Your Company Name

Your Company Address

Initial Intake Form

Demographic Information:

Patient Name: _____ Case No.:_____

Contact Number: _____ **Cellular Phone:** _____ **Home Phone:** _____

Address: Your Company Address

DOB: _____ **SSN:** _____

Medicaid No: _____ **Medicare No:** _____

Insurance: _____ **Policy:** _____

Legal Guardian (If Applicable) Name: _____

Relationship: _____

Telephone Number: _____

Address: _____

Note: Attach copies of court disposition and support documentation regarding legal representation, custody or guardianship when applicable

Eligibility Criteria (Patient's symptoms):

_____

_____

_____

Need for Special Accommodations: ▢ **Yes** ▢ **No** ▢ **Yes** ▢ **No**

If Yes, please specify: _____

_____

_____

Interpreter Needed:: ▢ **Yes** ▢ **No** ▢ **Yes** ▢ **No**

If Yes, what language::

_____

Assistive Device(s) Needed: ▢ **Yes** ▢ **No**▢ **Yes** ▢ **No**

If Yes, please specify: _____

_____ _____

Patient Signature Date

_____ _____

Parent, Legal Guardian or Authorized Representative Date

_____ _____

Employee Signature Date

Your Company Name

Your Company Address

Consent for Treatment

The main objective of Your Company Name is to provide comprehensive mental health services, which are sensitive to the needs of our recipient population.

I, an applicant for the services of Your Company Name and if applicable;

I, _____ representative/guardian of the above-named applicant:

▢ I, Authorize the staff of Your Company Name to provide services.

▢ Authorize release of necessary information from my service record to any insurer, compensation carrier, or other agency providing financial assistance for treatment/ services Information from clinical records may be used by The Department of Children and Families, and/or Human Rights Advocacy Committee for the purpose of monitoring facility, activity and complaints concerning the facility.

▢ Understand that, except for the above case, all information that you furnish to Your Company Name will be kept in strictest confidence, as required by Florida law, and will not be shared with any agency or person outside the facility, unless so requested by you.

▢ Agree that Your Company Name staff may contact me after the completion of treatment/service in order to evaluate its effectiveness.

▢ Certify that I will be responsible for all charges for treatment/services, commensurate with my ability to pay, and

▢ Documents were translated to me in native language (if needed)

_____ _____

Patient Signature Date

_____ _____

Parent, Legal Guardian or Authorized Representative Date

_____

Date

_____

Employee Signature

Your Company Name

Your Company Address

Demographic Form

Case No.: _____ Date: _____

Last Name: _____ First Name: _____

DOB: _____ SSN: _____

Gender: ▢ Male ▢ Female ▢ Male ▢ Female ▢ Male ▢ Female

Race: ▢ White ▢ African American/ Black ▢ Asian or Other Pacific Islander

▢ American Indian/ Alaskan Native ▢ Other

Ethnicity: ▢ White ▢ Hispanic/ Latino ▢ Non-Hispanic

Phone No.: _____ Cell No.: _____

Address: _____

City, State, Zip: _____

Medicaid No.: _____ Medicare No.: _____

Legal Guardian: _____ Phone No.: _____

Address: _____

Emergency Contact Person: _____

Relationship: _____ Phone No.: _____

In the event that you have an emergency may we contact this person? :

In the event that we need to contact you may we leave a message at your home identifying ourselves? :

This consent shall be reviewed by staff at least every 6 months as of the initial date.

Review Date (s): _____

_____ _____

Patient Signature Date

_____

Staff Signature Date

▢ **Documents were translated to me in my native language.**

Your Company Name

Your Company Address

Consent for Release and Request of Information

Patient Name: _____ Case No.: _____

DOB: _____ SSN: _____

Address: _____

City, State, Zip: _____

This will authorize: **Your Company Name**

to release/request general medical, psychiatric/psychological, alcohol and drug abuse information and/or records in accordance with Florida Statutes 394, 459, 396, 11, 297, 053, 90.50 and 458.21 **to/ <u>from:</u>**
Name of Facility, Individual or Agency: _____

In the form of:
For the purpose of:

I understand that the specific reports disclosed might include:

(explain) : _____

I understand this consent is revocable upon written notice to Your Company Name except to the extent that action by Your Company Name. has been taken in reliance on this authorization and that this authorization shall remain in force for a twelve-month period in order to affect the purpose for which it is given, unless resolved by Patient or legal representative, as above.
Alcohol and drug abuse information if present may be disclosed from records whose confidentiality is protected by Federal regulations (42 CFR, Part II) prohibit making any further disclosure of records without the specific written authorization of the Patient or legal representative, or as otherwise permitted by such regulations. This information may not be used to criminally prosecute the Patient.

_____ _____
Patient Signature Date
(Parent, Legal Guardian or Authorized
Representative)

_____ _____
Staff Signature Date

☐ **Documents were translated to me in my native language.**

Your Company Name

Your Company Address

Consumer Rights

Patient Name: _____ Case No.: _____

The purpose of this pamphlet is to remind and inform you of your RIGHTS as a consumer of services.

I. Right to Voluntary Services

If you are 18 years of age or older, you have the right to request voluntary (by your own choice) services.
If you are 17 years of age or younger, you usually must have permission of a parent or guardian to receive services.
You do not need parental consent; however, to receive treatment for alcohol or drug abuse, nor, if you are 12 or over, to admit yourself for residential or day treatment.
YOU HAVE A RIGHT TO:
1. Have a staff person assigned specifically to you to work with you in resolving your problems.
2. A personal assessment of your needs.
3. An individualized service plan developed with your Input and permission which will be reviewed on a regular basis.
4. Services to begin within a reasonable time.
5. Services even if you are unable to pay. Ability to pay is determined by certain standard criteria.
6. Another opinion regarding services provided. However, if you see someone outside of it is at your own expense
7.

II. Right to Refuse Services: YOU HAVE A RIGHT TO:
1. Refuse any form of service unless the service has been ordered by the court, or in emergency situations when necessary to prevent harm to yourself or others.
2. Be informed that without services, your situation may get worse.
3. Refuse to be filmed or taped without written permission.
4. Refuse to take part in experimental studies without your written permission.

III. Right to Confidentiality (Privacy)

All information about you is confidential to protect your privacy. This includes the fact that you have or have not received services. (Exception: the law requires all treatment facilities to notify the Health Department when communicable diseases are uncovered).
YOU HAVE A RIGHT TO:
1. determines the amount of information to be released either to or from anyone outside by signing a permission form. Determine the length of time that Information may be released and cancel your permission at any time. (However, Information may be released without your permission in a medical emergency to save lives, to prevent injury to yourself or others, or when court ordered).
2. See your record and/or obtain a copy of it after your written request has been approved by the Executive Director of_ or designee.

IV. Right to Humane Mental and Physical Environment

YOU HAVE A RIGHT TO:
1. Center facilities which are comfortable and safe, promote dignity, ensure privacy, and contribute to a positive outcome.

TO REPORT ABUSE, NEGLECT OR EXPLOITATION CONTACT: **FLORIDA ABUSE HOTLINE; 1-800-96-ABUSE (1-800-962-2873)**

V. Right to Information

YOU HAVE A RIGHT TO:
1. Be informed, verbally and/or in writing, of your rights.
2. Be informed, verbally and/or in writing, if any rights are being taken away and you have the right to a review of this action by requesting a Grievance Procedure.
3. Be informed of any actions, procedures or decision which might affect you.

Your Company Name

Your Company Address

Consumer Rights (continued)

Patient Name: _____ Case No.: _____

VI.Rights Pertaining to Medication
YOU HAVE A RIGHT TO:
1.The administration of medication only with the written order of a physician.
2.A complete explanation of the purpose of any medication, the possible side effects it may have on you, and possible results of long-term use, in a language you can understand.
3.Full consideration of your opinion and reactions to medication.
4.A regular review of your medication for the purpose of adjustment, as a check for possible side effects, and forpossible reduction or elimination of the medication.
5.Have accurate records kept, noting your medication history, which includes any adverse medication. reactions or drugallergies.
6.Have medication prescribed for you only when necessary and not as a convenience for others.
7.Refuse medication, except when it is court ordered, or when it is necessary to prevent serious physical harm toyourself or others.
VII.Right to Grievance Procedure
Any consumer or legal representative of a consumer may file a grievance as a formal notice of dissatisfaction regardingCenter operations and/or staff actions.
Whenever you wish to lodge a formal complaint you must proceed in the following manner:
STEP 1: Bring your grievance to the attention of your therapist/therapist supervisor - this may be done verbally or in writing. An answer the agency's management will be presented to you within 5 days. If your grievance involves your therapist/psychiatrist and you feel that you do not want to confront him/her directly with this matter, you may proceed to Step 2.
STEP 2 If therapist cannot resolve the problem satisfactorily, you may seek out the clinical director and present your complaint verbally or in writing. An answer from the supervisor will be presented to you within 5 working days.
STEP 3: If you are not satisfied with the decision of the supervisor, you may send the grievance, in writing, to: The: CEO:
Company Owner
Your Company Address

Your grievance will be reviewed by the Executive Director and he/she may seek a hearing with you and/or the parties Involved. If necessary, the Executive Director will make a decision and will respond to you within thirty (30) days, sending a copy of the response to the supervisor. The decision of the Executive Director will be final.
It is the sincere desire of the staff of Lighthouse Community Center LLC_. to address your grievances with an attitude of open mindedness and without prejudice. Every effort will be made to resolve your grievance at the lowest possible step in the procedure so as not to prolong any difficulty or problem.

I have read and understood my rights as a Patient of

_____ _____
Patient Signature Date

_____ _____
Parent, Legal Guardian or Authorized Representative Signature Date

_____
Date

_____
Employee Signature

Your Company Name

Your Company Address

Acknowledgement of Receipt of HIPAA "Notice of Privacy Practices"

Patient Name: _____ Case No.:_____

I, _____,recipient of services, and if applicable,
Print Recipients Name

I,_____ legal guardian or authorized representative
Print legal guardian/ authorized representative's Name

Hereby acknowledge receipt of Notice of Privacy Practices. This Notice of Privacy Practices provides detailed information about how may use and disclose my protected health and confidential information. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review the Notice before signing this form. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

I understand that reserved the right to change the Privacy Practices that are described in the Notice. I also understand that a copy of any revised notice with be made available to me upon request.

Provides this form to comply with the Heath Insurance Portability and Accountability Act (HIPPA).

_____ _____
Patient Signature Date

_____ _____
Parent, Legal Guardian or Authorized Representative Signature Date

_____
Date

_____
Employee Signature

Your Company Name

Your Company Address

Access to Services in an Emergency

Patient Name: _____ Case No.:_____

In the event of an emergency, recipients will request assistance from a 24-hour staff member, all of whom are trained in emergency procedures and would help them evacuate the building.

The following events would constitute an emergency that would require the recipient to report immediately to a staff member:

1. Smelling or seeing smoke or fire
2. Smelling of gas
3. Flooding water
4. Apparent illness of another person or staff member
5. Unlawful entry of a person onto the facility
6. Accidents or injuries of another recipient or staff member
7. Violence or altercations
8. Finding drugs on premises

Recipient or staff may call 911 in an emergency. In the event of a fire, all staff is trained during bi-annual fire drills to meet at a pre-designated area (located in the grass area in front of the corporate office building).

Recipients who are experiencing an emergency in their home would access immediate services by dialing 911 and then contacting their case manager for support.

The above written policy has been explained to me and I understand what I need to do in the event of an emergency.

_____ _____

Patient Signature Date

_____ _____

Parent, Legal Guardian or Authorized Representative Signature Date

_____

Date

_____

Employee Signature

Your Company Name

Your Company Address

Orientation checklist

Patient Name: _____ Case No.:_____

The following information has been provided as part of the Orientation Process. A check of the item and the signatures below indicate that each area has been fully explained and is understood by:

▣ Tour of facility (if applicable)
▣ Rights and Responsibilities of the Consumer
▣ Policy on grievance and appeal procedures
▣ Intent/consent to treat/serve
▣ Services provided, days and hours of operation, and expected level of participation
▣ Access to emergency services, including afterhours emergencies
▣ Code of ethics/conduct
▣ Confidentiality policy and limits of confidentiality
▣ Methods, opportunities, and policy on input
▣ Explanation of financial obligations, fees, and financial arrangements
▣ Fire, safety, and emergency precautions
▣ Policy on tobacco products no smoking on premise
▣ Policy on illicit or licit drugs brought into the facility
▣ Policy on weapons brought into the facility
▣ Identification of the staff(s) responsible for service coordination
▣ Program rules and regulations
▣ Purpose and process of mental health assessments.
▣ Individual plan development and the participation of recipient in goal development and explanation of the potential course of treatment/service
▣ Discharge/transition criteria and procedures
▣ Agency's Policy regarding response to and identification of potential risk to the recipient
▣ Agency's expectations for legally required appointments, sanctions, or court notification (if applicable)
▣ Education on advance directives (if applicable)
▣ The above has been reviewed with me and a copy has been provided to me.

_____ _____
Patient Signature Date

_____ _____
Parent, Legal Guardian or Authorized Representative Signature Date

_____
Date

_____
Employee Signature

Your Company Name

Your Company Address

FEE AGREEMENT

Patient Name: _____ Case No.:_____

I hereby certify that the financial information I have provided is true and complete to the best of my knowledge. I understand that . may use my protected health information in order to secure payment of my services from outside funding sources such as Medicaid, Florida Department of Children and Families, etc.

For more information concerning the use and disclosure of your protected health information, please refer to a copy of the . Notice of Privacy Practices.

I understand and agree to be responsible for any outstanding balance which may be refused for payment by my insurance company. I understand that I will be responsible for the unpaid balance or my sliding fee scale, whichever is less. If I have. If I have no insurance, I understand I am responsible for payment of services based on my sliding fee scale assessment.

SERVICES	FULL FEE	YOUR COST
Brief Mental Assessment Screening	$29.32	$0
Psychiatric evaluation	$210.00	$0
Medication management	$60.00	$0
Bio –psychosocial assessment	$48.00	$0
Limited functional assessment	$15.00	$0
Treatment plan	$97.00	$0
Treatment plan review	$48.00	$0
Individual and family therapy	$73.00	$0
Therapeutic behavioral onsite services	$64.00 per hour	$0
Psychosocial rehabilitation services	$36.00 per hour	$0
Home Visit (as needed)	$48.00 per hour	$0
Community Visit (as needed)	$48.00 per hour	$0
Service Planing	$120.00 per hour	$0
Service Plan Review	$120.00 per hour	$0

_____ _____

Patient Signature Date

_____ _____

Employee Signature Date

_____ _____

Parent, Legal Guardian or Authorized Representative Signature Date

Your Company Name

Your Company Address

Patient Financial Information

Patient Name: _____ Case No.:_____

# of Dependents: _____ Family Yearly Income: $_____

Discount from standard rate: _____ or fixed fee per visit: $_____

(100% means Patient pays nothing)

Responsible Party for Private Pay Charge

Last Name: _____ First Name: _____

Relationship to recipient: 1=Self 2=Spouse 3=Child 4=Other _

Address: _____ City: _____

State, Zip: _____ Phone: _____

Patient Third Party (Insurance) Information #1

Contract/Insurance No.: _____ Company Name: _____

Address: _____ City: _____

State, Zip: _____ Contact Phone: _____

Contact Name: _____ Contact Phone: _____

Policy Holder Information:

Last Name: _____ First Name: _____

Address: _____ City: _____

State, Zip: _____ Phone: _____

Relationship to recipient: 1=Self 2=Spouse 3=Child 4=Other _

Gender: ▢ Male ▢ Female

DOB: _____ SSN: _____

Financial Determination Worksheet

Sources of Yearly Income:

Your Earnings from full or part time work: $0

Your Spouses earnings: $0

Child Support: $0

Alimony: $0

Unemployment Compensation: $ 0

Workmen's Compensation: $ 0

Veteran's or GI Benefits: $0

Social Security: $0

Interest on Savings Account: $0

Income from Investments/royalties: $ 0

Temporary Assistance to Needy Families (TANF): $0

SSI": $ 0

SSDI: $ 0

Other Public Assistance: $0

Other Income: $0

TOTAL YEARLY INCOME: $0

_____

Name of Person Completing Form

Your Company Name

Your Company Address

Medical History

Patient Name: DOB: _____ Case No.:_____

_____

Primary Care Physician and Address:: _____

Physician Phone Number: _____

SECTION I. Place a check (√) next to any medical problem that you currently have or have had in the past. If you do not understand an item, please ask for assistance.

YES	NO		YES	NO		YES	NO	
	√	Diphtheria		√	Stomach Pain		√	Frequent Colds
	√	Mumps		√	Black Stools		√	Heart Palpitation
	√	Poliomyelitis		√	Night Sweats		√	Chest Pain
	√	Rheumatic Fever		√	Frequent Vomiting		√	Shortness of Breath
	√	Whooping Cough		√	Skin Trouble		√	Swelling of Feet
	√	Tuberculosis		√	Painful Muscles		√	Swollen Ankles
	√	Scarlet Fever		√	Painful Joints		√	Chronic Indigestion
	√	Hepatitis		√	Back Pain		√	Vomiting of Blood
	√	High Blood Pressure		√	Serious Injury		√	Jaundice (Yellowing of Skin)
	√	Kidney Trouble		√	Surgery		√	Constipation
	√	Kidney Stones		√	Arthritis		√	Bloody Stools
	√	Blood in Urine		√	Hemorrhoids		√	Cancer
	√	Burning Urine		√	Weight Loss		√	Diabetes
	√	Painful Urination		√	Frequent Headaches		√	Hay Fever
	√	Eye Trouble		√	Fainting		√	Hernia
	√	Hearing Trouble		√	Convulsions or Fits		√	Head Injury
	√	Fractures		√	Loss of Memory		√	Rheumatism
	√	Ear Infections		√	Nervousness		√	Epilepsy
	√	Frequent Nose Bleeds		√	Chronic Cough		√	Varicose Veins
	√	Frequent Sore Throat		√	Coughing of Blood		√	Anemia
	√	Hoarseness		√	Venereal Disease		√	Infectious Disease
	√	Allergies (including medications) If Yes, describe:						

Your Company Name

Your Company Address

Medical History (Continued)

SECTION II. Has anyone in your family had or been treated for:			
YES	NO		Who? (Father, mother, sibling, grandparent, etc.)
	√	Diabetes	
	√	Cancer	
	√	Tuberculosis	
	√	Heart Disease	
	√	Kidney Disease	
	√	High Blood Pressure	
	√	Hay Fever	
	√	Asthma	
	√	Epilepsy	
	√	Glaucoma	
	√	Siphilis	
	√	Nervous Disorders	
	√	Other (Explain)	

SECTION III FEMAEL ONLY		
YES	NO	
	√	Have you ever been pregnant?
	√	Have you ever had complications during a pregnancy?
	√	Have you ever had painful menstruation?
	√	Have you ever have excessive menstrual bleeding
	√	Have you ever had spotting or bleeding between periods?
	√	Are you currently on a form of contraceptive?

Age of first menstruation		Usual interval between periods	
Usual duration of periods		Date of last period	
Date of last pelvic exam (PAP)		Date of last breast exam	

Your Company Name

Your Company Address

Medical History (Continued)

SECTION IV		
YES	NO	
	√	Are you on a physician ordered special diet? If YES, type:
	√	Do you smoke? If YES, _____ packs per day for _____ years

SECTION V: List all current medications (include prescription and Non-prescription) in the mental health Assessment

SECTION VI: Have you ever had difficulty

YES	NO		YES	NO		YES	NO	
	√	performing certain motions?		√	reading?		√	being disorientated?
	√	assuming certain positions?		√	concentrating?		√	calculating?
	√	hearing?		√	comprehending?		√	writing a sentence?
	√	seeing?		√	being confused?		√	walking?
	√	speaking?						

SECTION VII: Information provided by mothers concerning child/adolescent Patient.

Pregnancy: ▢ Planned ▢ Unplanned		Delivery: ▢ Normal ▢ Complications If complications, explain:		
Birth Weight:	Length:	Breast Fed: ▢ YES ▢ NO	Bottle fed until age:	Age Weaned:

First year medical complications:

Age first walked:	Age first talked:	Age toilet trained:

Description of child as an infant:

Problem with bed wetting: ▢ YES ▢ NO and/or soiling ▢ YES ▢ NO

Immunizations:

Parent, Legal Guardian or Authorized Representative:	Date:
Patient Signature:	Date:
Employee Signature:	Date:

Your Company Name
Your Company Address

ADVANCE DIRECTIVE

Client Name: _____ Client No.:_____

YOUR COMPANY NAME does not require you to have “Mental Health Advance Directive”, however YOUR COMPANY NAME. will follow the terms of any advance directive that the Client has executed to the extent permitted by the law. If you already have a Mental Health Advance Directive, please provide YOUR COMPANY NAME with a copy.

▢ I HAVE executed a Mental Health Advance Directive and will provide Advance Health with a copy. The name and contact information for my surrogate is:

_____ _____
Name Relationship Phone Number

▢ I HAVE NOT executed a Mental Health Advance Directive.

▢ I hereby certify that I have read or been explained and understand my rights to have a Mental Health Advance Directive.

_____ _____
Client's Signature Date

Your Company Name
Your Company Address

PRIVATE TRANSPORTATION RELEASE CONSENT FORM

At times it becomes necessary to use . Transportation to transport Clients to and from . When this occurs, . requires that the Client sign the Private Transportation Release Consent Form that appears below:

I, Patient name

authorize . to transport me from and to my home to the Clinic for therapeutic services.

By signing this form, I hereby release ., as well as its directors, officers, administrators, employees, or other agents from all liability or damages for any and all injuries arising from the negligence of any of the above while traveling to this therapeutic activities via private transportation.

Name of Activity: Psychosocial Rehabilitation/ Individual Therapy Services and Clubhouse Activities.

Date(s): _____ to End of Treatment

Location(s): _____

. staff must have this signed form in their possession prior to the date of commencement of the specified activity.

_____ _____
Signature Date

_____
Date

_____
Staff Signature

Staff Name:_____

Your Company Name

Your Company Address

Informed Consent for Telehealth

Client Name:_____ Client Record: _____

This Informed Consent for Teletherapy contains important information focusing on doing Psychosocial Rehabilitation Services (PSR) which include intakes, biopsychosocial assessments, individual therapy and ongoing PSR sessions using the phone or the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Teletherapy Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, is otherwise unable to continue to meet in person, or, as in this case, sickness or pandemic prevents face-toface interactions. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person Psychosocial Rehabilitation Services and teletherapy, as well as some risks. For example:
- Risks to confidentiality. Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end we will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, we will not engage in teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work. The emergency protocols will be following which include to contact and/or appropriate authorities in case of an emergency.

- Efficacy. Most research shows that teletherapy is about as effective as in-person psychotherapy generally, there is no specific research that shows teletherapy is just as effective as in-person therapy for the type of therapy you will be receiving. Some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic communication We reserve the right to choose the electronic platform for services. We will use reasonable caution in choosing the platform, mindful of our obligation of privacy and confidentiality to our clients. You may have to have certain computer or cell phone systems to use teletherapy services.

You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy.

Confidentiality

We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telemedicine. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy). The extent of confidentiality and the exceptions to confidentiality that we outlined in the Informed Consent still apply in teletherapy. Please let us know if you have any questions about exceptions to confidentiality. Privacy laws that protect health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; raising mental/emotional health as an issue in a legal proceeding).

Emergency protocols

The telehealth's facilitator needs to know your location in case of an emergency. You agree to inform the telehealth's facilitator of the address where you are at the beginning of each session. Telehealth's facilitator also needs a contact person who may be contact on your behalf in a life-threatening emergency only. This person will only be contacted to go your location or take you to the hospital in the event of an emergency.

Client's location: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____

Client's Signature Date