FAMILY MATTERS
COUNSELING CENTER

9800 Hillwood Parkway Suite 140 · Fort Worth, Texas 76177
1751 River Run Suite 200 · Fort Worth, Texas 76107

INTAKE FORM FOR COUPLES COUNSELING

Please note that while you will be asked to talk about your answers in sessions, your partner will not be shown this form.

Client Information

First Name: _____ Today's Date: _____
Last Name: _____ Date of Birth: _____
Pronouns (please circle one): he/him/his she/her/hers they/them/theirs
Race/Ethnicity: _____ Gender: _____
Relationship Status: _____ How Long? _____
Monogamous/Non-Monogamous: _____
Do you have Children? Y / N If yes, current partner, previous partner, or both? _____
Do you have a religious or spiritual preference? Y / N
If yes please explain: _____

Contact Information

Home/Cell Phone: _____ OK to leave a message? Y / N
Work Phone: _____ OK to leave a message? Y / N
Email: _____ OK to send email to you? Y / N
Mailing Address: _____ OK to send you information? Y / N
_____

Emergency Contact Information

Emergency Contact Name: _____
Emergency Contact Relationship: _____
Emergency Contact Phone Number: _____

How Were You Referred?

- ☐ Found On My Own
- ☐ Facebook/LinkedIn
- ☐ Website
- ☐ Psychology Today Listing
- ☐ Counselor/Doctor/Clinician
- ☐ Friend/Family
- ☐ Attorney
- ☐ Church
- ☐ Other: _____

Current Employment Status

- ☐ Full-time
- ☐ Part-time
- ☐ Unemployed
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Other: _____

FAMILY MATTERS
COUNSELING CENTER

9800 Hillwood Parkway Suite 140 · Fort Worth, Texas 76177
1751 River Run Suite 200 · Fort Worth, Texas 76107

Employment Information

Current Job Title: _____
Current Employer: _____
Skills Used in Current Position: _____
_____

Highest Level of Education

- ☐ Less than 12th grade
- ☐ High School
- ☐ Some College
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate

Please List All Household Members

Name	Age	DOB	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History

Are you currently under a Doctor's care: □ YES □ NO
Doctors involved in your care/child's care:
_____
Health Problems (include allergies): _____
Are you currently taking medication: □ YES □ NO

Medication	Dosage	Prescribing Doctor	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations

Date(s)	Reason(s)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MATTERS
COUNSELING CENTER

9800 Hillwood Parkway Suite 140 · Fort Worth, Texas 76177
1751 River Run Suite 200 · Fort Worth, Texas 76107

Previous Counseling, Psychiatric Treatment, or Chemical Dependency Services

Counselor/Facility	Date(s)	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Relationship Information

What do you hope to accomplish through counseling?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

Please rate your current level of relationship satisfaction by circling the number that corresponds with your current feelings about the relationship:
(Extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (Extremely satisfied)

Have you received prior couples counseling related to any of the above problems? Y / N
If so, with who:
Name of Location: _____
Name of Counselor: _____
Address: _____
Phone Number: _____

Whose idea was it to come to therapy? _____

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:
_____
_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems? Y / N
If so, who?
_____

If married, have either you or your partner consulted with a lawyer about divorce? Y / N
If so, who? _____

FAMILY MATTERS
COUNSELING CENTER

9800 Hillwood Parkway Suite 140 · Fort Worth, Texas 76177
1751 River Run Suite 200 · Fort Worth, Texas 76107

Do you perceive that either you or your partner has withdrawn from the relationship? Y / N
If so, who? _____

How enjoyable is your sexual relationship?
(Extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (Extremely pleasant)

How satisfied are you with the frequency of your sexual relations?
(Extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (Extremely pleasant)

What is your current level of stress overall?
(No stress) 1 2 3 4 5 6 7 8 9 10 (High stress)

What is your current level of stress in the relationship?
(No stress) 1 2 3 4 5 6 7 8 9 10 (High stress)

Have either you or your partner physically restrained, harmed, or injured the other person? Y / N
E.g., pushed, shoved, grabbed, or slapped, etc.
If yes for either partner, who, how often and what happened?

_____
_____
_____

Have you or your partner ever emotionally or physically cheated on each other? Y / N
If so, who? _____

Name the top three concerns that you have in your relationship with your partner ("1" being the most problematic):

1. _____
2. _____
3. _____

What is the current way you handle conflict? (Please circle all that apply)
Criticism (verbal attacks) Defensiveness (victimize self/reverse blame)
Stonewalling (withdrawal/avoidance) Contempt (attack/blame yourself)

How important is it to you to improve the quality of your relationship?
(Not important) 1 2 3 4 5 6 7 8 9 10 (Extremely important)

How willing are you to make "working on this relationship" a priority in your life?
(Not willing) 1 2 3 4 5 6 7 8 9 10 (Extremely willing)

FAMILY MATTERS
COUNSELING CENTER

9800 Hillwood Parkway Suite 140 · Fort Worth, Texas 76177
1751 River Run Suite 200 · Fort Worth, Texas 76107

Please circle ALL of the following items that are currently a concern to you regarding
YOU AND/OR YOUR PRESENT RELATIONSHIP:

1. Premarital counseling
2. Marital relationship
3. Remarried relationship
4. Poor communication
5. Parenting concerns
6. Sexual difficulties
7. Anxiety
8. Depression
9. Family relationships
10. Alcohol/drug abuse
11. Stress
12. Physical problem
13. Self-esteem
14. Suicidal thoughts
15. Suicide attempt
16. Childhood emotional abuse
17. Childhood physical abuse
18. Incest
19. Anger
20. Grief/loss
21. Financial concerns
22. Work related concerns
23. Job loss
24. Physical abuse/violence
25. Verbal abuse/violence
26. Gender identity
27. Cutting/self-harm behavior
28. Divorce contemplation
29. Custody issues
30. LGBT issues
31. Eating disorder
32. Illness
33. Rape
34. Religion/ spiritual views
35. Past relationships
36. Divorce recovery
37. Other:_____

FAMILY MATTERS
COUNSELING CENTER

CONSENT AND INFORMATION FORM FOR COUNSELING SERVICES

We are very pleased and honored that you have chosen Family Matters Counseling Center, LLC. Please take the time to carefully read the following information regarding some important aspects of the counseling process. If you have any questions at all, please do not hesitate to discuss them with us.

CONFIDENTIALITY

Confidentiality refers to the process whereby the information that is shared by you with your counselor is kept private. In fact, even your identity as a client will remain confidential unless you yourself choose to disclose this information to someone else. Therefore, information regarding your counseling will not be released without your written authorization. However, please understand that in certain specific instances, there are limits to this confidentiality agreement. (1) In cases where a counselor has reason to believe that a person may be in imminent danger of harming him/herself or others, the counselor may notify the proper authorities. (2) The State of Texas mandates that any person who knows or suspects that a child, an elderly person, or a disabled person is in danger of being physically, emotionally, or sexually abused must report such abuse or suspected abuse to the proper authorities. Counselors are also required to report suspected or actual sexual exploitation of counseling clients by mental health professionals. (3) In Texas, confidentiality does not extend to criminal proceedings or to legitimate subpoenas from a judge in civil proceedings. If a court subpoenas counseling records, the therapist is required to provide the requested information.

BENEFITS/OUTCOMES

Counseling will seek to meet goals established by the individual. A major benefit that may be gained from participating in counseling includes a reduction in distress and a better ability to handle or cope with conflict, and gain confidence and assurance. Other benefits relate to the probable outcomes resulting from continued progress and effort put into the counseling process by the individual. I will do my best to assess progress on a regular basis and solicit your feedback regarding the counseling process to help provide you with the needed help you are seeking.

REALISTIC EXPECTATIONS

Work outside of the counseling sessions is a necessary element for success; therefore, we may ask you to perform some 'homework' related to your goals and our session content. We promise to work as efficiently as possible; at the same time, counseling may move more slowly than you anticipated. We will review your goals with you periodically, and we ask that you request a conversation about the status of our counseling whenever you have questions about progress.

RESPONSIBILITY REGARDING APPOINTMENTS AND CANCELLATIONS

You are responsible for meeting each appointment you agree upon. However, we understand that in certain cases, unexpected things can arise which prevent individuals from being able to keep a scheduled appointment.
Therefore, we adhere to the following policy. If we are prevented from keeping an appointment (e.g. due to sickness, an emergency, called out of town, etc.), we will notify you as soon as possible. Similarly, if you are prevented from keeping a scheduled appointment, we simply ask that you notify us by phone (817-361-4545) or email (familymatters@familymatterscounselingcenter.com) **24 HOURS in advance** so that another client may have the opportunity to utilize that time slot. **If we do not receive such advance notice, you will be responsible for paying the full fee for the session you missed.**

PHONE CONTACTS AND EMERGENCIES

Our phone is answered by voice mail 24 hours a day. Due to our work schedule, it may take several hours before we are able to return your call, with the exception of weekends and holidays. The phone number provided is not a crisis-hotline. For emergencies, please call 911.

FAMILY MATTERS
COUNSELING CENTER

FEES
The per-session fee you agree to pay is to be paid at the conclusion of each session.
Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee.

Counseling:

DOCTORATE LEVEL COUNSELORS
- ***Dr. Robyn Bone, Ph.D., LPC***

$150 per 50-60 minute individual session

MASTERS LEVEL COUNSELORS
- ***Eureka Williams, MS, LCSW***
- ***Lauren Claudio, MS, LPC***
- ***Earl Wilson, MS, LMFT***
- ***Aimee Marr, MA, LPC***
- ***Amanda Baker, MSSW, LCSW***

$130 per 50-60 minute individual session
$65 per 75-minute group session

GRADUATE STUDENT COUNSELORS*
- ***To be announced…***

They offer "pay what you can" services and will not turn anyone down based on ability to pay alone.

**Graduate Counseling Students are completing their 300 hours as required for their master's degree.*

ASSOCIATE COUNSELORS
- ***Shannon Watterson, MA, LPC-Associate***
  Supervisor: Dr. Richard Bishop, LMFT-S, LPC-S
  a. rbishop@txwes.edu
  b. 817-531-4444
  c. 1201 Wesleyan St., Ft Worth, TX 76107
- ***Andrea Talbot, LMSW***
  Supervisor: Suisan Walker, LCSW-S
  a. Suisan.walker@bestilltherapy.com
  b. 469-563-2941
  c. 601 Strada Circle, Mansfield, TX 76063
- ***Mitzi Smith, MA, LPC-Associate***
  Supervisor: Amy Standifer, LPC-S
  a. amyst@dbu.edu
  b. 214-333-5288
  c. 3000 Mountain Creek Pkwy, Dallas, TX 75211
  Supervisor: Heidi Tournoux-Hanshaw, LPC-AT/S
  a. info@heiditournouxstudios.com
  b. 817-921-2401
  c. 1616 Park Place, Ft. Worth, TX 76110

$106 per 50-60 minute session
*Associates can offer a Sliding Scale Fee if Required

Career Development:
- The rate for a professional resume created by a resume expert is $150.00.
- The rate for a cover letter added to each resume is $60.00.

Testing & Assessments:
- Usual and customary fees are between $8.00 and $20.00 for interest and ability testing.
- Usual and customary fees are between $25.00 and $45.00 for drug and alcohol assessments.
- Usual and customary fees are between $360.00 and $1,500 for Gifted/IQ testing and accommodation assessments.
- Usual and customary fees are between $250 and $500 for Pre-Surgical or Bariatric psychological evaluations.
- Usual and customary fees are between $1,500 and $3,500 for psychological testing.

Rush Fees:
Results are available on our standard 15 business day turnaround. If you need results in less than 15 business days, please see our rush fees below:
- 13-14 business days (+$500)
- 10-12 business days (+$1000)
- 7-9 business days (+$1500)
- 4-6 business days (+$2,000)

**To maintain the quality of our work, we cannot accommodate requests for results of assessments in less than 3 business days.*

FAMILY MATTERS
COUNSELING CENTER

Payments:
Cash, personal checks, HSA, and credit cards are accepted for payment (in the event of a check being returned due to insufficient funds, you will be responsible for paying the balance plus a $25 fee). You will be provided with a receipt for all fees paid via paper or email. In the event that you miss your scheduled appointment time, you will need to pay the remaining balance by the beginning of your next session. In the event that you miss two scheduled appointment times in a row, another appointment time will not be scheduled until you have paid your remaining balance. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, our staff has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which would require releasing information about you. If such action is necessary, its costs will be included in the claim.

INSURANCE
Family Matters is in-network with Blue Cross Blue Shield of Texas, Cigna/Evernorth, Optum, United Healthcare, Humana, First Care (Baylor Scoot & White), and Magellan. Clients with other insurance providers are welcome to use their out-of-network benefits. Benefits will need to be verified prior to initial appointment.

Questions about billing? Please call Mediclaim Services, Inc. at (888) 833-4256 x 201.

COURT APPEARANCES
Because the client-counselor relationship is built on the foundation of trust, and that trust being confidentiality, it's often damaging to the therapeutic relationship for the counselor to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition. Therefore, we ask that you only request a court appearance in extreme cases. In the event that it's necessary for a therapist to testify before any court, arbitrator, or other hearing officer at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay for services, including travel, preparation, and necessary expenditures (copies, parking, meals, and the like) at the rate of $250/hour, rounded to the nearest half hour, with a minimum commitment of eight hours, for a total minimum charge of two thousand dollars (8 hours x $250 = $2,000). The client further agrees to pay the $2,000 two weeks prior to the appearance, presentation of records, or testimony requested.

COMPLAINTS
A consumer who wishes to file a complaint against an individual licensed by the board may call:
1-800-942-5542 or write to:
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

I have read and understand the information contained in this consent form. Furthermore, I have discussed any questions that I may have had regarding this information with my therapist. My signature below indicates that I give my full and informed consent to receive counseling services.

_____
Client's Signature (Guardian if a minor)

_____
Client's Printed Name (Guardian if a minor)

_____

Date Signed

Phone: 817-361-4545 · Fax: 682-312-3501

Mental Health Questionnaire

The following questionnaire is intended to help your clinician to best understand your history and current psychological needs. The questions are intended to help your provider to gather a complete history and allow you to make the most of your therapeutic experience; though many may be challenging to complete, do your best to answer openly and honestly.

Your Full Name _____

DOB: _____

Primary Phone Number _____

Past/Current Medical & Psychological History:

Primary Care Physician _____

Phone Number _____

May we contact your PCP? _____ Yes _____ No

Current Therapist or Psychologist _____

Phone Number _____

May we contact your therapist/psychologist? _____ Yes _____ No

Who Referred You? _____

Phone Number _____

May we contact your referring party? _____Yes _____ No

Current medical history including hospitalizations or surgeries:

Family Medical or Psychiatric History:

Current Medications and Dosage

Medication Name	Dosage	Frequency	Prescribed For	Is Medication Helping?	Side Effects

Past and Current Psychiatric Medications (Please include dosage):

Have you ever had an outpatient or inpatient psychiatric hospitalization? (Include reason, dates, location. Please indicate V if voluntary N if hospitalization was non voluntary):

Have you ever seriously thought about suicide? _____ Yes _____ No

Have you attempted suicide before? _____ Yes _____ No

Current Functioning:

Please describe below how you have been feeling and what drove you to request treatment now?

Current Symptom Checklist

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep disturbance
- ☐ Loss of interest
- ☐ Problems with concentration/focus
- ☐ Change in appetite
- ☐ Excessive guilt/worry
- ☐ Fatigue
- ☐ Decreased libido or sexual interest
- ☐ Racing thoughts
- ☐ Impulsive thoughts or behaviors
- ☐ Increase in risky behaviors
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Volatility or crying spells
- ☐ Anxiety attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness

Please describe any other symptoms not listed above:

The following are a list of behaviors or actions you may take to avoid feeling or to help you to manage difficult feelings. Please check all boxes that illustrate behavioral choices you do or have made historically to manage challenging feelings.

Compensatory Behavior Checklist

- ☐ Codependence
- ☐ Over use of technology
- ☐ Over eating
- ☐ Under eating
- ☐ Withholding food
- ☐ Laxatives, vomiting, or weight loss supplements
- ☐ Over working
- ☐ Staying chronically busy
- ☐ Cleaning
- ☐ Avoiding others
- ☐ Over exercise
- ☐ Creating drama/chaos
- ☐ Sleeping too much
- ☐ Sleeping too little
- ☐ Shopping
- ☐ Promiscuity
- ☐ Unsafe sexual practices
- ☐ Masturbation
- ☐ Video/computer games
- ☐ Use of pornography
- ☐ Unhealthy online relationships
- ☐ Violence
- ☐ Getting into physical fights
- ☐ Abuse of prescription drugs
- ☐ Use of illegal drugs
- ☐ Use of alcohol
- ☐ Skin picking
- ☐ Hiding: Ruminating and avoiding
- ☐ Cutting/self-harm

Legal History:

Have you ever been arrested or convicted of a crime? _____ Yes _____ No

Are you currently on parole/probation? _____ Yes _____ No

Are you currently involved in any legal proceedings of any nature? _____ Yes _____ No

If yes, please explain:

Are you mandated by court to participate in mental health services? _____ Yes _____ No

If yes, please explain:

Do you or your children currently have legal representation? _____ Yes _____No

If yes, please explain:

Chemical Use History

Do you consume alcohol? _____ Yes _____ No

If yes, how much alcohol do you consume per day and week? _____

Do you use tobacco or tobacco products? _____ Yes _____ No

If yes, how much do you consume per day and week? _____

Do you use marijuana? _____ Yes _____ No

If yes, how much do you consume per day and week? _____

Do you use any other substances? _____ Yes _____ No

If yes, please describe by type and use below:

Have you ever considered reducing your consumption? _____ Yes _____ No

Have others criticized your substance use or encouraged you to reduce? _____ Yes _____ No

Do you have feelings of guilt or a sense of being out of control with your use? _____ Yes _____No

Have drugs or alcohol led to problems in your relationships? _____ Yes _____ No

Have drugs or alcohol ever interfered with your work or school? _____ Yes _____ No

Have you ever been arrested or convicted of a crime secondary to substance use? _____Yes _____ No

Have you ever received treatment for drugs or alcohol? _____ Yes _____ No

If yes, please describe:

Abuse History:

Please check any of the categories below and provide as much detail as you can including your age at the time of the abuse.

Emotionally Abused _____ Yes _____ No

If yes, please explain:

Physically Abused _____ Yes _____ No

If yes, please explain:

Sexually Abused _____ Yes _____ No

If yes, please explain:

Physically or Emotionally Neglected _____ Yes _____ No

If yes, please explain:

Witnessed Violence by Parents/Caregivers _____ Yes _____ No

If yes, please explain:

Abused as Part of Religious/Group Activities _____ Yes _____ No

If yes, please explain:

Personal Insights & Goals for Therapeutic Intervention:

What are your goals in seeking psychological services?

Have you created physical and mental room in your schedule to seek help?

What are your personal strengths, assets, and capacities that have assisted you in coping in the past?

Do you consider yourself to have good emotional and social insight/intelligence?

What do you currently do to manage your stress?

What type of communication works best for you?

Do you consider yourself open to the therapeutic process? What reservations, if any, do you have about seeking treatment?

Are you open to homework or strategies/techniques you may utilize or practice outside of the treatment room?

What are you looking for in a mental health provider, what would this look like if treatment was a success?

Client Name (Please print): _____

Client Signature: _____

Date Signed: _____

FAMILY MATTERS
COUNSELING CENTER

FINANCIAL OBLIGATIONS

I understand that as a courtesy to me, Family Matters Counseling Center, LLC will file to my insurance provider.

I understand that I am responsible for payment of services rendered and for paying any co-payment or deductible that my insurance does not cover.

I hereby authorize payment directly to Family Matters Counseling Center for the group benefits otherwise payable to me.

I hereby authorize the release of any information, including the diagnosis and records of treatment rendered, to my insurance company.

I understand that I am personally responsible for all costs of mental health treatment at time of service; this includes all co-pays and fees.

I understand that if I need some special consideration regarding timing of payment or payment plan, it is essential that I make arrangements with Family Matters Counseling Center **before** treatment is scheduled.

I understand that if a balance is not paid in full 30 days from of treatment date, my past due balance will be charged a $15 delinquent fee every month until the balance is either paid or sent to a collection agency. Past due balances of $25 or more are subject to collection actions.

I understand that past due balances greater than $25 must be collected before future treatment/sessions can be scheduled.

I understand it is my responsibility to obtain prior authorization for treatment from my insurance provider.

I understand that my insurance provider is not responsible for any No-Show/Late Cancellation charges, and I will be directly responsible for these charges.

I hereby acknowledge that I have received a copy of this Financial Obligation.

If I have billing questions about charges or my out of pocket portion, I can direct them to Mediclaim Services, Inc. at (888) 833-4256 x 201.

Client Name (Please print)_____

Client Signature _____

Date Signed _____

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____ SSN:_____

Email: _____

Billing Information:

Please indicate the information associated with the debit card you wish to use. ☐ I prefer to use a credit card.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Debit Card Information: ☐ I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

Telehealth Informed Consent

As a client or patient receiving behavioral services through telehealth technologies, I understand:

- Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.
- The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel.
- These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information:

The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

During my telehealth consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area such as _____, _____, or _____ or to contact my behavioral practitioner's office for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Self-Termination:

I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits. Risks of Technology:

These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

In emergency situations ■ _____

Disruption of Service:

Should service be disrupted ■ _____

For other communication ■ _____

Practitioner Communication:

My practitioner may utilize alternative means of communication in the following circumstances:
o _____

My practitioner will respond to communications and routine messages within _____

Client Communication:

It is my responsibility to maintain privacy on the client end of communication.

Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

I will take the following precautions to ensure that my communications are directed only to my psychologist or other designated individuals:
o _____
o _____

Storage:

My communication exchanged with my practitioner will be stored in the following manner:
o _____
o _____

Laws & Standards:

The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement: _____
Client Printed Name _____ _____
Signature of Client or Legal Guardian Date _____
Printed Name of Practitioner _____ _____
Signature of Practitioner Date

Addendum A

Name of Client/Patient: _____

Electronic Transmission of Information:

I, the undersigned, a citizen of _____, or _____, my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with _____, a behavioral health care practitioner (“practitioner”). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and

data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").
I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:
I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

TeleHealth Process:

My health care practitioner has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services:

I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

Electronic Presence:

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my practitioner.

Limitations:

Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation.

I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better.

My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

I understand that telehealth is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.

Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Release of Information:

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.

I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment.

I understand that I can still pursue in-person consultations.

I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.
Records:

I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.

I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.

I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored,

I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs.

I hereby authorize these disclosures to take place without prior written consent.

Compensation:

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telebehavioral consultation(s) or other information exchange.

Contact Information:

I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable).

I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser). _____
_____ Name Telephone Number _____
_____ Name Telephone Number _____
_____ Name Telephone Number

Release of Liability:

I unconditionally release and discharge _____ (name of organization), its affiliates, agents, employees; _____ (name of consulting organization), its affiliates, agents, and employees; and my practitioner and his or her designees from any liability in connection with my participation in the remote consultation(s).

Final Agreement:

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.
_____ _____ _____ (Name, Date, Witness)

Consent to Treat a Minor:

The above release is given on behalf of _____ because the patient is a minor or has been determined to be incompetent to give medical consent for the following reasons:
_____
_____
_____
_____ _____ _____ (Name, Date, Time)

FAMILY MATTERS
COUNSELING CENTER

HIPPA PRIVACY NOTICE

This notice describes how mental health information about you may be used and discussed and how you can get access to this information. Please review it carefully.

1. Your protected mental health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security number, and demographic data) may be used or disclosed by us in one of more of the following respects:
    a. To other care providers in connection with our rendering treatment.
    b. To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, date of payments, etc.)
    c. To certifying, licensing, accrediting bodies (i.e. American Psychological Association, state boards, etc.) in connection with obtaining certification, licensure, or accreditation.
    d. Internally, to all staff members who have a role in your treatment.
    e. To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
    f. To you family and close friends involved in your treatment.
    g. We may contact you to provide appointment reminders or information about treatment alternatives or other mental health related benefits and services that be of interest to you.
    h. Any other uses or disclosures of your protected mental health information will be made only after obtaining your written authorization, which you have the right to revoke.
2. Under the new privacy rules, you have the right to:
    a. Request restrictions on the use and disclosure of your protected mental health information.
    b. Request confidential communication of your protected mental health information.
    c. Inspect and obtain copies of your protected mental health information through asking us.
    d. Amend or modify your protected mental health information due to certain circumstances.
    e. Receive an accounting of certain disclosures made by us of your protected mental health information.
    f. You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 190 days of violation).
3. We have following duties to you:
    a. By law, to maintain the privacy of protected mental health information and to provide you with this notice of setting fourth our legal duties and privacy practices with respect to such information.
    b. To abide by the terms of our Privacy Note that is currently in effect.

   c. To advise you of our right to change the terms of this Privacy Note and to make the new notice provisions effective for all protected mental health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice.

4. Please note that we not obligated to:
   a. Honor any request by you to restrict the use or disclosure of your protected mental health information.
   b. Amend your protected mental health information if, for example, it is accurate and complete.
   c. Provide an atmosphere that is totally free of the possibility that your protected mental health information may be incidentally overheard by other clients and third parties.
   d. This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your question to this person at our office address.

I hereby acknowledge that I have received a copy of this Privacy Notice.

Client Name (Please print): _____

Client Signature: _____

Date Signed: _____