PERSONAL INFORMATION FORM – CHILDREN AND YOUTH

NAME :_____

ADDRESS :_____

MAILING ADDRESS (if different from above) :_____

EDUCATION:

Grade _____School_____Any Grade Level Retention? Y/N

PERSON RESPONSIBLE FOR PAYMENT:_____Child DOB:_____

PERSON WHO REFERRED YOU TO ME:_____

May I send a note of thanks for the referral? ( ) Yes ( ) No

FAMILY OF ORIGIN ATMOSPHERE:

Father's Name_____ Age_____

Living ( ) Deceased ( ) Date_____

Address_____

_____

Phone (H)_____ (W)_____

(C)_____

Occupation_____

Employer_____

Address_____

_____

Birthdate_____

Mother's Name_____ Age_____

Living ( ) Deceased ( ) Date_____

Address_____

_____

Phone (H)_____ (W)_____

(C)_____

Occupation_____

Employer_____

Address_____

_____

Birthdate_____

Parents separated or divorced? No ( ) Yes ( ) Child's age at time of separation/divorce_____

Did you have step-parents? No ( ) Yes ( ) Your age at time of parent remarriage_____

List brothers and sisters from oldest to youngest (include child coming for therapy)(Circle step-siblings)_____

_____

All living? Yes ( ) No ( ) If no, name(s) of deceased and date_____

Which of the siblings is the child most like?_____ How?_____

Which of the siblings is the child least like?_____ How?_____

Which of the siblings is the child in most conflict with?_____ Why?_____

Which sibling is more like Mom?_____How?_____

Which sibling is more like Dad?_____How?_____

Therapist:_____

Describe the relationship between you and your spouse._____

_____

_____

Who makes the decisions?_____ Do you agree on child rearing methods?_____

Do you disagree openly?_____About what?_____

Describe other environmental influences on the child._____

Who has been important to the child (Grandparents, other relatives, friends or neighbors)?_____

In what way?_____

Do any of the family members use alcohol or other drugs? Yes ( ) No ( ) If so, to what extent?_____

Is this a family problem? Yes ( ) No ( ) If so, how do you cope?_____

Any other pertinent family history/information:_____

_____

_____

PERCEPTION OF THE CHILD:

How does the child stand out in the family?_____

What has he/she been successful at?_____

What does he/she get into trouble for?_____

What does the child want to be when he/she grows up?_____

What are the child's responsibilities (getting self up in the morning, to sleep at night, household chores, pets, etc)?_____

_____

_____

Does the child have nightmares or dreams? Yes ( ) No ( ) How often?_____

What are the dreams about?_____

Does your child:

Get feelings hurt easily? Yes ( ) No ( )	Have any friends? Yes ( ) No ( )	Athletic? Yes ( ) No ( )
Have a bad temper? Yes ( ) No ( )	Have high standards? Yes ( ) No ( )	Follow rules? Yes ( ) No ( )
Complain/find fault? Yes ( ) No ( )	Try to please others? Yes ( ) No ( )	Acts selfishly? Yes ( ) No ( )
Do nice things for others? Yes ( ) No ( )	Help around the house? Yes ( ) No ( )	Like to be alone ( ) or with others ( )

FUNCTIONING AT LIFE TASKS:

How does child get along with adults?_____

Favorite adult to be with?_____Least favorite?_____

Therapist:_____

How does child get along with children in the neighborhood?_____

Does child prefer to play with other children of the same age, younger, or older?_____

How does child get along with peers at school?_____

Does child have a best friend?_____ Describe him/her: _____

Does the friend come over very often?_____

How do things go for him/her at school?_____

_____

What does he/she get into trouble about at school?_____

What do you do about it?_____

Does child make good grades? Yes ( ) No ( )

TRAUMA IN THE FAMILY:

What traumatic events have occurred during the child's life (divorce, death, abuse observed, etc.)?_____

_____

_____

BEHAVIORS:

If any, what are some of the behaviors that the child engages in that are annoying to you or to other family members?_____

_____

What do you do in response to these annoying behaviors? _____

_____

How do you feel if these annoying behaviors persist?_____

What does the child do in response to discipline? _____

RELIGION: _____

Religion is: Satisfying ( ) Challenging ( ) Dull ( ) Meaningless ( ) Irrelevant ( )

HEALTH:

General Condition: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Date of last physical _____

Physical Disabilities or Limitations: _____

_____

Current Medications and Dosage:_____

Injury/Illness/Allergies:_____

Has child ever contemplated or attempted suicide? Yes ( ) No ( ) If yes, when? _____

Has child ever contemplated or intentionally harmed another person? Yes ( ) No ( ) If yes, when? _____

Sleep Pattern: Normal ( ) Restless/Broken ( ) Insomnia ( ) Oversleep/Hard to Wake ( ) Nightmares ( )

Therapist:_____

Substance Use? (Alcohol, Tobacco, Illicit Drugs) Yes ( ) No ( ) If yes, what, when, and/or how often? _____

_____

PREVIOUS COUNSELING OR PSYCHOTHERAPY? Yes ( ) No ( ) If yes, when? _____

Received from: _____ Phone:_____

PLEASE RATE CHILD'S OVERALL HAPPINESS 1-5 (1=AWFUL; 5=GREAT):_____

DREAMS FOR THE CHILD:

What are your hopes for the child?_____

_____

_____

_____

Is there anything else that I should know about him/her? _____

_____

_____

PLEASE HAVE CHILD COMPLETE THE FOLLOWING SENTENCES:

Some of my strength are...

Fun for me is...

I came here today...

Six months from now...

I testify to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for a Tranquil Hearts Counseling Center therapist to consult and share, should she deem it necessary, pertinent information concerning me (my child) with other professionals in order to aid my counseling/growth process.

_____ _____

Client/Guardian Signature Date

Heart to Mind Counseling, PLLC
16712 Huffmeister Road, Building 400B
Cypress, Texas 77429

Therapist: ___ALISON LAMPTON, M. Ed, LPC_____

INFORMED CONSENT – THERAPY AGREEMENT

Welcome! This document answers many questions clients often ask about therapy and explains procedures, expectations, and our privacy policy. A separate document will go further into our privacy practices and explain the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. **When you sign this document, it will represent an agreement between us.** We can discuss any questions you have when you sign them or at any time in the future.

SESSION FEES:

Intake (60-75 minutes) **$160** Individual/Child (60 minutes): **$140**

All professional time will be billed for at a rate of $2 per minute. This includes writing or reading reports or letters on your behalf, scoring of rating scales/evaluations, consultation/phone calls, email communication, extended sessions, copying/mailing of records, off-site observations (including travel time), etc. While there is no charge for calls to schedule/change appointments, inquire about services, etc., after hours consultation calls are charged 150% of the usual rate.

Your session time is for you and is taken seriously. *You are contracting for the time you have scheduled*. Please make every attempt to attend your scheduled sessions and arrive on time. **Twenty-four (24) hour's notice is required in order to cancel an appointment.** To maintain consistency from one client to another and to maintain flexibility to be able to meet with clients in a timely manner, *exceptions (excluding unavoidable emergencies) will not be made.* **If an appointment is not canceled 24 hours in advance or you fail to show, you will be charged $100 for the missed session**. This helps to eliminate "No Shows" and insures maximum appointment availability for you.

PAYMENT:

Payment in full for all professional services is due at the time of the service. You (or parent/guardian) are directly responsible for payment. Fees may be adjusted individually, based on the needs of the client when agreed upon by the provider. Acceptable forms of payment are cash, check (payable to Alison Lampton), or Venmo. Credit cards are accepted with an additional $5 fee. Returned checks are subject to a $35 service fee, which must be paid prior to the next appointment, and further payments must be cash or money order. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with counseling/therapy progress and our working relationship.

INSURANCE:

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, we will assist you to the extent possible in filing claims and ascertaining information about your coverage but **you are responsible for knowing your insurance benefits/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. It is also your responsibility to let me know if/when your coverage changes**.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, we will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. Sometimes we must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. **By signing this agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.**

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. **Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit**. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

Your health insurance policy is a contract between you and your insurance company. If I am not a participating provider for your insurance plan, you may still be eligible for "out of network" benefits but you will need to research the extent of your coverage to make this determination. Keep in mind that insurance benefits may only apply to the counseling/therapy services which we provide as a Licensed Professional Counselor**. If you are seeking "out of network" benefits, you are responsible for completing and filing the necessary paperwork for insurance reimbursement.** We will provide you a receipt for services rendered and diagnosis to do so, but please note that not all insurance companies reimburse for out-of-network providers.

CONFIDENTIALITY:
All information shared in session is held in strictest confidence according to federal regulations. The following are exceptions: 1) Legal obligation such as child or elder abuse, court subpoena, cooperating with law enforcement officers, etc., 2) Suspected personal danger to yourself or an identifiable victim, 3) Information required by insurance companies for payment (for which you consented), 4) Information provided to parents if the client is a minor, 5) Valid collection of a debt, and/or 6) Consultation with other professionals in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given). Release of information to other individuals, agencies, or professionals may only be done with your written consent.

OFFICE HOURS/APPOINTMENTS:
Contact your individual therapist for office days and times. You may ask to have the same time each week for your appointment. We will do our best to accommodate your request, as certain time slots are in demand and fill quickly.

When in session with a client, we will not be able to take phone calls. Please leave a message on our individual voicemail. Since a typical session is 45 minutes in length, we use the remaining 15 minutes of the hour to return phone calls, complete paperwork, and address any self-care needs. We make every attempt to return calls daily. Emergency calls may be taken after hours and charged the 'after hours' rate. As we honor and value our personal self-care time and time with family, we ask that you limit after hour calls to emergencies only.

EMERGENCIES:
As a rule, our practice is not crisis oriented in nature. If you feel you will need more intensive after hours support on a regular basis, please inform us during our first session. We will be happy to help you locate a provider whose practice is more suited to on-going crisis intervention.

For an emergency, please attempt to contact your individual therapist. If we cannot be reached immediately by phone, you, your family member, or friend should call the **HOUSTON CRISIS HOTLINE at 713-468-5463, DIAL 911, or GO/BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM.**

LEGAL MATTERS:
If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information unless you provide written authorization or a judge issues a court order. Protections of privilege may not apply if we do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

Should you ever become involved in a divorce or custody dispute, **we will not provide evaluation (written or otherwise) or expert testimony in court.** You should hire a different/neutral mental health professional for any evaluation or testimony you require. This position is based on two main reasons: 1) Our statements will be seen as biased in your favor because we have a counseling/therapy relationship, and 2) the testimony may affect the counseling/therapy relationship, and we must put this relationship first. This applies to all clients regardless of age.

If, as part of your session work you create/provide to us records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies. You have the right to review or get copies of your personal health information with limited exceptions. You must submit a written request and allow a reasonable time period (maximum of 30 days) for compliance. If you are concerned that we have violated your privacy rights or disagree with a decision we have made in regard to access of your personal health information, please inform us immediately. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Violations: In our practice we follow the professional code of ethics of the American Counseling Association. Any violations of the Licensed Professional Counselor Act should be reported to: Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, 512-834-6658.

ABOUT THERAPY:

Seeking help through counseling/therapy is a wonderful way to gain new clarity as well as obtain practical tools to support you in your daily living and in navigating life transitions. Because you will be investing time, energy, and money, it is important to choose a therapist with whom you are comfortable.

Our work together will focus on wellness and increasing overall life satisfaction. Utilizing a problem-solving/skill-building approach, we will work together to identify developmental and/or life issues and concerns with which you may be dealing *and* useful skills to help you address your problems. We will devise a plan to help you incorporate your new skills into your daily living. Homework may be assigned which you will be asked to complete as a means of moving toward the achievement of your goals.

Although no counselor/therapist can ethically guarantee achievement of goals, it has been our experience that the more you put into the process, the better the chance for positive, lasting results. Because the work that we do *is* a process and often has a cumulative effect, *it can be helpful to commit to a minimum number of at least six sessions.*

While you most likely will experience gains in as little as one session, it generally takes longer for deeper work. You or your therapist have the right to terminate this agreement at any time. At least one session's notice is helpful for all involved, should the decision to terminate, by you or by the therapist, occur. This allows for closure. If needed, you will be provided the names and phone numbers of other qualified counselors/therapists.

The Benefits and Risks of Counseling/Therapy: There may be some risks as well as many benefits with counseling/therapy. You should think about both the benefits and risks when making any treatment decisions. For example, there is a risk that you will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other such feelings. You may recall unpleasant memories which may bother you in settings outside of our sessions. You may receive feedback from some people who mistakenly suggest participating in this process is a sign of weakness. (By the way, we believe investing in your personal growth is a sign of courage and strength!)

Also, this process has the potential to impact your relationships with people who are important to you such as members of your family. You may experience a temporary worsening of problems after beginning, although this usually passes as you learn new skills and increase your self-confidence in applying them. Most of these risks are to be expected when making important changes in your life. Finally, even with our best efforts, there is a risk that counseling/therapy may not work out well for you.

While you consider these risks, you should also know the benefits of counseling/therapy have been scientifically researched and validated. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Through this work, you will have a chance to talk things out fully until your feelings are relieved or your problems are solved. Your relationships and coping skills may improve greatly, increasing your overall satisfaction. Your personal goals and values may become clearer. You may find yourself growing in many directions and experience an increased ability to live authentically and fully enjoy your life.

What to Expect from Our Relationship: Services are best provided in an atmosphere of trust. You expect us to be honest with you about your problems and progress, and we expect you to be honest with us about your expectations for services, your compliance with medical advice from your doctor, and any other treatment issues. As a Licensed Professional Counselor (LPC), we will use our best knowledge and skills to help you achieve your goals. Our duty is to care for you and my other clients, but *only* in the professional roles of counselor/therapist. Ethically, we are bound to avoid "dual relationships." We are not able to advise you from other professional viewpoints such as law, medicine, finance, etc. We must honor confidentiality (excluding the areas mentioned below as confidentiality exceptions). To maintain privacy, we do not reveal the identities of our clients without their consent. Therefore, if we meet on the street, we may not say hello or talk to you very much. *This would not be a personal reaction to you, but rather an effort to maintain the confidentiality of our relationship.* Lastly, we cannot socialize or have a romantic relationship with any of our clients and cannot provide counseling/therapy to any family members or friends.

AGREEMENT:

I, _____, confirm that I have read, or have had read to me, in its entirety, this document, titled "Informed Consent – Therapy Agreement". I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the policies and procedures listed in this document. I understand that no specific promises have been made to me by my therapists about the results of treatment, the effectiveness of the procedures used by them, or the number of sessions necessary for therapy to be effective. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. I will make every effort to discuss my concerns about my progress with my therapist before making the decision to end therapy.

I hereby agree to enter a professional working relationship, as detailed above, with my therapist, (or to have my minor child enter), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____
Signature of Client (Parent/Guardian) Date

Having met and discussed with this client (and/or client's parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed; I believe this person fully understands the information presented. I find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent. Therefore, I agree to enter a professional working relationship, as detailed above, with this client as shown by my signature here.

_____ _____
Signature of Therapist Date

Heart to Mind Counseling, PLLC
16712 Huffmeister Road, Building 400B
Cypress, Texas 77429

Therapist: ___ALISON LAMPTON, M. Ed, LPC_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Heart to Mind Counseling, PLLC
16712 Huffmeister Road, Building 400B
Cypress, Texas 77429

Therapist: ___ALISON LAMPTON, M. Ed, LPC_____

EMAIL AND TEXTING CONSENT

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information (PHI) private and secure. Emails and texts are very convenient ways to handle administrative issues like scheduling or receipt requests, but email and texts are not 100% secure. Some of the potential risks you may encounter if we email or text include:

- Misdelivery of email/text to an incorrectly typed address.
- Email/text accounts can be "hacked", giving third party access to email/text content and addresses.
- Email/text providers (i.e., Gmail, Yahoo, etc.) keep a copy of each email/text on their servers, where it may be accessible to employees, etc.

For these reasons, I will not use email/text to discuss clinical issues (i.e., important things we talk about in session). If you are comfortable doing so, I am happy to use email/text (text for appointment reminders only) to handle small administrative matters like scheduling and billing. If you are not comfortable with these risks, we may handle administrative issues via phone calls.

Please indicate your preference about email/text below and sign.

_____ I do consent to use of email and/or text for administrative matters.

(initials)

_____ I do not consent to use of email and/or text for administrative matters.

(initials)

If given, consent will expire 2 years after our last appointment. Please remember reminders will be sent only via emails or texts. I will respond to you briefly via email but never text.

(Patient's Printed Name) _____

(Patient/Legal Guardian Signature/Date) _____

Heart to Mind Counseling, PLLC
16712 Huffmeister Road, Building 400B
Cypress, Texas 77429

Therapist: ___ALISON LAMPTON, M. Ed, LPC_____

Pre-Authorization Charge Form

I authorize Heart to Mind Counseling, PLLC to keep my signature on file and to charge my Credit Card listed below **for scheduled appointments, missed appointments and late cancellations.** By signing this form, I also authorize Heart to Mind Counseling, PLLC to use my signature on file for insurance claims where applicable.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Client's Name: _____

Cardholder's Name: _____

Cardholder's Signature:_____ Date: _____

Card Type: (Circle one) ***** LEAVE THIS SECTION BLANK IF CARD IS ON FILE WITH HEADWAY**

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Account Number:_____ Billing Zip Code: _____

Expiration Date:_____ Card Verification Number: _____

Tranquil Hearts Counseling Center, LLC

16712 Huffmeister Road, Building 400B

Cypress, TX 77429 www.tranquilheartscounselingcenter.com

PROPERTY DESTRUCTION/INAPPROPRIATE BEHAVIOR AGREEMENT

The therapists at Tranquil Hearts Counseling Center care about each person who enters our office and we strive to create a safe and comforting experience for everyone. In order for us to provide the finest tranquil environment possible while you and/or your loved one receives therapy, we ask that everyone is respectful of the people and property here.

Please understand that you are responsible for the cost of any property damaged while you are in our office, including toys in the waiting area, furniture, rugs, walls, etc. Included in this agreement is disruptive or offensive behavior of any kind which causes your therapy session or others to be interrupted for any reason.

By signing below, you indicate your acceptance of this agreement and understand that the minimum fee to be paid for destroyed property is $30, but may increase at the owner's discretion based on the situation and the amount of the actual cost of damage. If your behavior or that of your loved one becomes offensive or disruptive, you will be asked to leave the office immediately.

_____

Patient Name

_____

Responsible Party

Date

_____

Thank you for partnering with us to make our office a more peaceful place!

-Tranquil Hearts Counseling Center Therapists

Alison Lampton, M.Ed., LPC
Tranquil Hearts Counseling Center
16712 Huffmeister Rd, Building 400B
Cypress, TX 77429
(832)630-0777

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize Alison Lampton, M.Ed., LPC and

_____
(Name of person(s) or organization(s) which disclosure is to be made to and/or received from)

_____ _____
(Address) (Phone Number)

to disclose or release **one to the other** the following information from my records:

_____ All Health Care Information
Initials

_____ Health Care Information or Opinions Relating to any or all of the
Initials following treatment(s) and/or conditions:

_____ 1. Psychiatric or Mental Health Information
Initials

_____ 2. Academic and Confidential School Information
Initials

_____ 3. Testing
Initials

_____ 4. Other _____
Initials

For the purpose of treatment/management and/or supervision or psychological and/or medical conditions(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

_____ _____
PATIENT DATE

_____ _____
PARENT OR LEGAL GUARDIAN DATE

Tranquil Hearts
COUNSELING CENTER

Teletherapy Informed Consent Form

I,_____, hereby consent to engage in teletherapy with _____. I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent – Privacy Policy Agreement which I received with this consent form.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and confidentiality cannot be guaranteed.
4. I understand that teletherapy-based services and care may not be as complete as face-to- face services, and if the therapist believes I would be better served by another form of therapeutic service (e.g.: face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that I may benefit from teletherapy, but the results cannot not be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. During our first session, the therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour support.
6. I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; the information security on my computer; and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my therapy sessions.

I have read, understand and agree to the information provided above.

_____

Signature and Date

_____

Client Printed Name