Allison A. Grace, MSW, LCSW 2190 S. Mason Rd. Ste. 100 Des Peres MO 63131

Date_____

Name _____ Date of Birth _____

Phone# (s): _ _____ _____

Is it OK to leave detailed messages at this number? ___ _

Email: _____

Emergency contact: _____ Phone _____

Relationship of contact _____

I understand that everything I discuss with Allison Grace, LCSW in Psychotherapy is confidential and protected by HIPAA. The only exception to this could be if I share life threatening information or cases of child or elder abuse.

I understand that I may be charged for:

- Canceling an appointment without 24 hours' notice.
- Phone consults that last longer than 15 minutes.
- Denial of coverage from my insurance company.

Your signature below indicates that you understand that a copy of the CONSENT TO PSYCHOTHERAPY Agreement and the NOTICE OF PRIVACY PRACITCES can be found on my website at www.alligrace.com, and agree to their terms. You understand that if at any time you have questions about these terms we can discuss to your satisfaction.

_____Signature of Patient or Personal Representative

_____Printed Name of Patient or Personal Representative

_____Date

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's
Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by Allison Grace, MSW, LCSW as long as she is involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Allison Grace, MSW, LCSW provides a HIPAA compliant telehealth platform.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

Credit Card Guarantee

( ) Uninsured Clients

Clients who are uninsured or whose insurance does not cover Mental Health Counseling Benefits due to high deductibles or other limitations are personally responsible for payment. Any balance not paid after 90 days of invoicing will automatically be charged to your designated card below.

( ) Insurance Assignment

My Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you my billing company, Missing Piece Billing will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember however, that you are ultimately responsible for payment. On day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims will be immediately refunded to you.

I agree to the above term and authorize Awaken Grace Therapy or Missing Piece Billing Co. to charge any payment not paid by the end of the 90 day cycle.

Card Number: _____ Expiration date: ___/___ CVS_____

Billing address_____Zip code _____

Signature _____ Date_____

Awaken Grace LLC

2190 S. Mason Rd. Ste.100
Des Peres, MO 63131
314-578-3551
awaken.grace@gmail.com

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Allison Anne Grace, MSW, LCSW to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions

I further understand that Allison Anne Grace will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____
_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date