CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS
Lane Ogden, Ph.D.
Psychologist

TELETHERAPY INFORMED CONSENT: I understand that Teletherapy includes the use of audio, video, and/or other data communications. All communication is encrypted, confidential either way there is no recording of sessions on Dr. Ogden's part. HIPAA has waived some restrictions on the practice of Teletherapy at this time. I understand that there are risks to Teletherapy which include, but are not limited to technical difficulties in transmission such as an interruption or distortion in audio or video during the session. Should we get disconnected, I will contact you by phone and we will meet again online or by phone. Please be aware that misunderstanding can easily occur because the session is not-in person.
Initials_____

PRIVACY POLICY: I acknowledge having been offered access to a copy of Dr. Ogden's "HIPAA Notice of Privacy Policies and Client Rights" which is also available on his website.
Initials_____

CONSENT FOR TREATMENT: I hereby consent to treatment provided by Dr. Ogden. I authorize the services deemed necessary or advisable by Dr. Ogden to address my psychotherapy needs.
Initials_____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting health care operations at Dr. Ogden's office. I authorize Dr. Ogden to release my information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dr. Ogden may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company or its designated agent.
Initials_____

ASSIGNMENT OF BENEFITS AND RELEASE: I authorize and request my insurance company to pay Dr. Ogden directly the amount due for services. Further, I authorize the release of any pertinent information necessary to process insurance for services. This consent is subject to revocation at any time except where action has already been taken based upon it. Otherwise, the release will be null and void six months after the final payment has been received. Release and this consent are subject to state and federal confidentiality requirements.
Initials _____

LEGAL CONSULTATION/SUBPOENA: I understand that if I or my attorney subpoenas Dr. Ogden for any Court action I am responsible for payment of his regular professional fees for preparation time, travel, time spent in testimony, oral deposition, deposition by video, deposition by written questions, or deposition by other electronic means. I will be required to pay a retainer in advance of my appearance.
Initials _____

GUARANTOR AGREEMENT: I certify that all information given is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered to me by Dr. Ogden. If he is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by my insurance plan.

_____ _____ _____
Client or Guarantor Signature Relationship Date

_____ _____
Witness Date

Update 11/7/2020