Family PsychSolutions, PLLC

8603 Broadway Suite 140

Pearland, TX 77584

(281) 902-1050

Teletherapy Consent

Overview of Clinical Services

There are a number of different approaches that can be utilized to address the problems you are experiencing. I often use a variety of treatment modalities including individual, family, and couples therapy. I typically use a form of therapy known as Cognitive Behavioral Therapy which involves changing one's thoughts, feelings, and behaviors regarding a situation. However, I may use other approaches depending upon your goals, personality, and other factors. We will work together to determine your goals and how best to treat them by developing a treatment plan. Your needs may change over time, which may necessitate a reevaluation of your treatment plan. Therapy requires a large commitment of time and energy on both our parts. In order to receive maximum benefits from therapy, you will have to work both during our sessions and at home.

Benefits and Risks

You may be asked to recall personal events that at times may be discomforting. It may result in increased levels of stress, anxiety, guilt, sadness, relationship disruption, escalation in undesired behaviors, and anger. As a result, you have the right to end therapy at any time. However, I may ask that we formally meet for one final session to discuss your feelings and alternative resources so that we may have closure. Despite risks, there are numerous benefits to therapy such as a reduction in the problems which led you to seek therapy, a reduction in problem behaviors, a reduction in the frequency or intensity of negative emotions, a reduction in stress levels, improved relationships, and improvements in your overall level of functioning and general well-being.

Office Policies

Sessions generally last for 45 to 50 minutes. I am often not immediately available by telephone as I may be with a patient. Should you need to speak to me, please call (281) 902-1050. If I am unavailable, please leave a message and I will return your call as promptly as possible. If it is an emergency or in case you need a prompt response due to an urgent need, please visit the emergency room at the nearest hospital, call the police, or contact your family physician.

We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it. You need to use a webcam or smartphone during the session. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. It is important to not be in a public space. It is important to use a secure internet connection rather than public/free Wi-Fi. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of

technical problems or in case of a crisis situation. We need a safety plan that includes at least one emergency contact prior to your session.

There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversations, or stored data could be accessed by unauthorized people. Usually I will not engage in telepsychology with clients who are currently in a crisis situation. From time to time, we may schedule in person sessions. Your therapist will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. If a session is interrupted and you are having an emergency, call 9-1-1 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

Insurance Reimbursement/Payment Options

The same fee rates will apply for telepsychology as apply for in person psychotherapy.

If your clinician is an in-network provider with your mental health insurance carrier, the office will submit claims for payment on your behalf. You are responsible for any co-payments, co-insurance, and deductibles required by your health plan at the time of service. It is your responsibility to remit payment for charges not covered by your claim. You may be responsible for amounts your insurance does not pay. Payment is due in the form of credit card prior to the time services are rendered.

Insurance companies do not allow us to charge if you do not show up for your appointment or cancel. As a result, you will be charged for a no show or cancellation with less than 24 business hours notice. Your credit card will be charged $50 for the therapist's time. I understand that emergencies do occur. We may both discuss if you were unable to attend due to circumstances beyond your control. If frequent no shows/ or cancellations occur we may discuss discharging you and provide you with referrals for treatment elsewhere.

Confidential information may be disclosed to collect monies owed. If suitable arrangements for payment have not been agreed upon and your account has not been paid for more than 60 days, I have the option of using legal means to secure payment, including but not limited to collection agencies or small claims court.

If I am required to participate in any type of court proceeding, you will be responsible for my participation even if you are not the party compelling me to testify. The rate of $150 per hour for time spent traveling, preparing reports, testifying, and any other case related costs will be applied.

When using teletherapy, you will be asked to make a payment prior to your session time. We will ask that a credit card be kept on file.

Confidentiality and Limitations to Confidentiality

All records are kept in a secured setting. All forms of communication between a client and therapist are protected by law. I can only release information to others with your written permission. There are limits to patient confidentiality) when using teletherapy that differ from typically in-person sessions. Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).

However, there are a number of exceptions:

1) I am legally required to report to the proper authorities any allegations of abuse or neglect to a child, elder, or dependent individual.

2) If a disclosure of intent to harm yourself or others is made, I am required to report that intention to the proper authorities. In order to ensure your safety and the safety of others I may contact the police, family members, or another medical facility to assist with hospitalization.

3) If a court order, other legal proceedings, or statute requires disclosure.

4) To your mental health insurance carrier for authorization and reimbursement.

5) To a third party company, In-Sync Healthcare Systems who handles all insurance authorizations and reimbursement/payments for the office.

6) Supervision is required for any provisionally licensed clinician.

I, have read and fully understand the information provided. I agree to abide by the conditions of this contract. Your signature acknowledges the agreement and understanding.

_____ DATE:_____

(Print Full Name)

_____

(Patient Signature)

_____ DATE:_____

(Signature of Therapist)

Email and Texting Consent

HIPAA regulations and my professional code of conduct both require that I keep your protected health information private and secure. Emails and texts are very convenient ways to handle administrative issues like reminders for appointments or telehealth services. Emails and texts are not entirely secure. Some of the potential risks you might encounter if we email or text or videoconference include:

Misdelivery of email/text to an incorrectly typed address

Email/texts can be hacked which give third parties the content and addresses

Email/text providers (eg. Google, yahoo) keep a copy of each email/text on their servers where it might be accessible to others

For these reasons, we will not use email/text to discuss clinical issues. Though we will use a telehealth platform/video conferencing for sessions. If you are not comfortable with these risks, we can handle administrative issues directly via phone.

_____I DO Consent to the use of email/text/videoconferencing

(initial)

Consent will expire one year after your last appointment. Please remember that appointment reminders are a courtesy and will be sent only via email/text/voicemail.

_____ _____

Client signature Date

Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, as well as how you may gain access to this information. Please review it carefully and sign the acknowledgement of receipt.

Family PsychSolutions, PLLC is committed to protecting the privacy of client personal and health information. Applicable federal and state laws require that we maintain the privacy of clients' personal and health information. This notice explains our privacy practices, legal duties, and your rights. In this notice, your personal or protected health information (PHI) includes health information regarding your health care and treatment with identifiable factors such as your name, age, address, or financial information. Family PsychSolutions, PLLC reserves the right to change our privacy practices and the terms of this notice. We will communicate any changes to you.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose information to provide treatment to you. Treatment includes when an office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would include when an office consults with another health care provider to facilitate your getting services from another provider or making and/or obtaining appropriate referrals.

We may use or disclose information from your PHI to obtain payment for the services you receive. We may disclose information to determine eligibility or coverage, for billing, claims management, collection activities, and utilization review. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose PHI to allow health care operations. Health care operations are activities that relate to the performance and operation of the office. Examples are reviewing records for quality assessment and how care can be improved, audits, conducting training and educational programs, case management, contacting you about treatment alternatives, and coordinating care with other providers.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside treatment, payment, or health care operations when your written authorization is obtained. You have the right to revoke authorizations at anytime in writing. You may not revoke an authorization to the extent that the office has relied on that authorization to provide you services.

Confidentiality is maintained for the treatment of substance abuse, except in cases involving minors where information may be shared with the parent or guardian. For couples and families seeking conjoint treatment, PHI will not be released without authorization from all adults involved.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- To show compliance with HIPAA
- Abuse or Neglect of a Child, Elder, or Disabled person
- Health Oversight Activities-If a licensing board or accredited body is investigating an office you have filed a formal complaint against. For example, if a malpractice lawsuit was filed or an ethics violation being investigated by the Texas State Board of Examiners of Psychologists was to occur.
- Judicial and Administrative Proceedings-If you are involved in a court proceeding and a court subpoenas, summons, or issues a warrant for information about the professional services provided to you and/or the records thereof.
- To Law Enforcement Officials or the Social Security Administration- For example, to assist with locating a missing person or if you commit a crime on our premises or against any individual who works for us.
- To a coroner or medical examiner for identification, cause of death, or other duties authorized by law
- We may report births, infectious diseases, and deaths to public health authorities.
- National Security-To military authorities, Veterans Affairs, a correctional institution, and federal officials for such purposes as lawful intelligence, counterintelligence, and other national security activities.
- Worker's Compensation-To comply with worker's compensation or other similar programs that provide benefits for work related injuries or illness without regard to fault.
- Research Purposes
- Serious Threat to the Health or Safety of a person or the public-If you communicate a threat of imminent serious physical harm or death to identifiable victim(s), we have a legal duty to take the appropriate measures to prevent harm to that person(s) including disclosing information to the police and warning the intended victim. If you communicate a threat of physical harm or death to yourself, we may disclose information to police, family members, a hospital, or other medical personnel in order to protect you. We may disclose information about you in a medical emergency.

Your Rights

You have the right to receive notice of use and disclosure of your PHI. You have the right to consent to use and disclose your PHI.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have the right to receive confidential communications from us by alternative means and at alternative locations. For example, if you want to receive bills and other information at an

alternative address or you may not want a family member to know that you are being seen at this office.

You have the right to inspect and/or obtain a copy of your PHI. Your request must be in writing. We may take up to thirty days to provide you with the information you request. A reasonable fee may be applied for photocopying. Access to your PHI may be limited or denied under certain circumstances, for instance if we feel it may cause undue harm to you. We will provide you with an explanation if we deny your request.

If you believe information in your record is inaccurate or incomplete, you may request in writing an amendment of your PHI. The request must identify which information is incorrect and include an explanation of why you think it should be amended. We will reply within sixty days of the request. If the request is denied, a written explanation stating why will be provided to you. Amending a record does not mean that any portion of your health information will be deleted. It does not expunge any prior information; it is simply added to it.

You have the right to request an accounting of certain disclosures made by us. If your health information is disclosed for any reason other than treatment, payment, or health care operation, you have the right to receive a list of all disclosures for the previous six years. The accounting will include the date, name and address of the entity receiving the PHI, a description of what was disclosed, the purpose of the disclosure, and a copy of your written authorization. We have sixty days to provide you with the information. If more than one accounting is requested in a twelve month period, a reasonable fee may be charged.

You have the right to complain to the owner of the company about our privacy practices. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. If you choose to make a complaint, you will not face retaliation from us.

The US Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
1(877) 696-6775

By signing this consent form you acknowledge that a copy of the notice of privacy practices has been displayed and/or provided to you and consent to our use and disclosure of PHI for treatment, payment, or health care operations as described in this notice.

_____ Date: _____

Patient Name

_____

Patient Signature or Signature of Legal Representative

I have provided Family PsychSolutions, PLLC with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for psychotherapy services, telehealth services, missed appointments, balances, insurance payments, and other incidental charges.

Psychotherapy services and consultations will be charged at a rate of $100 a session unless a mutually agreed upon sliding scale fee was determined. For psychotherapy services, my credit card will be charged each time a service is provided or a no show/cancellation occurred . My card may also be charged for credit card chargebacks. Confidential information may be disclosed to collect monies owed. If suitable arrangements for payment have not been agreed upon and your account has not been paid for more than 60 days, I have the option of using legal means to secure payment, including but not limited to collection agencies or small claims court.

I understand that this form is valid for one year unless I cancel authorization through written notice to Family PsychSolutions, PLLC.

Name On Card: _____

Type of Card (Discover, Amex, Visa, Mastercard): _____

Card Number: _____

Expiration Date: _____

CVV: _____

Billing Address for Credit Card: _____

_____

Card Holders Signature: _____

Date: _____