Dr. Erin Pannell, Ed.D., LPC-S, RPT-S

• Phone 512-280-4425 • Fax 512-605-3724 • ErinPannell.com

INFORMED CONSENT

This informed consent agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on Dr. Erin Pannell unless we have taken action in reliance on this agreement or if you have not satisfied any financial obligations you have incurred.

Qualifications:

I am a Licensed Professional Counselor Supervisor, a Registered Play Therapist Supervisor. I provide comprehensive mental health services to adults, children, and adolescents. My master's degree is from Texas State University and is in counseling and guidance. I have a doctorate degree from Argosy University-Sarasota in Counseling Psychology. Post-graduate work has been acquired through Texas State University as well as through continued education seminars and training certified by the American Counseling Association, International Association of Play Therapy, Texas Association of Play Therapy, and Sandplay Therapists of America.

Experience:

I have counseled hundreds of children, adults, and families from varying ethnic, racial, sexual orientation and religious backgrounds during individual, child and adolescent, and family sessions. I have over fifteen years of combined public and private sector experience in working with moderate to severely impaired adults, children, and adolescents. This experience is centered in Adlerian counseling, meaning, "How does the individual use heredity and environment?"

The majority of my work is in helping individuals who have experienced trauma in a variety of forms. I have – and continue to provide – counseling assistance to those people suffering from relationship difficulties, sexual and physical abuse, parenting problems, as well as crisis counseling for those experiencing difficulties brought on by accidents and natural disasters.

Finally, I have assisted several professors at Texas State University in the areas of group dynamics, play therapy, and child and adolescent counseling techniques. I have also assisted graduate students in conducting play therapy and sandtray sessions in the counseling clinic at Texas State University.

Nature of Counseling:

It is my belief that psychotherapy is offered to assist a person in the difficult task of change. Psychotherapy does not do the work; the client must work the therapy in order to achieve successful change.

Named for Alfred Adler, Adlerian counselors believe the family constellation constitutes the primary social environment. I see my role as assisting the individual work through the four primary areas of theory: 1). Establishing and maintaining a trusting relationship between client and counselor; 2). Uncovering the dynamics

of the patient, including lifestyle and goals, and assessing how they affect life movement; 3). Interpretation culminating in insight; 4). Reorientation.

I challenge and assist the client in developing the skill one needs to have a more fruitful and enjoyable life. To do this, I will be asking some personal question about you, your extended family, and personal background and beliefs. With this confidential information, we can explore your areas of concern through talk therapy, role-playing exercises, Sandtray, Play Therapy, and Art therapy techniques. All of which are designed to release one from where they are "stuck" and unable to live as they choose.

Sessions are approximately 45-50 minutes, depending on the nature of the session and the age of the client. Some people need only a few sessions to resolve their difficulties or concerns. Others often need months or even years to achieve their stated goals. As a client, you are in complete control and can end our counseling relationship at any time. I do ask you to participate in a termination session. You have the right to refuse or negotiate modifications of any suggestions that you may feel uncomfortable experiencing. At any time, either you or I may initiate discussion of possible positive or negative effects of entering, not entering, continuing counseling, and/or refusing certain techniques. I adhere to the ethical standards of the LPC board, the International Association of Play Therapy, and the Sandplay Therapists of America.

Our sessions are psychologically intimate and the need to keep the counseling relationship a professional one rather than a social one is necessary. Our contact will be limited to counseling sessions you arrange with me.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call 911
- Go to the emergency room of your choice.

In addition, as a consideration to other clients, as well as your child, please make child care arrangements for small children and siblings.

Explanation of Fees:

Session fees are $125 per 45 to 50 minute session. Payment is required when services are rendered. Clients (or guardians of minors) will be responsible for any insurance co-payment, deductibles, or unpaid claims. Any outstanding balance not paid within 30 days will be turned over to a collection agency for recovery and a $145.00 collection fee will be charged to the client's account.

If an account is turned over for collection the client will become liable for the full amount of charges, including costs of collection, taxes and any court costs that may be incurred. Any discounts or adjustments that have been made to the account may be eliminated. No further services will be rendered until all fees have been paid in full.

Court cases are billed at a flat rate of $1500 per day payable 7 days in advance. This includes but is not limited to testimony or being on 'stand-by' for testimony. Any cancellation of my scheduled appearance will require a 72-hour notice or prepayment will not be refunded. Insurance companies will **NOT** cover court appearances.

When a minor is in counseling, parents are required to attend a session every four to six weeks in which information is shared, and future therapeutic treatment is discussed. Please note this is most important for the child's continued growth in the therapeutic process.

A $40 fee will be assessed for all returned checks. In addition, any fee not paid within 30 calendar days of billing may be turned over to a collection agency or attorney for nonpayment unless a payment plan has been arranged.

If a client or a client's representative requests a copy of their counseling file, a flat administration fee of $65 is charged. The request must be in writing with the original signature of the client (parent or guardian of a minor child). This office reserves the right to redact any information from a child's file that the counselor believes may be harmful to the child.

Cancellations:

A 48-hour cancellation notice is required, otherwise a fee of $75 will be charged to your account as this office cannot bill insurance companies for no-show/late cancellations. In addition, the notice allows for other clients on the waiting list to be seen. If the fee is not paid within 4 weeks, no further services will be rendered until the fee is paid in full.

If a client fails to keep 2 consecutive appointments without notification, the counseling relationship will be terminated, and the client's time slot will be given to another client.

Confidentiality:

All communication occurring between therapist and client will be held in the strictest of confidence. However, if the client is using insurance, an office manager may be responsible for handling your file and billing the insurance company. The office manager is trained in ethics and confidentiality, and will not share information with anyone other than the insurance company and/or its representatives. Also, the insurance company may require the client to sign a release of information for the release of certain portions of your record.

Under normal circumstances, no information will be released to any individual or institution without the written consent of the client. There are circumstances preceding this. According to Texas statutes, confidentiality must be breeched if one or more of the following occur: 1) the client is deemed by the therapist a danger to self or someone else, 2) if child abuse/neglect is suspected, 3) if abuse/neglect of another individual within the family home is suspected, 4) if a court orders confidential records to be released, or 5) if the client agrees in writing for the release of one's information. In the event of one of the above situations, the proper steps will be taken including notification of medical and/or law enforcement agencies as needed.

Referrals:

If any time, for any reason, you are not satisfied with my services, please let me know. If I am not able to resolve those concerns, I will provide three referral choices.

Complaints:

If you have a complaint concerning your treatment and/or your therapist, you may report it to the Texas State Board of Examiners of Professional Counselors at 512.834.6658.

Equality:

I understand that I have the right to fair, equitable and comparable treatment at all times. I understand that I have the right to view my file with a 30-day notification period.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may *use* or *disclose* your *protected health information (PHI),* for *treatment*, *payment*, and *health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment*, *Payment*, and *Health Care Operations*"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, social worker, therapist, psychologist, or psychiatrist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility of coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or

(2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Abuse by a Therapist:** If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment**,** I will report this to the appropriate State Examining Board.
- **Health Oversight:** If a complaint is filed against me with the appropriate State Board overseeing me – The Texas State Board of Examiners of Psychologists, The Texas Board of Medical Examiners, the Texas State Board of Social Work Examiners, or the Texas State Board of Professional Counselors – they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and My Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send information to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you a revised copy at your next visit or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, talk to me about these concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next visit or by mail.

Dr. Erin Pannell, Ed.D., LPC-S, RPT-S

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INFORMED CONSENT, PROFESSIONAL DISCOSURE AND COUNSELING CONTRACT SIGNATURE PAGE

If there is a minor child with divorced or separated parents, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT, AGREE TO ITS TERMS, UNDERSTAND THE CURRENT PROCEDURES AS STATED WITH REGARD TO APPOINTMENTS, FEES, METHODS OF PAYMENT, HISTORY, CONFIDENTIALITY, AND CLIENTS' RIGHTS AND AGREE TO ABIDE BY THEM. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE WAS MADE AVAILABLE TO YOU.

_____
Client Name (Please Print)

_____ _____
Client Signature Date

If Applicable:

_____
Parent/Legal Guardian's Name (Please Print)

_____ _____
Parent/Legal Guardian's Signature Date
Signature of parent or guardian for clients less than 18 years old

_____ _____
Dr. Erin Pannell Date
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor

Dr. Erin Pannell, Ed.D., LPC-S, RPT-S

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CLIENT INFORMATION FORM

NAME: _____

CHILD'S NAME: _____

ADDRESS: _____ CITY/ZIP: _____

PHONE: _____ CAN MESSAGES BE LEFT? Y/N

WORK PHONE: _____ CAN MESSAGES BE LEFT? Y/N

CELL PHONE: _____ CAN MESSAGES BE LEFT? Y/N

EMAIL ADDRESS: _____ CAN MESSAGES BE LEFT? Y/N

LIST OF CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

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HEALTH INSURANCE CLAIM FORM

Client's Full Name: _____

Client's Date of Birth (MM/DD/YY): _____

Client's Address/City/Zip Code (as given to insurance company):

_____

_____

Client's Relationship to the insured: _____ Self _____ Spouse _____ Child _____ Other

Client's Social Security #: _____

Client's Driver's License # and State: _____

****

(This is information about who carries the insurance)

Insured's Full Name: _____

Insured's ID Number: _____

Insured's Address/City/Zip (If different from the client's):

_____

_____

Insured's Phone Number (If different from the client's): (____) _____

Insured's Social Security # _____

Insured's Driver's License # _____

Insured's Policy Group or FECA Number: _____

Insured's Date of Birth (MM/DD/YY): _____

Insured's Employer's Name or School Name: _____

Insurance Plan Name or Program Name: _____

Authorization # (must have prior to your first appointment): _____

Number of sessions approved: _____

Client's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services (Dr. Erin Pannell, M.Ed., LPC-S, RPT-S)

Signed: _____ Date: _____

Dr. Erin Pannell, Ed.D., LPC-S, RPT-S

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INFORMATION, AUTHORIZATION, & CONSENT TO TECHNOLOGY-ASSISTED SERVICES

Thank you so much for choosing the services that I provide. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to Technology-Assisted Services. Technology-Assisted Services is defined as follows:

> "Technology-Assisted Services means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Technology-Assisted Services facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers."

Technology-Assisted Services is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Protected Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Technology-Assisted Services in order to provide you with the highest level of care. Therefore, I have completed specialized training in Technology-Assisted Services. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, I do not utilize texting in my therapy practice, and I will not respond to a text message for your protection.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc.:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. Please refrain from making contact with me using social media messaging. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

In the event you follow one of the social media accounts, you are comfortable with the general public being aware of the fact that your name may be attached to this account.

Please refrain from making contact with me using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Google, Bing, etc.:

It is my policy not to search for my clients on Google, Bing or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize VSee. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that VSee is willing to attest to HIPAA compliance and assumes responsibility for keeping

our VC interaction secure and confidential (https://vsee.com/hipaa). If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Faxing Medical Records:

If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine. However, my fax machine is kept behind two locks in my office. And, when my fax machine needs to be replaced, I will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment.

Electronic Record Storage:

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically on a storage device secured in a physical location under my control and requiring my login credentials for access.

Electronic Transfer of PHI for Billing Purposes:

If I am credentialed with and a provider for your insurance, please know that I utilize a billing service that has access to your PHI. Your PHI will be securely transferred electronically to Office Ally. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize Square as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know

if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Dr. Erin L. Pannell, LPC-S, RPT-S.

Your Responsibilities for Confidentiality & Technology-Assisted Services

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Technology-Assisted Services sessions.

In Case of Technology Failure

During a Technology-Assisted Services session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone/cell. Please make sure you have a phone with you, and I have that phone number.

If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

Cost of Sessions

I may provide phone, and/or video conferencing if your treatment needs determine that Technology-Assisted Services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, Technology-Assisted Services, or both. We will discuss what is best for you.

Technology-Assisted Services sessions fee are $125 per 45-50 minute session. I require a credit card ahead of time for Technology-Assisted Services therapy for ease of billing. Your credit card will be charged at the conclusion of each Technology-Assisted Services interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable for payment.

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover Technology-Assisted Services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for Technology-Assisted Services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a Technology-Assisted Services appointment, you must notify me at least 48 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of Technology-Assisted Services Therapy Services

Technology-Assisted Services should not be viewed as a complete substitute for therapy conducted in an office. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

Communication Response Time

I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls within 24 hours. However, I do not return calls or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call 911
- Go to the emergency room of your choice.

Emergency Procedures Specific to Technology-Assisted Services

There are additional procedures that we need to have in place specific to Technology-Assisted Services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Technology-Assisted Services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine it necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: _____ Phone: _____

You agree to inform me of the address where you are at the beginning of every Technology-Assisted Services session.

You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Technology-Assisted Services session). Please list this hospital and contact number here:

Hospital: _____ Phone:_____

Consent to Technology-Assisted Services

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Your signature below indicates that you have read this document (INFORMATION, AUTHORIZATION, & CONSENT TO TECHNOLOGY-ASSISTED SERVICES), and agree to its terms, and you are authorizing me to utilize the Technology-Assisted Services methods discussed. I also understand during all Technology-Assisted Services I must be physically located within the state of Texas.

_____ _____

Client Name (Please Print) Date

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) Date

_____

Parent's or Legal Guardian's Signature
Signature of parent or guardian for clients less than 18 years old