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OFFICE POLICIES, AGREEMENT FOR SERVICES & CONSENT FOR TELEHEALTH

First, let me welcome you to therapy with me. I intend to provide you with ethical, compassionate, and experienced professional outpatient psychotherapy services.

Fees: My standard fee per 50-60 minute session is $150/session, or the contracted amount if I accept your insurance, or _____ per our sliding scale agreement. This is due at the beginning of our session, unless I am billing your insurance, in which case you must pay your copayment and/or deductible at the session. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, etc. will be billed at the same rate as your sessions. You agree to be financially responsible to me for all charges, including unpaid charges by your insurance company or any other third-party payer.

Payment: I accept payment by any of the following methods: cash, check, credit card via Square, the IvyPay app for therapists (I send you a text and you enter payment on your end), or PayPal/credit card on my website. If you give me your credit card info for Square or we agree to use IvyPay, you agree that I will charge the usual amount of your payment either during or immediately after a session, or as soon as may be convenient for me (usually within 24 hours). You also agree that I may charge for missed sessions per our agreement. I agree to ONLY charge for services rendered or for appointments not canceled in advance per our agreement.

Changes in Insurance: Due to insurance company rules about billing, you must inform me of any new or changed insurance (even changes to copays), and give me your new insurance info. I will start claims from the date info is provided, and also for recent past sessions paid out of pocket, if within reason, but in no case longer than 60 days prior to being informed of the new insurance.

Cancellation Policy: You may be charged your normal fee or the amount your insurance pays, for sessions missed or cancelled without 24-hour notice, unless you are sick - if you let me know before noon the day of the appointment. ***Please do not come to an in-person session if you feel ill.***

Emergency: You may leave a message for me at any time on my confidential voicemail 510-581-7850. Be sure to leave your name and phone number – even if you think I have it. I am generally available to return calls within 24 hours, Mon - Fri. I am unable to provide 24-hour crisis service. In the event you feel unsafe or require immediate medical or psychiatric assistance, you should call the Alameda County Crisis Line 800-309-2131, or 911, or go to the nearest emergency room.

Acknowledgement: By signing below, you acknowledge that you reviewed, understand and consent to the terms of the **Office Policies & Agreement for Services** and **Informed Consent** and that you have clarified to your satisfaction any questions you have, and you consent to participate in therapy. Moreover, you agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Privacy Policy: By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** that I have given to you. My **Notice of Privacy Practices** provides information about how I may use and disclose your protected health information. I encourage you to read it. My **Notice of Privacy Practices** is subject to change. If I change my notice, you may obtain a copy of the revised notice by contacting me at 510-581-7850.

Parents: If you are signing this agreement as the parent or guardian of a child under the age of 18, you are doing so as the legal guardian. If there is joint custody, your signature indicates that you are discussing the decision to seek counseling for the child with the other custodial parent, and you understand that the other parent will have equal access to information about the child's treatment.

Consent for Telehealth Consultation

1. I understand that my therapist has offered to provide therapy via phone or video telehealth consultation.
2. I understand that the limitations to confidentiality and all other agreements outlined in our original Office Policies, Agreement for Services and Informed Consent apply all sessions done in either in-person or telehealth format.
3. I authorize us to meet via phone or a HIPPA-compliant online video service platform. I understand that my therapist will do her best to utilize industry best practices for telehealth, to ensure both client confidentiality and the security of the communication medium. I am aware that there may be additional charges from my internet provider.
4. I understand that video or phone technology that will be used will not be the same as a direct client/ psychotherapist session due to the fact that I will not be in the same room as my provider, so it may be more difficult for my therapist to see body language and other cues which can be helpful for therapy.
5. I understand that a telehealth consultation has potential benefits including easier access to care, continuity of care, and the convenience of meeting from a location of my choosing.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties, which cannot be predicted. I understand that my therapist or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
7. I agree that recording of video or phone sessions is NOT permitted by either my therapist or I, and at the end of session we will both disable computer and device-generated recording to the best of our abilities.
8. I understand it is important to connect from a quiet room, with no interruptions, where others cannot hear me, and where my privacy is guaranteed.
9. I understand that during each telehealth session, my psychotherapist will assess whether treatment by telehealth is appropriate for me or my situation, and will provide alternate recommendations if it is not.
10. Emergency: In case of emergency, my therapist may contact this Emergency Contact Person: _____ (name) _____ (phone) _____ (relationship).
11. Location: I agree to inform my therapist of the address where I am located at the beginning of each session. The county of my primary location is _____ , the nearest mental health hospital is _____, and the nearest police department is _____.
12. I understand that I have the right to withdraw consent at any time without affecting future treatment.
13. I agree that there have been no guarantees or assurances made about the results of this service.

I have read and understand the information provided above, including the Office Policies and Agreement for Services, and the Consent for Telehealth Consultation. I also acknowledge that I have received a separate Informed Consent and Notice of Privacy Practices. I have discussed these with my psychotherapist and all of my questions have been answered to my satisfaction.

_____	_____	_____
Signature of Client (or Parent)	Client or Parent Name (please print)	Date