Jenean Poley, LPC, LCPC

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THERAPY INFORMED CONSENT

Thank you for choosing Jenean Poley, LPC, LCPC at Holland Therapy Group. Starting therapy is a major decision and you may have many questions. This document is intended to inform you of standard policies, State and Federal Laws, and your rights.

CONFIDENTIALITY AND RELEASE OF INFORMATION: With the exception of certain specific exceptions described below, your therapy will remain strictly confidential. This means without your prior written consent, I cannot and will not discuss with anyone else what you have discussed or that you attend therapy with me. Under the provisions of the Healthy Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release to me in writing to share information about you. You may direct me to share information with whomever you chose, and you may revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. Under this same act you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. Should you wish I communicate with your physician, clergy, family member, attorney, DSS, or anyone else, you will be asked to sign a standard release of information form.

You are also protected under the provisions of the Federal Healthy Insurance Portability Act (HIPPA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

THE FOLLOWING ARE LEGAL EXCEPTIONS TO YOUR RIGHT TO CONFIDENTIALITY. I WOULD INFORM YOU OF ANY TIME WHEN I THINK I WILL HAVE TO PUT THESE INTO EFFECT

1. I HAVE A DUTY TO WARN. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. I HAVE A DUTY TO REPORT. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. I HAVE A DUTY TO PROTECT. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. A COURT ORDER FROM A JUDGE.

EMERGENCIES
Jenean Poley LPC, LCPC does not provide 24 hour on call crisis emergency services. In case of an emergency when she is unavailable you should go to the emergency room or call 911.

APPOINTMENTS AND FINANCIALS: Payment is due at each session. If you carry a balance on your account for over 30 days, you will be notified in writing and requested to pay in full within 10 days or when services are rendered, whichever comes first. A reasonable payment arrangement may be negotiated in certain cases. After 60 days, any unpaid balance will be charged 1.5% interest per month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Payment is accepted by cash, check, or credit card. There will be a $25 fee for any bounced checks.
You are responsible for coming to your session on time and at the time we have scheduled. Sessions are 50 minutes. Your appointment is held exclusively for you. If you are late, we will end on time and not run over into the next person's session. If you need to cancel or reschedule an appointment, please give at least **24 hours advance notice**, otherwise you will be billed at the full hourly rate.

CONSENT FOR TREATMENT

I have read and understand this Notice, and I give my consent for treatment.

Signature(s)_____ Date_____

TELETHERAPY INFORMED CONSENT

I _____, hereby consent to engage in teletherapy with Jenean Poley LPC, LCPC. I understand that "teletherapy" includes consultation and treatment using interactive audio and video. I understand that teletherapy also involves the communication of my mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my mental health information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are outlined in the Informed Consent and Confidentiality Form provided to me.

3. You are responsible for information security on your computer and it's up to you to keep that information secure. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Jenean Poley LPC, LCPC, 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 information could be accessed by unauthorized persons. However, Doxy is encrypted, so it is confidential.

4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if Jenean Poley LPC, LCPC believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improved, and in some cases may even get worse.

5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

6. 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. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

I have read, understand, and agree to the information provided above.

_____ _____

Signature Date

No Show/ Late Cancellation Policy

If you need to cancel or reschedule an appointment, please provide at least **24 hours** advance notice. If you fail to cancel a scheduled appointment or cancel late, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment or cancellation with less than 24 hour notice.

I give Jenean Poley LPC, LCPC permission to charge any Cancellation fees and No Show fees to my credit or debit card listed below. This is a credit/ debit card (circle one).

Type of card (Circle): Visa MC other:_____

Card #_____

Exp Date:_____ CVV number: _____ Zipcode: _____
(3-digit number on back of card)

Signed by client or parent: _____ Date: _____

FEE SCHEDULE

EFFECTIVE January 1, 2021

Initial Consultation	$125.00
Individual Counseling	$100.00
Family/Couples Counseling	$100.00
Divorce Mediation- Court ordered Three hours	$400.00
Review of records	$75.00 per hour
Minimal phone consultation or correspondence	no charge
Extensive phone consultation: correspondence more than 10 minutes	$25.00 per quarter hour
Missed appointment/late cancellation fee	$100.00

Based on information provided by your insurance company, your portion of the fee at the time of service is estimated to be:

Medical deductible of _____ met/not met/unknown

Initial consultation $_____
Individual sessions $_____
Family sessions $_____
Extended sessions $_____

Insurance does not reimburse for mediation, review of records, extensive phone consultation or missed appointments.

Cash Client pre-arranged fees:

Initial consultation $_____
Individual sessions $_____
Family sessions $_____
Extended sessions $_____

This is merely an estimate and we cannot guarantee this is the final amount due.

By signing below I acknowledge that I understand and agree to this fee schedule. I understand my insurance coverage as well as my personal responsibilities for payment.

_____ _____

Client or Responsible Party (print name & date) Client or Responsible Party (signed)

Client Emailing/Texting Consent Form

Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts.

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

- Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
- Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
- Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
- Provider is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name: _____

Client signature: _____ Date:_____

Emergency Contact Information

Client's Name _____

Emergency Contact _____

Phone Number _____

Relationship to Client _____