**CLIENT FORM**
**CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES;**
**CONFIDENTIALITY STATEMENT; & PAYMENT AGREEMENT**

I, _____, consent to receive psychotherapy, psychological testing, or other professional services for myself from my clinician at Up Therapy, LLC. I understand that all information disclosed by me or my child in therapy or during testing is maintained in strict confidence and that documents pertaining to my child's treatment will not be released to others parties without my consent, except when mandated by law (such as suspected child or elderly abuse, serious intent to physically harm myself or another person). I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my child's confidentiality.

I also understand that Dr. Pilgrim sometimes works with Interns who are learning to be competent professionals. Interns only work for several months while they are in school. If you have been assigned an intern you will be notified and you do have the option of having another therapist assigned.

I understand that payment is due at the time services are delivered. The rate is _100__ per hour for individual counseling.

The payment plan for psychological evaluations is 200 deposit; 800 day of the evaluation; and 500 the date of the report is completed (unless otherwise agreed upon). I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those fees in the event that I fail to show for an appointment or cancel an appointment with less than twenty-four hours' notice. I understand that repeated late cancellations or failure to show for scheduled appointments may result in the termination as a client.

I understand that my clinician will return any phone calls as soon as possible. However, if I experience an emergency situation and need to contact someone immediately to help me, I have been provided with the following numbers:

Emergency Services: 911

BHL (GA 24/7 Crisis Line) 1-800-715-4225

Peachford Hospital Assessment Center: (770) 454-2302

Ridgeview Institute Access Center: (770) 434-4568 Ext. 3200

# INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

Thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations. Teletheapy is an important tool to use when social distancing is necessary.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here: _____.

**If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.**

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

**I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.**

**I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.**

***Consent to Treatment***

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Dr. Chanda Pilgrim to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Dr. Pilgrim at any time. I understand Dr. Pilgrim will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.