Northeast Georgia
Employee Assistance Program
Service Record

Appt. Date _____
Appt. Time _____
Location ☐ Athens ☐ Winder

1) **For Office Use Only**

Client Number: _____ **Record Name:** _____ **Category: (NEG)** ☐ **Bas** ☐ **Inc**

Assigned Counselor: _____ **Office Location:** ☐ **Athens** ☐ **Winder**

Intake Date: _____ **Intake Coordinator :** _____

Employer Name _____ **Number of EAP Sessions Authorized:** _____

Employee Name: _____

Is this a supervisory referral? ☐ **yes** ☐ **no** **If yes, is it** ☐ **voluntary** ☐ **initiated**

If yes, supervisor contact _____ **Phone Number** _____

Please complete the next section for the person identified as the primary person receiving services.
Example: for you-your name, for couples or families-the name of either adult, for child-the name of child.

This information pertains to: ☐ **Employee** ☐ **Dependant**

Name _____ Age _____ DOB _____ Sex _____ Race _____ SS# _____

Address _____

City _____ State _____ Zip _____ County _____

Phone (H) _____ (W) _____ (C) _____

Marital Status _____ Spouse/Partner Name _____

Spouse/Partner Employer: _____

****Notice to Couples:** The record will be established in the name of the caller. Therefore any records release will require this person's signature.

Emergency Contact Name: _____ Phone _____

Problem Statement and Scheduling needs:

Briefly describe why you are seeking help _____

What, if anything, led to your contacting us at this time (i.e. recent incident, court or employer involvement, etc.)

_____

Have you had any past treatment for these same concerns? If so, where? _____

What days/times are best for you to schedule appointments? _____

Fee Agreement

Funding support from donors allows Family Counseling Service, Inc. (FCS) to provide counseling on an ability-to-pay basis, including a lowered fee for those with no income, or others who cannot afford the Agency's minimum fees.* "Ability to pay" is defined based upon gross household income and insurance coverage as indicated below:

	Therapist	Graduate Intern
1. Standard charge per session	$ 110.00	$ 110.00
2. Minus amount to be paid by insurance	$ _____	$ _____
3. Remaining balance	$ _____	$ _____
4. **Client fee obligation** (copayment) to be paid each visit (at $1.25 per $1,000 annual income with $45.00 minimum fee)	$	$

Benefits quoted by your insurance carrier, including copayment, are not a guarantee of payment until a claim has been filed. Therefore, please be aware that your client obligation is subject to change.

*Due to a limited number of staff openings for those requesting waiver of the standard fee, requests will be handled on a "first come, first served" basis. Anyone requesting a fee below the standard charge ($110.00) must complete the work/income information on the Service Record and provide proof of income.

Total amount of household income: $ _____ Annually

Your medical insurance may be used to pay a portion of the Agency's standard charges. We will file for you provided you sign the Assignment of Benefits Statement below. Clients who have insurance coverage may elect not to use it; however, they will be responsible for payment of the amount which would have been collected through insurance **in addition to** their copayment (item #4 on above fee agreement). If your deductible has not been met, you are responsible for the entire about of the standard charge until the deductible has been met. Payment plans are available. **Your insurance cannot be billed for missed or late-cancelled appointments.**

I understand that unless I give **twenty-four (24) hours' notice of cancellation,** I am responsible for payment.

X _____ Please initial. ***PLEASE READ AND SIGN ATTACHED PROCEDURE REGARDING MISSED APPOINTMENTS.***

Rights to Privacy Notification

X _____ My initials here indicate I have been advised of the Notice of Privacy Practice.

Assignment of Medical Benefits

I hereby assign all medical benefits of which I am entitled to Family Counseling Service, Inc. A photocopy of this assignment is to be considered as valid as an original. I further authorize said assignee to release all information necessary to secure medical payments for services rendered.

Please provide signatures below to affirm your agreement to the policies and procedures outlined above.

Signature	*Date of signature*	*Date of birth*	*Social security number*
Signature	*Date of signature*	*Date of birth*	*Social security number*
Witness signature	*Date of signature*		

Statement of Understanding

The Northeast Georgia Employee Assistance Program (NEGEAP) is designed to help you and your family members manage personal problems. The NEGEAP offers assessment, short-term counseling, referral, and follow-up services.

Your NEGEAP counselor works with you to assess your problem and develop an appropriate action plan to help resolve that problem. This plan may include short-term counseling with your NEGEAP counselor and/or the NEGEAP counselor might facilitate a referral to another provider or organization with the expertise in your area of need.

All NEGEAP services are provided at no cost to you or your family members. However, if your action plan involves seeking services outside of the NEGEAP, the financial responsibility for payment to the referral source is yours. It is possible that the services may be coordinated through the benefit plan offered by your employer.

The information you share with your NEGEAP counselor is confidential. Limits of confidentiality do apply, however; according to federal regulations, licensed clinical providers are mandated to report information that professional judgment would determines constitutes threat or serious harm to self or others, or of information regarding child or elder abuse or neglect.

Disclosure of information: Under certain circumstances, disclosures of information may be made:

1. When the client consents in writing.
2. When the disclosure is allowed by a valid court order.
3. When the disclosure is made to medical personnel in a medical emergency.
4. When the disclosure is made in a non-identifiable form for research, audit, or program evaluation.

☐ **Rights to Privacy Notification:** *My initials here indicate I have been advised of the Notice of Privacy Practice.*

I hearby certify that I have read and understand the content of the information stated above.

Signature of client	*Date*
Signature of witness	*Date*

NORTHEAST GEORGIA EMPLOYEE ASSISTANCE PROGRAM

Name of person receiving services:

Relationship to employee with EAP benefit: ☐ Self ☐ Spouse ☐ Child ☐ Other dependent

*Please complete this box with information about the **Employee** with the EAP benefit.*

Name of employee with EAP benefit:

Employee job title: **Approximate date of hire:**

Work hours: **Hourly or Salary?** ☐ Hourly ☐ Salary

Highest educational grade completed:

Employment status (select one):

If "other," please describe:

How were you referred to EAP services? (select one):

Is this your first time using EAP services? (select one): ☐ Yes ☐ No

Primary concerns (check all that apply):

- ☐ Depression/anxiety
- ☐ Health
- ☐ Stress
- ☐ Anger/violence
- ☐ Family/life issues
- ☐ Job performance/supervisor referral
- ☐ Other workplace concern:
- ☐ Legal/financial
- ☐ Marital/family/partner
- ☐ Parent/child
- ☐ Grief/loss
- ☐ Substance use/abuse
- ☐ Mental/behavioral health

Do you feel that any of your concerns are affecting your job? Items are rated on a scale of 1-5, with 1="not at all"; 5="very much."

Attendance:

Performance:

Productivity:

Other (please explain below):

Current Concerns

Please provide the following information so we may better address your concerns. If you are completing for someone else, base on statements made to you.

A) Areas of Concern (Rated on a scale of 1-5, where 1= "not at all"; 5= "very much")

Marriage/Partner	
Family	
Eating Habits	
Sleeping Habits	
School or Work Performance	
Ability to Concentrate	
Health	
Motivation/Energy	
Ability to Parent Children	
Ability to Manage Anger	
Ability to Trust Others	
Ability to Establish Relationships	

B) Medical History (Please answer "Yes," "No," or "N/A" as applicable)

High Blood Pressure	
Diabetes	
Lung Problems	
Heart Problems	
Kidney Problems	
Liver Problems	
Miscarriages	
Learning Problems	
Nerve Problems	
Menopausal Symptoms	

Current Concerns

Mental Illness/Schizophrenia	
Depression	
Drinking Problems	
Drug Problems	
Cancer	
Seizures	
Other	

C) Depression Inventory

How often per week have you felt depressed **in the past two weeks**?	☐ **0 days** ☐ **1-2 days** ☐ **3-4 days** ☐ **5-7 days**
How often per week have you felt tired **in the past two weeks**?	☐ **0 days** ☐ **1-2 days** ☐ **3-4 days** ☐ **5-7 days**
How often per week have you avoided people **in the past two weeks**?	☐ **0 days** ☐ **1-2 days** ☐ **3-4 days** ☐ **5-7 days**
How often per week have you noticed losing pleasure in things you usually care about/enjoy **in the past two weeks**?	☐ **0 days** ☐ **1-2 days** ☐ **3-4 days** ☐ **5-7 days**
Have you felt depressed or sad most of the time **in the past year**, even if okay sometimes?	☐ **yes** ☐ **no**
Have you felt depressed or sad most of the time **in the past two years**, even if okay sometimes?	☐ **yes** ☐ **no**
Have you considered suicide?	☐ **yes** ☐ **no**
Have you attempted suicide?	☐ **yes** ☐ **no**

D) Drinking/Drug Use History

Has anyone (you or anyone significant to you) attempted to stop drinking/using other drugs?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
Has anyone (you or anyone significant to you) expressed concern about the drinking or non-prescription drug use by someone else in the home?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
Has an employer been concerned about someone's (you or anyone significant to you) alcohol/drug use?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
Has anyone had a DUI?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**

E) Prescriptions Used/Prescribed by whom:

Current Concerns

F) Safety Concerns

In the past year, have you or anyone significant to you felt threatened?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
In the past year, have you or anyone significant to you been pushed, hit, or physically threatened?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
In the past year, have you or anyone significant to you been subjected to patterns of verbal abuse or intimidation?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
In the past year, have you or anyone significant to you been sexually abused?	☐ **yes, me** ☐ **yes, someone else** ☐ **no**
In the past year, have you pushed, hit, verbally/physically/sexually abused others, or threatened to do so?	☐ **yes** ☐ **no**

G) Other Concerns and Additional Information

Missed or Cancelled Sessions

As indicated in the Consent to Services form you signed at your initial visit, we ask for a 24-hour notice to cancel appointments. We understand that there may be isolated, unforeseen emergencies where it is difficult or impossible to give adequate notice. Barring such rare circumstances, the following guidelines apply to missed sessions without adequate notice. Please read the following carefully:

A. If you are using insurance for therapy sessions, there will be a $50.00 charge for a missed session. Please be aware that ***your insurance company cannot be billed if you are not present***; therefore, you will be responsible for the $50.00 charge regardless of your copayment.
B. If you are not using insurance (paying out-of-pocket), and your assessed fee is less than $50.00 per session, you are responsible for paying your assessed fee.
C. If you are using your Employee Assistance Program (EAP) benefits, there is no charge for a missed session; however, you will have one less session available to you.
D. If missed appointments become a concern, your counselor will discuss this with you. Should this continue to be a problem, please be aware that FCS reserves the right to require pre-payment for sessions or to discontinue sessions.

Please feel free to call FCS at (706) 549-7755 should you need to verify your appointment day or time. Your signature below indicates your understanding and agreement to adhere to the above policy. If you have questions about this policy, please discuss them with your counselor.

Print client/legal guardian name

Signature *Date*

HIPAA Notice of Privacy Practices

Family Counseling Service of Athens, Inc.
1435 Oglethorpe Avenue, Athens, GA 30606
(706) 549-7755

NOTICE TO OUR CLIENTS REGARDING NEW PRIVACY PRACTICES

As you are probably aware, federal law requires that you be notified of your rights regarding protection of information you share with us during treatment. The information on this form summarizes those rights as defined in federal law.

Signing this form only indicates you have been made aware of these rights. It does not authorize us to release any information regarding your services here. It is our policy to only release information after you have signed **our** consent form. The only exception to this is situations that are mandated by state or federal law; i.e. threat to self or others including child abuse or neglect as stated in our Consent to Services form which is also included for your signature.

In other words our protection policy is stricter than federal guidelines. If you have any questions, please discuss with your counselor.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your therapist, clinical nurse specialist, psychiatrist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a therapist, clinical nurse specialist, or psychiatrist to whom you have been referred to ensure that these individuals or organizations have the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in the course of normal business operations. These activities include, but are not limited to, case review, quality assessment activities, supervision of health care workers in training, licensing, and conducting or arranging for other business office activities. For example, we may disclose your protected health information to student interns that see clients at our office. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sharing Your Information: There are situations when we are permitted, and in some instances, required to disclose information without your authorization. These situations are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities, if any, required of us such as complaint investigations, licensing, audits, and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates; for organ and tissue donations; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for workers’ compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of providing treatment, obtaining payment or office operations. For example, front office staff responsible for records maintenance and billing.

Finally, under the law, we must make disclosures to you and, if required, by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Private Practices Law.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. Under federal law, however, you may not inspect or copy the information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to law that prohibits access to protected health information, and in some instances psychotherapy notes taken by your therapist.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

However, your therapist, clinical nurse specialist, or psychiatrist is not required to agree to a restriction that you may request if the therapist, clinical nurse specialist or psychiatrist believes it is in your best interest to permit use and disclosure of your protected health information. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your therapist, clinical nurse specialist or psychiatrist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Grace Edmonds, in person or by phone at (706) 549-7755.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print name of client/legal guardian	*Signature of client/legal guardian*	*Date*

Information, Authorization, & Consent to Telemental Health

The following is important information about your services as related to Telemental Health. 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)

Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Georgia law requires all licensed mental health clinicians to have training in telemental health. **We at FCS have developed several policies and measures to ensure that your Protected Health Information (PHI) remains confidential.**

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 a cell phone or our VOIP (voice over internet protocol) service. If this is not an acceptable way to contact you, please let us know. Telephone conversations lasting more than 15 minutes are generally 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. Telephone conversations lasting over 15 minutes with your clinician are billed at your clinician’s hourly rate. If this is a problem, please let us know, and we will discuss our options.

Email: Email is not a reliably secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. If we email you anything other than an appointment confirmation or something about a change in your appointment, we will use an encryption service to protect access to that information. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy. 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."

Social Media (Facebook, Twitter, LinkedIn, Instagram, Pinterest, etc.)**:** It is our policy not to accept "friend" or "connection" requests from any current or former client on our personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. However, FCS has a professional Facebook page. You are welcome to "follow" us on this professional page. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Family Counseling Service. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Recommendations to Websites or Applications (Apps): During our treatment, your clinician may recommend that you visit certain websites for pertinent information or self-help. They 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/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 adjunct to your treatment or if you prefer that your clinician not make these recommendations. Please let them know by checking (or not checking) the appropriate box at the end of this document.

Faxing Medical Records: If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, we may need to fax that information to the authorized entity. We use our secure scanner/fax. Additionally, information that has been faxed may also remain in the hard drive of our scanner. However, this machine is kept behind two locks in office. And, when it needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Communication Response Time: We are required to make sure that you're aware that we are located in the Southeast and as such we use 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. Your clinician is not available at all times. If at any time this does not feel like enough support, please inform your clinician to discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We generally will return phone calls within 24 hours. However, your clinician may not return calls or emails on weekends or holidays. We do have an after-hours (outside of normal business hours) number that you can call for assistance. This number will contact the clinician on call for urgent but non-life-threatening calls. This number is 706-549-7755. When you reach the voicemail on this line leave a name and number and the nature of your urgency and the call will be returned as soon as possible. However, do not wait for this return call if this is a true life threatening emergency. In that instance, please follow the instructions below. Please ask your counselor if you have questions about this. Our After Hours service is only available to “current” clients. Your file will be placed in “closed” status if you have not been seen or do not have a scheduled appointment for 3 months. When this happens you will have to re-contact our office during normal business hours to resume services.

In Case of an Emergency: If you have a mental health emergency, we encourage you not to wait for communication back from your clinician, but do one or more of the following:

Call the Georgia Crisis and Access Line (“GCAL”)/Behavioral Health Link at 1 (800) 715-4225

Call Lifeline National Crisis Line at 1 (800) 273-8255

Call SummitRidge Hospital at (678) 442-5858

Call Ridgeview Institute at (770) 434-4567

Call Peachford Hospital at (770) 454-5589

Call 911. Go to the emergency room of your choice.

Video Conferencing (VC): Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. We utilize Doxy.com meetings. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.com is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If you and your therapist choose to utilize this technology for a session by video, your therapist will give you directions and a code to log-in securely. 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.).

Your Responsibilities for Confidentiality & TeleMental Health: Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, coworkers, 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.

SPECIAL INFORMATION FOR VIDEO OR PHONE SESSIONS:

Structure and Cost of Sessions: We may provide phone, and/or video conferencing if you and therapist decide that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. Your clinician will discuss what is best for you. The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions listed on your clinician fee sheet. Your clinician will require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card Payment Form, which indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. This includes any therapeutic interaction other than setting up appointments . Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out about your insurance policies. You will be responsible for payment of all fees for services not covered by your insurance policy. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Emergency Procedures Specific to TeleMental Health Services: 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, your clinican may determine that you need a higher level of care and TeleMental Health services are not appropriate.

We require an Emergency Contact Person (ECP) whom we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or your clinician 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 your clinician determine necessary, the ECP agrees 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. Please list your ECP here:

Name: _____ Phone: _____

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 (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital: _____ Phone: _____

In Case of Technology Failure: During a TeleMental Health session, we 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 that your clinician has that phone number. If you get disconnected from a video conferencing or chat session, end and restart the session. If the connection cannot be reestablished within ten minutes, your clinician will call you by phone. If you are on a phone session and get disconnected, please call back or contact your clinician to schedule another session. If the issue is due to our phone service, and we are not able to reconnect, we will not charge you for that session.

Cancellation Policy: In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify your clinician at least 24 hours in advance. If such advance notice is not

received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services: TeleMental Health services should not be viewed as a complete substitute for therapy conducted in 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, we might not see a tear in your eye. Or, if audio quality is lacking, we might not hear the crack in your voice that we could easily pick up if you were in the office. There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction Your clinician may require at least one face to face in office visit before doing any telemental health sessions. Check with them regarding their policy.

Consent to TeleMental Health Services: Please check the TeleMental Health services you are authorizing us to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

☐ Phone

☐ Email

☐ Video Conferencing

☐ Recommendations for Websites or Apps

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. Please print, 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 me to utilize the TeleMental Health methods discussed.

Preferred email address for communication with FCS

Preferred phone number for phone sessions

Name of counselor

Print name of client/legal guardian

Signature of client/legal guardian

Date