INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information focusing on doing mental health counseling using the phone or the Internet. Please read this carefully and let me 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 mental health counseling services remotely using telecommunications technologies, such as a 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 locations. This can be helpful in ensuring continuity of care if the client or clinicians moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. 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 mental health counseling, as well as some risks. For examples:

- Risks to confidentiality: Because teletherapy sessions take place outside the therapist private office. There is potential for other people to overhear sessions if you are not in a private place during the session. On my end will take reasonable steps to insure 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 devices. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation unless you allow them to be part of your sessions.
- Issues related to technology: There are many ways that technology may 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 can be access unauthorized people or companies.
- Efficacy: Most research shows that teletherapy is as effective as in person. However, some therapist believe that something is lost for not being in the same room. For example, there is a debate about therapist ability to fully understand non-verbal information when working remotely.

Electronic Communication
World of Hope Counseling Center uses a software Doxyme to provide teletherapy services. You need to use a computer of cell phone that has a camera capability to engage in teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy.

For communication between sessions, I only use email or phone for communication. This includes things like setting and changing appointments, billing matters and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Please **do not** use email communication if there is an emergency, immediately call 911.

Treatment is most effective when clinical discussion occurs at your regularly scheduled sessions. But if an urgent issue arises you should feel free to reach me by phone or email, I will try to return your call or email within 24 hours except on weekends and Holidays. If you are unable to reach me and feel you cannot wait for me to return your call, contact your family physician or go to your nearest emergency room and ask for the mental health provider on call. If I am going to be unavailable for an extended time, you may call my office and leave a message. I will try to reach out to you and if I am not able to, I will ask the counselor-intern at World of Hope Counseling Center to reach out to you.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communication. I 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 I outlined in my Informed Consent in the World of Hope Intake packet still applies to teletherapy. Please let me know if you have any questions about expectations to confidentiality.

Appropriateness of Teletherapy
From time to time, we may schedule in-person sessions to "check-in" with one another when possible I will let you know if I decide that teletherapy is no longer the most appropriate form of treatment for you. We will discuss options of engaging in an in-person counseling or referrals to another professional in your location who can provide the appropriate service.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in teletherapy services.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back: instead call 911. **National Suicide Prevention Lifeline** at 1-800-273-8255, or go to your nearest emergency room. Call ne back after you have called or obtained emergency services.

If the session is interrupted and you are having an emergency, disconnect from the session and I will wait two (2) minutes and then reconnect via teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within 2 minutes then call to the number given in intake.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of the actual session time.

Fees
The same fee rates will apply for teletherapy as apply for in-person counseling. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic teletherapy sessions,

you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be cowered.

Records

The teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of out sessions in the same way I maintain records of in-person sessions in accordance with the policy of World of Hope Counseling Center.

Informed Consent

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

_____	_____
Client	Date
_____	_____
Therapist-Intern	Date
_____	_____
Therapist/Clinical Supervisor	Date

World of Hope Counseling Center

Initial Therapy Intake Form

Name:_____

Address:_____ City:_____ Zip_____

Primary Phone:_____

Birth Date:_____ AGE:_____ SEX:_____ SS#:_____

Occupation:_____ Employer_____

Work Address:_____ Zip:_____

Who is the referral source:_____

Have you been married:_____ Name:_____ Yrs_____

Emergency Contact:_____ Phone #:_____

Describe your Current Family
Dynamics:_____
_____
_____

Describe your current physical
health:_____
_____
_____

Name of Physician:_____ Phone#:_____

Name of Psychiatrist:_____ Phone#:_____

Are you taking any medications?
List_____

Have you ever been hospitalized for physical or mental issues?
If so, for what?
_____

Have you used any drugs? Yes_____ No_____ If yes, list_____

_____

Do you drink alcohol? Yes_____ No_____
If Yes, amount?_____

Have you had counseling before? Yes_____ No_____

If so, From:_____ To:_____ With Whom_____

For what?_____

Why did you stop going to therapy?
_____
_____
_____

Current reasons for seeking counseling:
_____
_____
_____

What is do you want to accomplish in therapy?
_____
_____
_____

What are your current symptoms?
_____
_____
_____

Any other information that I need to know:
_____
_____
_____

World of Hope Counseling Center

Payment Information

To properly file and process your claim with your insurance company we will need a few pieces of information. Please fill out in entirely, If we are not able to process due to missing information you will be held responsibility for the balance in full.

Name: _____

Address: _____

Telephone: _____

DOB: _____

SS#:_____

Insurance Name: _____

Insurance ID #: _____

Group Number (if aaplicable): _____

Info on back of card (ex. Phone numbers, website, prayor ID)

If you are using EAP service, please fill out the below section

EAP Name: _____

Authorization Number: _____

Number of visits approved: _____

World of Hope Counseling Center

Financial Policy

Fees:

If you do not have insurance, full private payment will be due at the time of service. Yolanda Sanchez, LPC-S is insured by various panels.

Intern:	**Full Licensed:**
Initial Assessment: $90.00	**Initial Assessment: $150.00**
Individual Therapy: $65.00	**Individual Therapy: $120.00**
Family Therapy: $75.00	**Family Therapy: $130.00**

Intern/Full Licensed

Anger Management Group Therapy $180 for 4 classes 1.5 hours

Meditation/Stress Management Group $180 for 4 classes 1.5 hours

Cancelation and Missed appointment: $40.00

Payment of fees is expected at the time of service. You as the client are responsible for paying all charges for services regardless of payment from health insurance or other sources. If you are having difficulty paying for your therapy please let us know to make arrangements. Please be advised that any unpaid bills may be turned over to collection agency. Our therapist supports the Bexar County District Attorney's policy regarding "hot"checks.

I understand that any balance left on my account will be charged directly to my account, including missed appointments, unless other arrangements have been made up on the incurred charges:

Complaint procedures: If you are not satisfied with our worked together, please tell us as soon as possible. We will make every effort to hear any complaints you have and seek solutions for them. If you feel we (or any other therapist) have treated you unfairly or have even broken a professional rule, please tell us. You may also file a complaint with your therapist licensing board. You may contact the Texas State Board of License Professional Counselors to make a complaint.

My signature below shows that I have read this document and fully understand it. I have also had the opportunity to have my questions answered. If i will be using my insurance to help pay for my sessions, my signature here also indicates assignment of benefits to my therapist.

Printed name:_____

Guardian or Client Signature:_____ Date:_____

LPC-Intern: _____Date:_____

Therapist Signature:_____ Date: _____

In our practice as counselors, we do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations, We will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to our attention immediately.

World of Hope Counseling Center

I am a Licensed Professional Counselor in the State of Texas. I hold a Master of Science in Psychology with a concentration in Family, and Marriage Counseling from Our Lady of the Lake University, 2003. My passion is to treat trauma in different facets. I am trained to use the Eye Movement Desensitization and Reprocessing Technique to treat PTSD symptoms. I have worked in the field of Psychology for 27 years with children, at-risk adolescents, families, couples, survivors of violence and the acute in psychiatric hospitals and in their natural environment. I have a team that works with dual diagnosis and anger issues. An essential component in growing in the therapy process is the collaborative therapeutic relationship. The focus in the session will be strictly on you. Light will be shed on recurrent destructive behaviors to assist in ending vicious cycles. The therapist will be walking beside you in your personal journey to assist in gaining insight and self-awareness. The relationship with your therapist is strictly professional and the focus of treatment will be on you. Everything you say to your therapist is confidential with the following exceptions: (a) you direct the therapist to tell someone else, (b) the therapist determines that you are a danger to yourself or others, (c) there is possible child or elder abuse. Therapeutic services to you in a manner consistent with ethical standards. if at any time or any reason you are unhappy with my services please let me know. I will attempt to resolve the issue to the best of my ability.

What to Expect: Sessions will generally be 50 minutes in length. You and your therapist will determine how often you will visit, but usually sessions are scheduled weekly or every other week. Your therapist will complete a psycho-social assessment with you, and develop a treatment plan or list of goals for your therapy. Our team utilize a variety of therapeutic approaches and techniques to better assist the client's individually. We encourage you to ask your therapist what approach they are using during the session.

Therapy often results in various benefits to clients, but it does involve some risks and you need to be aware of that. While in therapy, you may remember unpleasant events, or feel uncomfortable and possibly intense emotion such as sadness, anger, anxiety, frustration, loneliness, or helplessness. Sometimes when clients make changes in their lives, it threatens loved ones and may result in strained relationships. Sometimes and for some people, therapy is not effective in resolving problems. While you consider these risks, you should know that there are many benefits from therapy demonstrated by scientist in many research studies. Benefits from therapy include: improved mood, improved self-esteem, increase of self-worth and the ability to regulate difficult emotions. You may gain a better understanding of your personal beliefs and values, greater maturity and growth as a person, and increased professional growth.

Initial:_____

World of Hope Counseling Center

Statement of Client's Rights

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other members information kept confidential. Only where permitted by law records may be released without the member's permission.
- Easily access care in a timely manner.
- Know about treatment choices. This is regardless of the cost or coverage by the health plan.
- Collaborative effort in developing the treatment plan.
- Receive a clear explanation of the mental condition and treatment options.
- Receive information about this therapist, the providers, and treatment modalities.
- Know about the therapist's work history and training.
- Know about advocacy and community groups and preventions programs.
- Decline participation or withdraw from the treatment services.

Statement of Client's Responsibilities

- Treat Therapist with dignity and respect.
- Give providers and Insurance Companies information that they need. To deliver quality care and insurance company can deliver appropriate services.
- Ask questions about our care and understand your care.
- Follow the treatment plan developed collaboratively.
- Keep the scheduled appointment. If the appointment needs to be cancelled
- or rescheduled call the therapist as soon as possible.
- Let the therapist know if the treatment plan is not working.
- Report abuse or fraud.
- Inform your insurance company if you terminated services or decided to withdraw from therapy.

_____ _____

Client signature Date

World of Hope Counseling Center

Confidentially

We take your privacy seriously. Federal and state laws, as well as professional rules and ethics require us to keep what you tell the therapist confidential. If you want us to share information with anyone (i.e. family members, physicians, psychiatrists) you will have to sign a Release of information form. There are some situations in which we are required to disclose information about you without your permission and consent:

- If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request,or other lawful process.
- If you make statements that give us reasonable cause to believe and / or suspect that a child, elderly, or disabled person has been abused or neglected
- If you make statements that indicates a probability of imminent physical, mental, or emotional injury [i.e. suicide and homicide] by you to yourself or others.
- If you make statements that give us reasonable cause to suspect that another professional has engaged in an inappropriate, sexual, or exploitative relationship with you.

Minors (under age 18): Texas law requires that we have the written permission of either a parent or legal guardian to provide therapy services to a minor. Exceptions to this occur when a minor is seeking therapy for suicide prevention, drug/alcohol use, or if they are the victim of abuse. We are not responsible for your children therefore we require that you remain present in the waiting area during your child's session.

Please check one
[ ] I certify that I am the above- named client or the legal guardian of that client.

[ ] I have the full legal authority to consent to treatment of the minor without obtaining consent or approval from another person.

[ ] I have joint custody of the minor present to a decree that requires both my consent and the consent of another person.
Note: if the consent of another guardian not present is required the child may not be seen until written consent is gained,

initial: _____

World of Hope Counseling Center

Consent to Use and Disclose your Health Information

This form is an agreement between you and Yolanda Sanchez, LPC and billing staff. When we diagnose, treat, or refer you, she will be collecting what the law calls " protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. Yolanda Sanchez, By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share you information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from us by calling, e-mailing, writing, or by visiting our website.

If you need more information or have questions about your PHI, please speak to our staff about them. After you have signed this consent, you have the right to revoke it in writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of Client or Parent /Legal Guardian Date

_____ _____
Printed name of Client or Parent/ Legal Guardian Date

_____ _____
LPC-Intern Date

_____. _____
Signature of Therapist/Clinical Supervisor Date

Credit Card Consent Form

We require a 24-hr cancellation notice as a courtesy to other clients wanting to be seen and to our Therapist

Our practice requires all patients have a credit card on file for **missed appointments and outstanding balances** that are not paid for after verbal or billing statement notice. Please fill this document out completely, you will not be seen without doing so.

How we handle your credit card information: once this sheet filled out we scan it into a secure file that is stored in a secure cloud after which we shred this page.

- No-show $40.00
- Cancellation without 24-hour notice $40.00

Information to be completed by the card holder:

Card Type: ___ Visa. ___ Master Card. ___Discover

Cardholders Name: _____

Patient's Name: _____

Card Number: _____

Valid until Date: _____. Security Code: _____ (3 digit code on the back)

Billing Address: _____

City: _____. State: _____ Zip Code: _____

Email Address: _____

ACKNOWLEDGEMENT

I hereby authorize **World of Hope Counseling Center** to charge my credit card on file for any missed appointments and/or late cancellation. I also authorize **World of Hope Counseling Center** to charge my credit card in the event I have an outstanding balance not payed for a month after notification that I have an outstanding balance either verbally or through a billing statement.

The above information is completed and correct to the best of my knowledge. I agree to update any information pertaining to this account. I understand that **World of Hope Counseling Center** will do everything in their power to protect my personal information and will not be held responsible for any breaches for any breaches that could accrue.

Cardholder Signature: _____ Date: _____

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Fax: 1-800-508-0086