Atlanta Psychological Services
2308 Perimeter Park Drive • Suite 100 • Atlanta, GA 30341
AtlantaPsychological.com
770.457.5577 • 770.457.5599

Check one: rev 6-23-2021

___ Allyson Crehan, PsyD ___ J. Todd George, PsyD ___ Andrew Gothard, PsyD
___ Carolyn Johnson, PhD ___ Yoshitaro Oba, PhD ___ Angela Stewart, PhD

Client Information

Please Print Clearly:

Date _____

Who referred you to our office? (Or how did you you find us?) _____

Name of person completing this form: _____

Client's Name: _____ **Client Date of Birth:** _____
(First Name, Last Name)

Client Address: _____

City: _____ State: _____ Zip Code: _____

(For Children)
Parent/Guardian's Name: _____

Guardian's relationship to client: _____
(i.e., mother, father, foster parent, case manager, etc.)

Circle most appropriate option:

Gender Identity: Male - Female - Transgender - Choose not to disclose - Other:_____

Sexual Orientation: Lesbian, gay, or homosexual - Straight or heterosexual - Bisexual - Unknown
Choose not to disclose - Other:_____

Race/Ethnicity: American Indian or Alaska Native - Asian - Black or African American -
Hispanic or Latino - Native Hawaiian or other Pacific Islander - White or Caucasian -
Choose not to disclose - Other: _____

Relationship Status: Single - Married - Divorced - Partnered - Other:_____

Client Status: Full-time employed - Part-time employee - Student - Unemployed/Other

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Insurance and Payment Information

Client Social Security Number: _____

Payment Source (Check or initial only one from below):

___ Insurance (only one plan): The client has only one insurance plan (and I am authorizing this clinician to bill this insurance plan for services received).

___ Insurance (multiple plans): The client has primary and secondary insurance plans (and I am authorizing this clinician to bill these insurance plans for services received).

___ Self-Pay: The client will pay for services via cash, check, or credit card.

___ 3rd Party Pay: The services will be paid for by another party or agency (i.e., DFCS, Court, etc.).

(If applicable) <u>Primary Insurance Information</u>:

Insurance Company Name: _____Policyholder's Member ID #: _____

Policyholder's Name: _____Policyholder's Date of Birth: _____

Relationship to Client: _____
(child, spouse, mother, father, other _____)

(If applicable) <u>Secondary Insurance Information</u>:

Insurance Company Name: _____Policyholder's Member ID #:
_____

Policyholder's Name: _____Policyholder's Date of Birth:
_____

Relationship to Client: _____
(child, spouse, mother, father, etc.)

Primary Care Provider (PCP) or Pediatrician Information (required)

Primary Care Provider Name: _____ PCP Phone Number: _____
(Physician or Pediatrician's Name)

PCP Fax Number: _____ PCP Email (if known): _____
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Communications Agreement

Only include contact information you approve for us to use to reach you (Text messaging is limited to appointment reminders only, and will not to be used for treatment or other services)

Email Address: _____

***Check preferred contact method*:**

___ Home Phone #: _____ Voicemail Ok? (circle one) YES or NO

___ Cell Phone #: _____ Voicemail Ok? (circle one) YES or NO
Text OK? (circle one) YES or NO

___ Work Phone #: _____

By signing and submitting this communications agreement form, you are agreeing to the following acknowledgment:

My clinician and/or other employees of Atlanta Psychological Services may contact me using the electronic contact information I entered above.

My clinician and APS employees will limit their disclosure of my medical information and Protected Health Information (PHI) when communicating with me indirectly (via phone or otherwise).

I understand that I am responsible for the device or platform I use in communicating electronically with APS employees and my clinician. I know that I should communicate only on a device that I know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password-protected, not accessing the internet through a public wireless network, etc.).

If an email address is provided above, you give APS employees and your clinician permission to contact you through this means.

> *Our email platform is hosted by Google Suites with Paubox Encryption, which meets federal standards for protecting medical information and is HIPAA compatible. A Business Associate Agreement (BAA) has been signed with both companies, meaning they have attested to HIPAA compliance and assume responsibility for keeping your medical information secure.*
>
> *If email is authorized, we encourage you to also use encrypted email for protection on your end (several options are available at www.TeleHealth.org). Otherwise, when you reply to one of your clinician's emails, everything you write in addition to what he/she has written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.*
>
> *For evaluation reports, providing your email address allows you to receive the report as soon as possible.*

I understand that if I (or my child) am experiencing an emergency situation and need to contact someone immediately to help, I will call any of the emergency numbers that are listed on the consent for treatment form. **If you are in a crisis, please do not communicate this to us via email or electronic means because we may not receive it in a timely matter.**

I understand that I can revoke or amend this agreement at any time.

Any revocation or change will not apply to communications already completed.

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES; CONFIDENTIALITY STATEMENT; & PAYMENT AGREEMENT

Please review the following information. With your signature and submission of this form, you are agreeing to the following:

For adult patients: I consent to receive psychotherapy, psychological testing, or other professional services from the above noted clinician at Atlanta Psychological Services.

For child patients (and patients with legal guardians): I consent for my child (or individual I am legally responsible for) to receive psychotherapy, psychological testing, and/or other professional services from the above noted clinician at Atlanta Psychological Services.

Confidentiality & Records: I understand that communications with me (or my child) will become part of a clinical/medical record, and this information is referred to as Protected Health Information (PHI). I understand that all information disclosed by me (or my child) in therapy or during a psychological evaluation is maintained in strict confidence and this information will be kept private and secure according to HIPAA procedures and standards.

Any information about me (or my child) that is stored electronically in any means will be encrypted and otherwise stored and maintained in compliance with HIPPA requirements.

In the event of the clinician's death or disability, my (or my child's) clinical record will be maintained by Atlanta Psychological Services. If records are requested, or desired, and the office can legally and ethically provide those to you, the Practice Manager will make those records available.

I understand that no information pertaining to my (or my child's) therapy or evaluation will be released to other parties without my consent, with the following exceptions:

- I have signed a **"Release of Information"** form allowing my (or my child's) clinician to release information.
- My clinician is **ordered by a judge** to disclose information about me (or my child).
- If my (or my child's) clinician determines that I (or my child) am a **danger to myself or to others**, confidentiality may be broken to ensure you (or your child) are safe.
- Mandated Reporting: If my (or my child's) clinician receives information that suggests a child, an elderly person, or a disabled individual has been **abused or neglected** and is at substantial risk of being harmed, the clinician is legally and ethically required to report such concern to the Division of Family and Children Services (DFCS) for that individual's protection.
- **For billing purposes**, I am authorizing necessary disclosures to be made to my (or my child's) insurance company related to billing for any services furnished.
- I understand that I am authorizing the release of any information contained in my (or my child's) medical record to any relevant third party, or to its assignees, as requested by such third parties as necessary to pay any particular claim.

Psychotherapy and Counseling

Psychotherapy: I understand that information that I (or my child) provide to a clinician in therapy is legally termed **"privileged communication,"** meaning that it is my (or my child's) right as a client to have a **confidential relationship** with a therapist. However, I understand that in very rare circumstances, a court may order the disclosure of my (or my child's) private information. I understand that if I am receiving couples therapy or family therapy, my therapist does not agree to keep secrets, and any information revealed in any context may be discussed with other family members involved.

Professional Relationship: Psychotherapy is a professional service, and the relationship between you (or your child) and the clinician must remain professional, as there is the potential for harm if your clinician were to interact with you (or your child) in other, non-professional ways.

Statement Regarding Ethics, Client Welfare & Safety: The services provided to you (or your child) will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that we are not performing in an ethical or professional manner, please discuss this with your (or your child's) clinician immediately so we can work to resolve your concern.

Psychotherapy Considerations: Due to the nature of psychotherapy, your (or your child's) therapist cannot guarantee specific results regarding therapeutic goals. However, with active participation, we will work to achieve the best possible results for you (or your child). Please also be aware that changes made in therapy may affect other people in your life (or your child's life).

At times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you (or your child) begin discussing certain sensitive areas of your life. However, a topic usually is not sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success.

Psychotherapy with children: If I am bringing my child for psychotherapy, I agree to allow my child to have some degree of privacy in his or her relationship with the therapist. It is my expectation that I will be made aware of my child's general progress in therapy, but I understand that I may not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

Please speak with your child's clinician at the onset of treatment, and as necessary, with any questions or expectations you may have about privacy and disclosure of information shared in therapy.

Termination of treatment: If I (or my child) am an ongoing therapy client, I understand that if I miss a scheduled appointment, and a session is not re-schedule within 60 days, my clinician will understand that as notice that I have voluntarily terminated services for myself, and the therapeutic relationship and case file will be closed or terminated. However, I can have the file re-opened and services resumed by calling the office and scheduling an appointment with my clinician.

Psychological Evaluation and Testing

I understand that if I (or my child) am receiving a psychological evaluation for diagnosis and treatment planning (without court involvement), the outcome of the report will be discussed with me, and I will be asked to sign a release of information form if the report is to be released to any other individual or agency.

Professional Relationship: Psychological evaluation is a professional service, and the relationship between you (or your child) and the clinician must remain professional, as there is the potential for harm if your (or your child's) clinician were to interact with you (or your child) in other, non-professional ways.

Statement Regarding Ethics, Client Welfare & Safety: The services provided to you (or your child) will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that we are not performing in an ethical or professional manner, please discuss this with your clinician immediately so we can work to resolve your concern.

Psychological Evaluation Considerations: The goal of a psychological evaluation is generally to answer questions regarding your (or your child's) functioning in a variety of areas, depending on the reason for referral. This may include assessment of your (or your child's) cognitive, academic, neuropsychological, emotional, personality, parental, psychosexual, developmental, and/or social functioning.
Psychological evaluation is generally accomplished through in-depth interviews, collection of collateral information, review of records, observation, and administration of standardized and non-standardized testing measures.

The results of the assessment include a description of functioning and are usually interpreted and integrated into a

psychological report, which reviews the history, provides test data, and provides a detailed analysis of results.

Diagnostic impressions are usually offered, as are recommendations for further direction. However, diagnoses are not always clearly defined and may be provisional as symptoms continue to emerge.
Psychological evaluation is generally a low-risk process. It is, however, possible that clients may feel some discomfort or anxiety at the prospect of being tested and during the evaluation itself.

Additionally, the possibility exists that the clinician's findings, diagnoses, opinions, and recommendations may not necessarily be on par with what you expect or desire, and you may not agree with conclusions drawn. This is especially true for forensic evaluations.

Payment Agreement and Fees

By my signature below, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason.

Acceptable forms of payment: Cash, checks, and credit cards.*

- Unless alternative payment arrangements have been made prior to the delivery of services, payment is due at the time services are delivered.
- This office will provide, upon request, a receipt of payment.
- There is a $25 fee for any returned checks.
- *There is a 4% convenience fee added if you choose to use a credit card.

Health Insurance: The billing specialists at our office will do their very best to determine the benefits of your (or your child's) insurance and any costs you may be responsible for before completing the service. However, insurance companies have many rules and requirements specific to certain plans, and the cost for services may be higher or lower once the service is billed to the insurance.

After the insurance receives the bill for service, the resulting Explanation of Benefits (EOB) from the insurance company customarily outlines any patient costs or responsibilities that were due for the completed services. If I (or my child) have health insurance, with my signature below I am giving permission for appropriate charges to be billed to the insurance company. If I choose for my (or my child's) insurance not to be billed, I will discuss that with the provider.

Psychotherapy/Counseling Fees

- All therapy services are billed at $200/hour, including the initial intake and subsequent session.

Doing psychotherapy by telephone is not ideal, and I understand that needing to talk to my therapist between sessions may indicate that I need extra support, but I understand that any telephone calls that exceed 10 minutes in duration will be billed at $10.00 for every 6 minutes.

Psychological Testing and Evaluation Fees

The fee for psychological evaluations is:

- $200* per hour, which includes:
    - The clinicians total time for interviewing,
    - Records review (if applicable),
    - 3rd party/collateral contact interview(s) (if applicable),
    - Testing materials, scoring, interpretation of tests, and
    - Preparation of the written report.

**$275 per hour for custody-related and court/legally-related evaluations.*

Evaluation and Testing fees include retroactive billing for any substantial professional time required from the time of the initial referral or inquiry (e.g., phone calls and/or e-mails related to case coordination) prior to the first appointment.

Psychological evaluation reports will not be completed and/or released until payment for the evaluation is made in full, regardless of the source of payment.

If it is expected that an insurance company will pay for an evaluation, we will make every reasonable and possible effort to obtain payment from that insurance company. However, a pre-authorization for payment from an insurance company is not a guarantee of payment. **If the insurance company does not pay for an evaluation for whatever reason, the report will not be completed and/or delivered until the service is paid for by the client.**

Feedback: You are encouraged to ask questions and seek feedback on your psychological evaluation report. This can be done in one of several ways. If you have questions that can be answered in a brief e-mail response or brief telephone conversation (less than 10 minutes), this will be provided free of charge. If you desire a feedback session, these are $200 for a one hour session (*$275 for custody-related evaluations).

Depositions and court testimony are $375/hour, which includes all time required out of the office (i.e., including drive time) and/or time scheduled that the clinician otherwise would not be able to schedule or see clients. All preparatory time needed prior to the date of testimony is billed at $275/hour, including for example all time needed in reviewing the file, preparation with the attorney, and/or needed communications related to preparation for testimony. I understand that if I request court testimony, I will be advised at that time of additional policies, such as retainer amount needed, minimum billable time that is applied to retainer, cancellations, or potential refunds.

I understand that the fees noted above are subject to future increases.

Cancellation Policy: I understand that if I do not show for an appointment, or if I cancel an appointment with less than 24 hours notice, I will be financially responsible for that session. I understand that insurance companies do not reimburse for missed sessions. I further understand that repeated late cancellations or failure to show for scheduled appointments may result in my (ort my child's) termination as a client.

In Case of an Emergency: Atlanta Psychological Services is an outpatient facility. The clinicians at this office are not available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls or emails within 24-48 hours during the workweek.

If you have a mental health emergency, we encourage you not to wait for a call or email response, but to do one or more of the following:

- Call Ridgeview Institute at 770-434-4567
- Call Peachford Hospital at 770-454-2302
- Call the Georgia Crisis and Access Line at 1-800-715-4225
- Call 911
- Go to your nearest emergency room.

Privilege and Court Related Services

- If you are receiving a psychological evaluation or therapy at the request of an attorney or agency (e.g., court system or other agency like DFCS), it is customary to give that referring individual or agency "privilege" to the final report, conclusions of the evaluation, and/or therapy notes and findings.
- When you give privilege to someone or an agency, this means that only that individual or agency will be able to receive the final report/therapy notes and conclusions, and this information will be sent directly from your clinician to the referring individual/agency designated as holding privilege.
- Designating privilege over the evaluation/treatment findings also means that person or agency must give your clinician permission to release the findings to anyone (including you).
- Your evaluation/treatment findings could also be disclosed by the clinician if the clinician is court-ordered to release this information.

- In court-related evaluations/therapy, you are also agreeing that anything you disclose to the clinician is subject to being included in the evaluation/therapy report.

I understand that by receiving an evaluation/therapy for any court or other legal or administrative related purpose, I am paying for the clinician's professional time involved, regardless of the clinician's ultimate diagnoses, findings, opinions or recommendations and the impact that those diagnoses, findings, opinions or recommendations have on my case.

Please choose one: (required)

____ My evaluation/therapy is not court related, and I am not designating privilege over the results to an individual (i.e., attorney) or agency (i.e., DFCS). I wish to receive the results directly from the clinician.

____ My evaluation/therapy is court related, and I understand that I am giving "privilege" over my evaluation/therapy findings to the following individual (i.e., attorney's name) or agency (i.e., DFCS):

Individual/Agency Name: _____

Name or agency you give privilege of the report to (i.e., DFCS, attorney name, court)

3rd Party Release: Do you give this clinician permission to release information in the future to anyone that the above named holder of privilege allows the clinician to send information to? (circle one) YES NO

If you have any questions about these forms, please ask your clinical to explain them to you. Your signature indicates that you understand these forms and that you will ask for clarification or explanations if there is anything that you do not understand.

_____

Client Name (Please Print)

My signature below indicates that I have:

1) Read, been advised of, and understand the above information and that I give informed consent for me to receive psychological services under these conditions,

2) Read and I understand the HIPAA Georgia Notice form,

3) Read and I understand the Social Media Policy form.

For Adults: _____ _____

Client's Signature **Date**

For Children: _____

Parent's or Legal Guardian's Name (Please Print)

_____ _____

Parent's or Legal Guardian's Signature **Date**

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FOR OFFICE USE ONLY

_____ _____

Psychologist's or Therapist's Signature **Date**
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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

I, (**print your name**) _____, authorize my clinician to disclose to, and obtain from, another person, information about me, including personal information, mental health information, and other relevant Protected Health Information (PHI) mental health information in the course of providing psychological services.

(**print your Atlanta Psychological Services clinician's name**) _____

(**print name of person to receive or send information to clinician**) _____

(Method of communication can include any appropriate method [encrypted email, verbal, US mail, fax] unless otherwise specified to your clinician.)

I am authorizing the release for the purpose of: ☐ psychological evaluation ☐ psychotherapy

☐ (other reason) _____

This consent and authorization to release information pertains to (**check one**):

☐ ME or ☐ MY CHILD, _____ (date of birth_____):

I understand that this will include information relating to (check and initial if applicable):

☐ All records and information (no exclusions)

☐ Mental Health Information and/or General Medical Information

☐ Alcohol/Drug Treatment ☐ HIV-Related Information

☐ I authorize the release of any records that have been obtained by my clinician from other providers.

Affirmation of Release: I give my clinician permission to release only the information I have selected on this form to the individual or agency I have named and only for the purposes designated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization. I may revoke this authorization at any time per the Privacy Rule, the revocation must be in writing, and it will take effect on the day it is received in writing. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. As a patient I have the right to access my treatment records as allowed by HIPAA. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations. I understand that any information disclosed pursuant to this release of information might be subject to re-disclosed and might no longer be protected by the Privacy Rule.

Expiration Date: _____

(for adults) Client's Signature: _____ Date: _____

(for children) Parent's/Legal Guardian's Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION FOR COURT TESTIMONY OR DEPOSITION

I, _____ , hereby authorize the above indicated clinical to provide expert testimony regarding **(*circle one*)**:

ME

or

MY CHILD, (*name of child*) _____ (*date of birth*_____)

in a court of law, and/or during any depositions, discovery, other trial or hearing related situations, or any court or litigation administrative needs. This permission to disclose any and all information regarding my evaluation or treatment includes no exceptions, including but not limited to psychological testing results, information regarding therapy, and/or psychological testing raw data.

I understand the need for, and the implications of, this authorization for release of information, and this authorization and request to release information is being made voluntarily on my part. I understand that I may revoke this consent in writing at any time except to the extent that action based on this consent has already been taken. I understand that unless I revoke this release, it remains effective until the expiration date below. I further understand that should I revoke this release in the future, my clinician still might be required to testify and me and my case, if ordered to do so by any court of law.

Expiration Date: _____

(for adults) Client's Signature:_____ Date: _____

(for children) Parent's/Legal Guardian's Signature:_____ Date: _____

Consent to receive TeleMental Health Services

Your signature below indicates that you understand your clinician will be using telehealth according to the definitions below, even if you are seeing your clinician in the office, as telehealth is defined to include storage of your health information.

_____

Client's Name (Please Print)

For Adults: _____ _____

Client's Signature **Date**

For Children: _____

Parent's or Legal Guardian's Name (Please Print)

_____ _____

Parent's or Legal Guardian's Signature **Date**

TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection.

Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, our clinicians and staff have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline: It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your clinician know. Telephone conversations (other than just setting up appointments) are billed at your clinician's hourly rate.

Cell Phones: In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only for purposes of setting up an appointment if needed. If this is a problem, please let your clinician know, and he/she will be glad to discuss other options. Telephone conversations (other than just setting up appointments) are billed at your clinician's hourly rate.

Text Messaging: Text messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, we do not

utilize texting in our therapy or evaluation services. If you happen to send your clinician a text message by accident, you need to know that she or he is required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy, but your clinician will not respond to a text message for your protection.

For appointment scheduling communications and reminders, text messaging may be used if approved by you in advance (not for clinical communications).

Email: We utilize a secure email platform that is hosted by Google Suites for Healthcare with Paubox encryption services. We have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the companies are willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure.

If we choose to utilize emailing as part of the services you receive from us (to provide/receive clinical information and to receive psychological evaluation reports), we encourage you to also utilize encrypted email for protection on your end (several options are available at www.TeleHealth.org). Otherwise, when you reply to one of your clinician's emails, everything you write in addition to what he/she has written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password-protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Email is billed at your clinician's hourly rate for the time she or he spends reading and responding to them. Finally, you also need to know that we are required to keep a copy or summary of all email as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, etc: It is our policy not to accept "friend" or "connection" requests from any current or former client on any of our clinician's personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of your relationship.

However, Atlanta Psychological Services has professional Facebook, LinkedIn, Twitter, Google My Business, and Instagram pages/accounts. You are welcome to "follow" us on any of these professional pages where we post psychology information, counseling information, and therapeutic content. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Atlanta Psychological Services. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Video Conferencing (VC): Video Conferencing is an option for your clinician to conduct remote sessions with you over the internet where you may speak to one another as well as see one another on a screen. We utilize the Google Meet VC platform because it is encrypted according to the federal standard, is HIPAA compatible, and Google has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Google is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your clinician choose to utilize this technology, your clinician will give you detailed directions regarding how to log-in.

We also ask that you please sign on to the platform at least five to ten minutes prior to your session time to ensure you and your clinician get started promptly. Additionally, you are responsible for initiating the connection with your clinician at the time of your appointment. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password-protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps): During the course of your treatment or evaluation, your clinician may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as an adjunct to your treatment, or if you prefer that your clinician does not make these recommendations. Please let your clinician know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage: Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI may be stored electronically with Google Suites for Healthcare and Therapy Notes, which are secure storage companies who have signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point with federally approved encryption.

Electronic Transfer of PHI for Billing Purposes: If your clinician is credentialed with and a provider for your insurance carrier, please know that we utilize a billing service (Therapy Notes), who has access to your PHI. Your PHI will be securely transferred electronically from Therapy Notes to your insurance carrier. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point with federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, our billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions: We also utilize Therapy Notes as the company that processes your credit card information. Additionally, please be aware that the transaction will also appear on your credit card bill or statement.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. If using electronic communications, it is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. **Additionally, you agree not to record any TeleMental Health sessions.**

Communication Response Time

I'm required to make sure that you're aware that I'm located in the Southeast, and we abide by Eastern Standard Time. Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your clinician, and he or she can discuss additional resources or transfer your case to a clinician or clinic with 24-hour availability. We will return phone calls and emails within 24 hours during normal business hours, and we cannot guarantee any form of response on weekends or holidays.

Emergency Procedures Specific to TeleMental Health Services

If you are having a mental health emergency and need immediate assistance, please Call 911, go to your nearest emergency room, or call one of the phone numbers listed in the Consent for Services form above. There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please include this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency.
- Additionally, if either you, your ECP, or we determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above.
- You agree to inform your clinician of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform your clinician of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

(The following are all required for your clinician to conduct TeleMental Health Services)

Emergency Contact Person (ECP): _____

ECP Phone Number: _____

Name of nearest hospital to you: _____

Phone number for nearest hospital: _____

In Case of Technology Failure

During a TeleMental Health session, you and your clinician could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and your clinician has that phone number.

If you and your clinician get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call your clinician.

If you and your clinician are on a phone session and you get disconnected, please call your clinician back or contact her or him to schedule another session.

If the issue is due to your clinician's phone service, and the two of you are not able to reconnect, she/he will not charge you for that session.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, your clinician might not see a tear in your eye. Or, if audio quality is lacking, he or she might not hear the crack in your voice that he or she could have easily picked up if you were in our office.

There may also be a disruption to the service (e.g., phone cuts off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let your clinician know if something she or he has done or said upset you. We invite you to keep the communication with your clinician open at all times to reduce any possible harm.

Face-to Face Requirement

If you and your clinician agree that TeleMental Health services are the **primary** way that you and your clinician choose to conduct sessions, **we require one face-to-face meeting at the onset of treatment**. **We prefer this initial meeting to take place in our office.** If that is not possible, we can utilize video conferencing as described above. During this initial session, your clinician will require you to show a valid picture ID and another form of identity verification such a credit card in your name. **At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you**.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please provide your name, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing us to utilize the TeleMental Health methods and technology discussed.