Each person attending therapy should complete a separate form.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Landline phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which phone number is best to contact you?

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to contact you via email? [ ]Yes [ ]No

May we leave a message on your home phone? [ ] Yes [ ]No

May we leave a message on your work phone? [ ] Yes [ ] No

May we leave a message and/or text on your cell phone? [ ] Yes [ ] No

Referral Source/How did you hear about this counseling practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact and Relationship to you Name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The primary concern(s) that led me to seek counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My problem / symptom(s) began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date).

My symptom(s) increased: \_\_\_\_\_\_\_\_\_\_\_\_\_(date). My three biggest worries/concerns currently in life are:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any medical problems / Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications and dosage (include psychiatric, sleep, over-the-counter, vitamins and supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Psychiatrist/phone (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Symptoms (check all that apply):**

[ ] Crying [ ] Sad Mood [ ] Lack of Motivation [ ] Insomnia [ ] Sleep too much

[ ] Appetite Changes ↑ or ↓ Weight Changes ↑ or ↓ [ ] Lack of Interest [ ] Decreased Self Esteem [ ] Hopeless / Helpless [ ] Feeling Energy Level ↑ or ↓ [ ] Startled Response

[ ] Outburst of Anger [ ] Anxiety [ ] Panic Attacks Restlessness, [ ] Keyed Up, [ ] Decreased Concentration [ ] Irritability [ ] Muscle Tension, [ ] Decreased Sleep [ ] Hypervigilance [ ]

[ ]Obsessions [ ]Compulsions (constant checking, washing, or counting) [ ]Frequent Worry [ ]Avoidance of stimuli associated with trauma [ ]Agoraphobia [ ]Social Anxiety [ ] other Phobia (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Post-Traumatic Stress (Intense Fear, Flashbacks, Nightmares) [ ] Inattention or Hyperactivity [ ] Paranoia or Hallucinations (hearing voices, seeing things no one else sees) [ ] Racing Thoughts with faster speech [ ]Decreased need for Sleep and Increased Activity [ ] Impulsive [ ] Isolating self from others or pleasure [ ] Memory impaired with organizing & sequencing problems [ ]Amnesia [ ]Agitated (Irritable, easily annoyed provoked to anger) [ ]Chronic Pain (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substances:**

Alcohol: of drinks in the last week: \_\_\_\_\_\_\_\_\_\_\_\_\_ Other Substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Issue(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grief / Loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUICIDE IS A DEFINITE POSSIBILITY** NOW [ ] Yes [ ] No

**HISTORY**

**My Family of Origin:**

Father - What was he like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother - What was she like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers / Sisters - how many of each? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you fit in the birth order? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of relationship did you have with your siblings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Summary:** I grew up in \_\_\_\_\_\_\_\_\_\_\_\_\_\_(state). I grew up in the country, [ ]a small town, [ ] a large city. Both parents [ ]were [ ]were not in the home. My childhood was [ ]good [ ] difficult [ ] very difficult in the sense of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **My teen years were** [ ]good [ ]difficult [ ]very difficult in the sense of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

In high school, **my life revolved around** [ ]sports, [ ]work, [ ]church, [ ]social, [ ] academics, [ ] other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. After high school, life has been [ ]good [ ]difficult [ ]very difficult in the sense of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I am currently** [ ]single [ ]married for \_\_\_\_ years. I presently live [ ]alone [ ]with my spouse [ ]with my parents [ ]other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**My current support** system is [ ]good [ ]fair [ ]poor.

Life now centers around [ ]family [ ]work [ ]friends [ ]other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Recently life has been** [ ] good [ ]difficult [ ]very difficult in the sense of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Client Agreement / Informed Consent**: Welcome to Truhearted Counseling! Whether you need brief supportive therapy or longer therapy from past wounds that continue to impact you today, it is our goal to provide a safe space for you. We work collaboratively with our clients to achieve their goals. Hope often emerges when we invite safe people into the mess. We look forward to joining you on the journey in a way that creates space for hope, healing, and connection.

**Overview of Services:** We offer counseling services for individual adults, couples, and youth. Counseling and psychotherapy both refer to a supportive relationship with a professional practitioner who has undergone extensive training and personal exploration to understand the dynamics of human experience and psychological development. At Truhearted, we not only possess extensive psychological training, but we also believe that religious faith is valuable in its own right, complementing the psychological, biological, and social dimensions.

**Please sign you are informed and agree**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_

**Michelle’s History:** Experience and Education: Michelle Meyer is a Licensed Professional Counselor and Licensed Marriage and Family Therapy with a master’s degree in Marriage Family Therapy from Western Seminary.

She deeply enjoys and has extensive experience helping clients with depression, anxiety, trauma, abuse, obsessions, loss, anger, sense of self, relationships, and spiritual issues. She is also passionate about coming alongside people who have wounds from the past that are affecting present-day living. As a result, she pursued training in two additional areas. First, she received a Bachelor of Arts degree in Christian counseling and a Master of Arts degree in Theology, which significantly influenced her direction in Marriage and Family Therapy. Next, she was trained in EMDR therapy in 2017 and has since undergone recent retraining in 2025. Michelle has received multiple certifications for a deeper understanding of a variety of issues in today’s culture.

**Effective Therapy:** Effective therapy requires a partnership of mutual respect between the therapist and the client. We will work together to determine what makes the most sense at this juncture in your life. Progress depends on several factors, including the therapeutic alliance and the client’s availability to work toward goals in between sessions. Benefits of therapy include finding a fresh perspective or resolution to a difficult problem; developing skills for improving relationships; learning new ways to navigate stress, anxiety, anger, or depression; working through trauma or loss; having a safe context to process and release wounds; growing in connection with self, spirituality, and with others; and living in increasing health, hope, and freedom. Certain discomforts and tensions associated with the counseling process should be understood before work begins. These include but are not limited to the following:

* Recalling unpleasant events can surface feelings of fear, anger, sadness, and other strong emotions that may be uncomfortable but are a normal part of the healing process.
* Significant relationships may experience varying degrees of tension.
* Sometimes, problems temporarily worsen at the beginning of treatment. Most of these are to be expected when someone is making significant changes.
* It is impossible to guarantee specific therapy results; however, our goal is to work with you to achieve the best possible outcome.

**Confidentiality:** Psychotherapy, counseling, assessment, and associated services related to diagnosis, evaluation, and treatment provided by licensed professionals are confidential and protected under the laws of California and Oklahoma. All communications and records with your counselor are held in strict confidence, with the following exceptions:

1) The client signs a written release indicating consent to release records or share treatment information. 2) the client is at risk of imminent serious harm to self or someone else.

3) mandated reporting of any known abuse, neglect, or exploitation of a minor, elderly person, or disabled person.

4) a court order is received directing the disclosure of information; and

5) as outlined in the HIPAA Notice of Privacy Practice. Electronic Communication Confidentiality cannot be guaranteed with electronic communications, including telephone calls, voicemail, texts, emails, and faxes.

These electronic modes can be used for scheduling and other forms of communication. If you prefer not to be contacted by a specific method of communication, please indicate this on the Counseling Intake Form, and we will honor your request. Should you want to make changes to your preferred method of communication, you can let your counselor know at any time. Therapeutic Relationship The client-therapist relationship is a professional collaboration. Over the course of treatment, therapy can be psychologically intense and emotional. For an effective therapeutic environment, it is a necessary requirement that we maintain a professional relationship and not a social one.

**FEES:** Counseling Sessions/Fees. Generally, counseling sessions are 45-50 minutes on a weekly basis, with a sliding scale fee of $50-$125 per session, payable by cash or check. A session's frequency, length, and fee may vary depending on the client’s specific needs. A client can request a 90-minute session from $75-$160 per session when scheduling an appointment. Additionally, EMDR therapy sometimes requires an extended session; if so, this will be discussed in advance with the client.

Payment is due at the time of service. We accept cash or checks. A service charge of $50 will be charged for each check returned to Truhearted Counseling. After receiving a returned check, we will only accept cash payments.

**Scheduling and Cancellation**: If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. Sessions must be canceled with at least a 24-hour notice to avoid the full session fee.

**Litigation Fees:** If your therapist’s involvement is required for litigation, the fee is $300 an hour paid in advance. This includes time spent on photocopying, preparation, travel time, deposition, and courtroom appearances.

**Referrals**: A client has the right to withdraw from our agreed-upon treatment process at any time and request a referral for any reason. It is recommended that you schedule a termination session to reach closure. Counselors reserve the right to withdraw from the treatment process if your needs fall outside our scope of knowledge and expertise or if we determine that we can no longer be helpful to you. In the event treatment is withdrawn by your request or ours, we will provide you with appropriate referrals, which you are free to accept or decline. Referrals may also be made in conjunction with therapy, for example, a referral for a medical evaluation while you continue with therapy.

**Grievance/Complaint**: You can expect our counseling services to be consistently delivered in a professional manner, adhering to acceptable ethical standards. If you have any issues, concerns, or questions regarding any aspect of your experience, you are invited to discuss them with your therapist so that accommodations can be made. However, suppose you believe that your counselor has treated you unethically or caused you harm. In that case, you may submit your grievance in writing and/or inform the California or Oklahoma State Board of Behavioral Sciences.

**In Case of an Emergency:** Please be aware that we do not provide 24-hour emergency services. If you experience a life-threatening emergency, please contact 911 or go to the nearest hospital emergency room. If you are suicidal and therefore at risk of imminent harm to yourself, help is also available by contacting 911 or go your nearest hospital.

**Client Agreement:** I agree to pay the counseling fee at the time of service and for cancellations with less than 24-hour notice. I agree to receive a mental health assessment and authorize treatment and other services as considered advisable, and I can refuse therapy service at any time.

Teletherapy treatment is very similar to in-person counseling. To achieve better teletherapy, clients should have a high-quality computer camera with good sound input and output in a confidential space free from distractions. I understand the following:

* Teletherapy encompasses technology (i.e., landline or cellular phone, interactive audio, video, or other data communications) for consultation and other medical information, as well as for other purposes. Most therapeutic models can be efficient through telehealth but there are times when in-person should be utilized.
* Teletherapy is practiced in the states of Oklahoma and California (USA) and is governed by the laws of these states, depending on the client's location at the time of counseling.
* Teletherapy will take place between client and therapist either in California or Oklahoma, utilizing technology rather than being in the same physical location. I would like to utilize this method occasionally or as my primary mode of care. This document will be kept on file for future teletherapy sessions. This request can be canceled at any time by either the client or the therapist, and in-person meetings can be arranged as needed.
* I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
* In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understood, agreed to, and consented to the conditions of service stated in this agreement. If I require additional clarification or review at any time, I agree to request information from Truhearted Counseling.

Client Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA COMPLIANCE AGREEMENT**

I hereby acknowledge that I have been offered a copy of Truhearted Counseling Notice of Privacy Practices (NPP), which explains how my protected health information may be used and disclosed. I have read and understand this document and have been given the opportunity to ask questions and clarify my rights as a client.

Client's Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Client's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR TECHNOLOGY / TELEHEALTH

Technology / Telehealth incorporates counseling or therapy services held via a video-conferencing application. You will be provided with the link for technology/telehealth. Please use the link five minutes before our scheduled session the first time. Please ensure you are in a private location where you can speak openly without being overheard or interrupted by others. If possible, it is recommended you wear a headset or earbuds for confidentiality and sound quality. This is not required. Please know that per best practices and ethical guidelines, I can only practice in the state I am licensed in, California and Oklahoma.

You agree to inform me if your therapy location changes or if you move out of the state of California or Oklahoma. If we lose connection during our telehealth session, and we are unable to reconnect via the video conferencing link, I will call you immediately using the phone number provided in your intake paperwork. Please let me know if your phone number has changed.

If I have concerns about your safety at any time during a telehealth (video or phone) session, I will need to break confidentiality and call 911, the emergency services in your area, and/or your emergency contact immediately.

Please note that everything in the informed consent that you signed, including confidentiality exceptions, still applies during telehealth sessions. By signing this document, I, as the client, acknowledge and agree to the following:

1. I understand that this form is in addition to the regular Client Agreement / Informed Consent Form and Notice of Privacy Practices for Protected Health Information, commonly known as HIPAA.

2. I understand that telehealth is not the same as in-person due to the fact that I will not be in the same physical space as my provider.

3. I understand that telehealth therapy has potential benefits, including easier access to care and the convenience of meeting from a location of my choice.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth therapy if it is felt that the video conferencing connections are not adequate for the situation.

5. I understand that my provider and telehealth therapy is NOT Emergency Services, and in the event of an emergency, I will use a phone to call 911.

6. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

I have had the opportunity to ask questions in regard to telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me in a language that I understand.

BY SIGNING, I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_