is/Has the child been a part of a divorce or custody issue? ☐ No ☐ Yes
Explain:

Is the child adopted? ☐ No ☐ Yes If adopted, have they been told? ☐ No ☐ Yes
Explain:

HEALTH QUESTIONNAIRE					
Now	**Past**	**Neurological**	**Now**	**Past**	**Disease**
☐	☐	Stroke	☐	☐	AIDS/HIV
☐	☐	ADD or ADHD	☐	☐	Anemia
☐	☐	Headaches	☐	☐	Venereal Disease
☐	☐	Seizures	☐	☐	Mononucleosis
☐	☐	Injury	☐	☐	Hepatitis
☐	☐	Sleep disturbance			**Respiratory**
☐	☐	Dizziness	☐	☐	Asthma
☐	☐	Fainting	☐	☐	Allergies
☐	☐	Tics	☐	☐	Bronchitis
		Digestion	☐	☐	Pain
☐	☐	Stomach pain	☐	☐	Pneumonia
☐	☐	Constipation			**Special Senses**
☐	☐	Diarrhea	☐	☐	Hearing disorder
☐	☐	Diabetes	☐	☐	Visual disorder
☐	☐	Frequent urination	☐	☐	Speech disorder
☐	☐	Bed wetting			**Other**
☐	☐	Overeating	☐	☐	Heart disease
☐	☐	Under eating	☐	☐	Drug abuse
☐	☐	Vomiting	☐	☐	Alcoholism
☐	☐	Nausea	☐	☐	Pain disorder
☐	☐	Bleeding	☐	☐	Kidney Disease
☐	☐	Food Allergies	☐	☐	Thyroid Disorder

If any are checked, please explain:

THERAPY GOALS

Please list what you hope to help your child accomplish through therapy.

1.

2.

3.

4.

By signing below, I acknowledge that all legal guardians of the child have given consent for treatment.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____

CLINICIAN SIGNATURE **DATE**

_____ _____

MEDICAL DIRECTOR SIGNATURE **DATE**

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

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 me on the phone number I provided you (_____-_____-_____).

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 payor, 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.

_____ _____
Client Date

_____ _____
Therapist Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, my other staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

_____ You will only keep your in-person appointment if you are symptom free.

_____ You will take your temperature before coming to each appointment. If it is elevated (100.5 degrees Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.

_____ You will wait in your car or outside or in a designated safer waiting area until no earlier than 5 minutes before our appointment time.

_____ You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

_____ You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.

_____ You will wear a mask in all areas of the office.

_____ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands).

_____ You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

_____ If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.

_____ You will take steps between appointments to minimize your exposure to COVID.

_____ If you have a job that exposes you to other people who are infected, you will immediately let me know.

_____ If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.

_____ If a resident of your home tests positive for the infection, you will immediately let me know and we will then begin/resume treatment via telehealth

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, my staff and all of our families safe from the spread of this virus. If you show up for an appointment and I or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.
If I or my staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____ _____
Client Name (please print) DOB

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

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