



• Towson, MD • 21286 • Phone • 443-885-0682 •
Email: Healthyrelationships2020@gmail.com

Therapist: _____

AGREEMENT FOR PAYMENT AND FINANCIAL RESPONSIBILITIES

By Signing below, I agree that I will be responsible for my session fees. The standard fee for the initial intake session is \$170 and the standard fee for ongoing couples counseling is \$170 per 50-60 minute session and \$200 per 65-75 min session. The fee will be billed 30minutes prior to the counseling session. Fees are subject to change.

Please Sign: _____

Client's Name: _____

Address: _____

Primary Phone: _____

Email: _____

Date of Birth: _____ Age: _____

Gender: _____ Preferred Pronoun: _____

Parent or Guardian (if under 18) : _____

Who Referred You? _____

Emergency Contact: Spouse/Partner/Other:

Name: _____ Relationship: _____

Marital Status: _____

Race: _____

Spirituality: _____

Occupation/Year in School: _____

Partner/ friend's Name: _____

Date of Birth: _____ Age: _____

Phone: _____

Email: _____

Gender: _____ Preferred Pronoun: _____

Please list any additional people who may be or will be attending the counseling session

Household Income: _____

Household size: _____

Party responsible for payment: Self: _____ Other/Relationship:



HEALTHY RELATIONSHIPS

HEALTH HISTORY – ADULT

1. Do you have a Primary care provider? Yes No

2. Any medical illnesses? Yes No

If so, please list: _____

3. Are you taking any medications? Yes No

If so, please list: _____

4. Have you ever been treated for depression/anxiety? Yes No

If yes, by whom and when? _____

Internist OB/GYN Psychiatrist

5. Have you had any previous counseling? Yes No

If yes, with whom and when? _____

What did you like about it? _____

What did you dislike about it? _____

6. Are you or have you been in the care of a psychiatrist?

Yes No If yes, with whom and when?

7. Have you ever been treated for alcohol or drug abuse? Yes No

If yes, when and where? _____

Are you currently sober? Yes No

8. Have you been the victim of physical or sexual abuse? Yes No

If yes, is this occurring in your current relationship? Yes No

9. Do you have current suicidal thoughts? Yes No

10. Have you had a suicidal attempt? Yes No if yes, when: _____

11. Do you or have you had an eating disorder? Yes No

12. Do you have a history of infectious diseases? Yes No if yes, please list:

13. Is there past or present nicotine use? Yes No

14. Do you wish to improve your relationships? Yes No

15. Does your partner wish to improve your relationship? Yes No

16. Please list concerns you are having within your relationship(s):

17. What service are you interested in:

Pre-marital Counseling Mediation Couples Therapy (married)

Couples Therapy (not married) Relationship Counseling

Relationship life coach Discernment Counseling



HEALTHY RELATIONSHIPS

CONSENT FOR SERVICES

Welcome to Healthy Relationships.

Healthy Relationships is a for-profit, relationship-counseling agency with a mission to enhance personal relationships. This document contains important information about the services and policies of Healthy Relationships, LLC. Please review the information carefully, sign the document, and discuss any questions with your therapist.

Confidentiality

Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. It is the policy of Healthy Relationships, LLC to protect the privacy of every client to the maximum extent possible. Generally, information about you or services furnished to you will not be released without your prior written consent. There are, however, some circumstances which require the disclosure of information without your consent, such as when:

- Mandated by state or federal law due to suspicion nor knowledge of child abuse and/or neglect or elder abuse and/or neglect.
- There is an imminent risk or serious threat of physical harm to self or to others.
- Specifically ordered by a court of law.

In accordance with the quality assurance standards set by Healthy Relationships, your file may be reviewed to ensure record keeping compliance. Your therapist may anonymously discuss your treatment with a supervisor to ensure the provision of quality care. All Healthy Relationships, LLC supervisors and staff are obligated to follow laws of confidentiality.

Cancellation Policy

Healthy Relationships, LLC requires 24-hour notice in the event you need to cancel or reschedule your appointment. To cancel or reschedule your appointment contact your therapist by calling his / her direct phone number, or email HealthyRelationships2020@gmail.com.

Appointments that are cancelled or missed without the 24-hour notice will be billed to your account in the amount that Healthy Relationships, LLC would collect if the service had been provided as scheduled. You will be billed 30 minutes prior to your appointment. Insurance does not reimburse for missed appointments; therefore, you are responsible for full payment of this fee. Please discuss with your therapist any questions about the cancellation policy.

Messages/ Contact:

If you call, text, or email your therapist, please allow them 48 hours to respond. If it is an emergency, please dial 911 or crisis hotline at 410-433-5175

Emergencies:

Please discuss with your therapist how to handle emergencies. If you experience a mental health crisis outside of a session there are several resources for help. These resources are available 24 hours per day, 365 days per year. Alternatively, you may go to the nearest Emergency Room or call 911.

Fees and Insurance:

The fee for your services are pre-set. The standard fee for the initial intake session is \$170 and the standard fee for ongoing couples counseling is \$170 per 50-60 minute session and \$200 per 65-75 min session. The fee will be billed 30 minutes prior to the scheduled counseling session. Fees are subject to change. Healthy Relationships, LLC accepts MasterCard, Discover, and Visa. (Please initial)

_____ I acknowledge that I am financial and legally responsible for the full payment of charges for services received.

Healthy Relationships, LLC, does not currently participate in Insurance panels. If Healthy Relationships, LLC decides to accept insurances, you will be contacted to determine, if you wish to utilize your insurance. Should you wish to file for reimbursement using out-of-network benefits, a super-bill can be provided. It will include all the information necessary to submit claims to the insurance company. Clients may call their insurance company for more information on how to file a claim.

Termination of Services

Clients have the right to terminate treatment at any time. Please notify your therapist of your desire to end therapy. She/he may request to have a final session with you to allow for therapeutic termination and to provide aftercare planning. Services through Healthy Relationships, LLC may be terminated for a variety of other reasons, including but not limited to:

- There is mutual agreement by the client and counselor to end counseling
- The client does not return for counseling or reschedule for 60 days.
- The counselor decides to discontinue counseling because it is no longer effective or because the client does not comply with treatment recommendations
- The client is engaged in residential or inpatient treatment (i.e. hospitalization) and does not expect to return to counseling
- Healthy Relationships, LLC therapists may use their clinical judgment to determine a client needs to be referred to another clinician or to another provider organization to ensure appropriate treatment
- Healthy Relationships, LLC reserves the right to terminate with a client who has violated cancellation policies to the point that it has become disruptive to their treatment and/or to the therapist's schedule. Please note that clients are still responsible for making payments on all balances after they have ended treatment, no matter the circumstances.

Client Consent

My signature below indicates that I reviewed this document, agree to the policies, and authorize services through Healthy Relationships, LLC. I accept financial responsibility for payment of services received, and for payment of late cancellations. I acknowledge that I am financial and legally responsible for the full payment of charges for services received. I understand that Healthy Relationships, LLC and my Provider will make the best ethical and clinical decisions regarding my care.

Client Name (Print): _____

Client Signature: _____

Date: _____

Therapist Signature: _____ Date: _____



HEALTHY RELATIONSHIPS

Appointment Reminders

Healthy Relationships, LLC offers the option to receive an appointment reminder the day prior to your scheduled appointment by email or by text.

Please select ONE of the following options:

Email: I authorize Healthy relationships, LLC to send an email message appointment reminders to me on my provided email address below:

_____ @ _____ .com

Text Message: I authorize Healthy Relationships, LLC to send text message appointment reminders to me on my provided cell phone number: _____

Text message charges from my cell phone provider may apply. Example of text message: "Do not reply-reminder-You have an appointment MON 01/21 at 4:00 PM – If you have any questions please call us at (314) 878-4340 – Name of Counselor

None of the above: I will remember my appointments on my own.

I understand that Late Cancellation and No-Show appointment fees will apply if I cancel my appointment with less than 24 hours' notice. Appointment information is Protected Health Information under HIPAA. By signing, I give my permission to receive appointment reminders as selected. My signature indicates that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services if applicable. I understand that this authorization can only be revoked in writing.

Printed Name

Signature

Date



HEALTHY RELATIONSHIPS

CLIENT GUIDE TO TELEHEALTH SERVICES

“Telehealth Services” encompasses Video Therapy and Telephone Counseling. Telehealth involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with Healthy Relationships, LLC (“Provider”) and a client who are not in the same physical location. Telehealth Services may be used for diagnosis, treatment, follow-up and/or education. Please note that prior to beginning Telehealth Services, new clients will be screened by phone by their Provider to ensure suitability for this treatment modality.

Healthy Relationships, LLC is dedicated to ensuring you receive the best possible care with minimal interruptions. Many clients and Providers are moving to Telehealth services during a national crisis and to ensure health, safety, and continuity of care.

This guide is intended to help you successfully participate in Telehealth Services. It is not exhaustive and should not replace conversations with your Provider.

SETTING UP FOR VIDEO THERAPY

To participate in Video Therapy, you will need the following technology:

- A secure internet connection with at least 1mb of bandwidth
- A computer or tablet with a video camera and microphone

Once your appointment is scheduled, a Healthy Relationship, LLC staff member will send you a link to your session along with confirmation of your Provider’s name, the appointment date, and time.

You will use the same URL for all future sessions unless your Provider tells you otherwise. Prior to your appointment, please check your bandwidth to ensure compatibility with the platform

- Zoom requires 1megabyte per second (1mbps) bandwidth to operate

- This free website can help you test your internet bandwidth:
www.speedtest.net Please log in to the session a few minutes prior to your start time to ensure your connection is working Turn on your video and microphone Please ensure your Provider can see you.
- it is ideal to sit in a well-lit room and to have your face illuminated
- please position the camera so that your Provider can clearly see your face

SETTING UP FOR TELEPHONE COUNSELING

Your Provider will call you at a designated phone number at the start of your session time. Please be sure your Provider knows the best number to reach you. Have your phone and ringer turned on to ensure you hear your Provider's call. If you have not heard from your Provider within 10 minutes of the session start time, please contact her/him directly.

PRIVACY

Healthy Relationships, LLC values your confidentiality. To ensure your privacy in Telehealth Services, your Provider will connect with you from a space where she/he can reasonably ensure confidentiality and lack of interruption. Your Provider may use headphones and/or sound machines to enhance your privacy. To ensure your confidentiality, please set up in a private space where others will not be able to hear your conversation. Using headphones/earbuds with a microphone may help minimize what other people nearby can hear.

Your Provider should be informed either in advance of or at the beginning of each session if someone else is in the room or will be participating in the session. Your Provider has the right to exercise her/his clinical judgment and decline to continue a session. To ensure the productivity of the session, please do your best to avoid interruptions. We suggest meeting privately in a room with a closed door. It is ideal to leave pets and other household members out of this space during the session.

For Video Therapy: Only use a secure internet connection. Using public Wi-Fi may mean that other people can access your information during your session.

WHAT TO EXPECT IN YOUR TELEHEALTH SESSIONS

Your provider is obligated to confirm your location, as she/he is typically only authorized to serve clients in a state she/he is licensed in.

- Please check with your provider prior to the session if you will be participating in

sessions while located in a different state than your residence.

VIDEO THERAPY SESSIONS:

- When you connect via the link sent to you, you will enter your Provider's virtual waiting room. Your Provider will be able to see when you have entered, but no other clients can see you or your information.
- At the start of the session time, your Provider will connect with you and you should see and hear her.
- If this is your initial session with this Provider, she will need to see your drivers license or other state-issued ID to confirm your identity. In subsequent sessions, your Provider can visually confirm your identity.

TROUBLE SHOOTING TECHNICAL ISSUES IN VIDEO THERAPY

Your Provider can't hear you or see you?

- Check that you have unmuted your microphone and enabled video capabilities

You cannot connect via the link sent?

- Ensure you are connected to the internet and have adequate bandwidth.
- Double check the link sent and try again. Call your Provider if you still cannot connect.

Is the image pixelated or is there a delay in the video/sound?

- Usually this clears up in a moment. If not, check that you have adequate internet bandwidth.

BACK UP PLAN

Prior to your initial Telehealth session, your Provider should establish a backup plan with you in the instance that the video therapy platform is not operational, or there is no connection for Telephone Counseling. Typically, the backup plan may include your Provider calling you at a pre-determined phone number and/or sending you a new link for Video Therapy session.

If you cannot connect and have not heard from your Provider within 10 minutes, you may call your Provider directly at the number provided.



HEALTHY RELATIONSHIPS

CONSENT TO TELEHEALTH SERVICES

Name: _____ DOB: _____

Telehealth (also known as “Video Therapy” and “Telephone Counseling”) involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with Healthy Relationships, LLC (“Provider”) and a client who are not in the same physical location.

Telehealth may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Video Therapy: counseling sessions provided via video conferencing
- Telephone Counseling: counseling sessions provided via telephone
- Electronic transmission of clinical records, photo images, personal health information or other data between a client and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files. The vendor of the electronic systems used in the provision of Video Therapy Services (Zoom) has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

STATEMENT OF POTENTIAL RISKS AND BENEFITS

Potential Benefits of Telehealth Services

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient

for you.

- You can interact with a Provider without the necessity of an in-office appointment.

Potential Risks of Telehealth Services

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not be able to provide clinical treatment for your particular condition via Video Therapy or Telephone Counseling. You may be required to seek alternative care. In this case, your Provider would offer you referral suggestions and resources to the best of her/his ability.
- Delays in clinical evaluation/treatment could occur due to failures of the technology.
- Security protocols or safeguards could fail causing a breach of privacy. If this were to occur, Care and Counseling would notify you promptly.

By accepting this Consent to Telehealth Services, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via Telehealth is a n evolving field and that the use of Video Therapy or Telephone Counseling in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of Telehealth Services may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.

4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using Telehealth Services, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other healthcare services also apply to these Telehealth services. My Provider cannot ensure my privacy at my location.
7. I agree that I will not record my sessions. Instructions for accessing my medical record have been outlined for me in the Center's Privacy Practices.
8. I agree and authorize my Provider and Center to share information regarding my Telehealth treatment with other individuals for treatment, payment and health care operations purposes as allowed by law.
9. I agree and authorize Healthy Relationships, LLC and/or Zoom to provide me with technical support if I request it.
10. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment.
11. If my health insurance provider does not reimburse for provision of Telehealth Services, I may be solely responsible for covering the costs of my Video Therapy or Telephone Counseling, as outlined in the form "Agreement for Payment and Financial Responsibilities."
12. I understand that my Provider may only utilize Video Therapy for my treatment when I am located in the state of my residence and/or in which the Provider has authorization or licensure to practice. As such, my Provider will ask to verify my location at the beginning of

sessions.

13. I understand the need to participate in Telehealth Services from a secure, private location to the best of my ability. I will communicate any privacy limitations to my Provider at the beginning of the session.
14. My Provider has shared a Client Telehealth Guide with me, which can help me set up for video therapy and trouble shoot potential technical issues. My Provider and I have discussed a back-up plan if the technology fails to work during a session.

CLIENT CONSENT TO THE USE OF VIDEO THERAPY

By signing below, I indicate agreement to the following:

- I have read this Consent to Telehealth Services form and Client Guide to Telehealth carefully and understand the risks and benefits of the use of Video Therapy and/or Telephone Counseling in the course of my treatment.
- I have discussed Telehealth Services with my Provider, and all my questions have been answered to my satisfaction.
- I hereby give my informed consent for the use of Video Therapy and/or Telephone Counseling in my mental health care.
- I hereby authorize my Provider to use Video Therapy and/or Telephone Counseling in the course of my diagnosis and/or treatment.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT
UNLESS REVOKED BY ME IN WRITING.**

Client Signature : _____ Date/Time: _____

Therapist Signature: _____ Date/Time: _____