Centre Psychology Group

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www.centrepsychology.com

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TELETHERAPY INFORMED CONSENT FORM

Definition of Services:

I hereby consent to engage in teletherapy with _____, Centre Psychology Group. Teletherapy is a form of psychological service provided via secure internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted face-to-face at the office. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

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

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of Pennsylvania

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. However, there are both mandatory and permissive exceptions to confidentiality.

4. I understand that there are risks and consequences from teletherapy, including, the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse.

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8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for Teletherapy services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

11. I understand that I have a right to access my medical information and copies of medical records in accordance with the law.

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

Client's Signature: _____Date_____

Therapist's Signature: _____ Date_____

1993 Cato Avenue • State College, PA 16801 • (814) 231-8820 • Fax (814) 231-8857 • centrepsych@gmail.com

Intake Form

Thank you for taking a few minutes to fill out this form. If you have any questions, just ask!

Today's Date:_____

Name:_____Age: ____ Date of Birth:___/_____/____

Address: _____

street city state zip

Phone (Primary):_____(Secondary/Work):_____

Email (please print clearly): _____

My current gender identity is: _____ My sexual orientation is: _____

My sex assigned at birth is: _____ My pronouns are: _____

Racial Identity: _____ Ethnic Identity: _____

Education: _____ Occupation: _____

What is your religious background / involvement? _____

Emergency contact person (name, relationship, phone, address): _____

Family Information:

Marital Status (check any that apply): Single ☐ Dating ☐ Committed relationship ☐ Engaged ☐

Married ☐ (how long? _____) Separated ☐ (how long? _____) Divorced ☐ (how long? _____)

Spouse's Name (if applicable) _____ Age _____ Occupation _____

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Legal History (arrests, prison, DWI, parking tickets?) _____

Have you participated in any therapy before? Yes ☐ No ☐

If yes, when?_____ Reason: _____

Substance abuse / addiction history? No ☐ Yes ☐ (please explain)

_____

Insurance:

Medicare Number (if applicable): _____

Name of your insurance: _____

How can we help? Please tell us in your own words what brings you here today

_____

_____

_____

_____

What are your **TWO** most important goals for therapy?

1. _____

2. _____

Common Problem/Symptom Checklist.

Check all that apply

☐ Marriage	☐ Divorce/Separation	☐ Alcohol/Drugs	☐ God/Faith
☐ Pre-marital	☐ Child custody	☐ Other addictions	☐ Church/Ministry
☐ Relationship	☐ Disabled	☐ Grief/loss	☐ Trauma
☐ Sexual issues	☐ Work/Career	☐ Depression	☐ Co-dependency
☐ Family	☐ School/Learning	☐ Fear/Anxiety	☐ Intimacy
☐ Children	☐ Money/Budgeting	☐ Anger control	☐ Communication
☐ Parents	☐ Aging/Dependency	☐ Loneliness	☐ Self-Esteem
☐ In-laws	☐ Weight/Body Image	☐ Mood swings	☐ Stress control

Crisis Information:

Are you having any current suicidal thoughts, feelings, or actions? Yes ☐ No ☐

If yes, please explain: _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Yes ☐ No ☐

If yes, please explain: _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Yes ☐ No ☐

If yes, please describe: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes ☐ No ☐

If yes, please describe: _____

Who referred you to us? _____

THANK YOU for taking the time to fill out this information sheet

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PSYCHOLOGICAL AND MEDICAL HISTORY SHEET

Note: This information will remain confidential with other information in your chart

Name	Date of Birth
Date of last medical exam (month/year)	
Primary Care Physician (Name and Practice)	
Current Medical Problems (please list)	

Check all that apply to you:

☐ Neurological disorder ☐ Autoimmune disorder ☐ Thyroid disorder

☐ Cardiovascular problems ☐ Chronic pain ☐ Headaches ☐ Sleep disorder ☐ Cancer

☐ Substance use problem ☐ Physical Disability ☐ Seizures ☐ Vision/Hearing deficit ☐ Diabetes

Current Medications (including over-the-counter and supplements)
Family Medical History (note family member and illness)
History of Psychiatric Hospitalizations/Rehab (month/year/place)
Prior Counseling or Psychotherapy (date range and therapist name)

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Policy for Electronic Communications

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. Many of these common modes of communication put your privacy at risk and can be inconsistent with the law and with the standards of our professional practice. We generally and expressly recommend against using electronic forms of communication as an aspect of your treatment. This policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. Each provider at this practice retains the right to make specific exceptions to this policy as determined on a case to case basis with the individuals they serve. If you have any questions about this policy, please feel free to discuss this with your clinician.

Email Communications and Text Messaging
This office will not initiate communication using email, except with client permission when specifically pertaining to payment of services, or unless under usual circumstances (e.g., we are unable to contact you by any other means in an emergency). Your clinician will only use email communication and text messaging with your verbal permission (this will be documented in treatment notes) and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with this office should be limited to things like setting and changing appointments, billing matters and other related issues. Do not use PHI (personal health information such as name, date of birth, etc.) when using electronic communication, because access to electronic information is not assumed to be protected or private. Please do not use email or texting for treatment-related issues. Please note that our support staff routinely review incoming email. They are bound by an agreement of employment by our practice that requires them to follow our HIPPA Policy and privacy practices.

Social Media
We do not communicate with, or contact, any clients through social media platforms like Twitter and Facebook. In addition, electronic relationship status will be cancelled if a clinician discovers that an online relationship has been accidentally established. This is because these types of casual social contacts can create significant security risks for you. If you have an online presence, there is a possibility that you may encounter your clinician by accident. If that occurs, please discuss it during the next scheduled session.

Websites
We have a website that you are free to access (www.centrepsychology.com). It is used for professional reasons to provide information to others about our practice. You are welcome to access and review the information that you find on our website and, if you have questions about it, please discuss this during your therapy sessions.

Web Searches
Your clinician will not use web searches to gather information about you without your permission, because this constitutes a violation of your privacy rights. If you encounter any information about your clinician through web searches, reviews, or in any other fashion, please discuss this during your next session as it may potentially impact your treatment.

Other Providers and Individuals
If other providers or individuals contact this office about you by means of electronic communication (email, texting, etc.) we will not respond without your express written consent. If you anticipate this, please complete a written authorization today. Please note that a written consent does not imply that electronic communications can be made private or secure.

Please sign below if you understand our policy regarding electronic communications:

_____

Client Signature Date

_____

Guardian/Power of Attorney Signature Date

_____

Witness Signature Date

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Attendance Policy

Regular attendance is an essential part of successful and effective therapy. Most clients are seen weekly or every other week. Regular attendance can assist clients in reaching goals and maintaining gains in treatment. The following attendance policy reflects the needs of the client as well as the needs of your therapist.

1. 24 hours notice **by phone** is expected for cancellations. Email messages will not constitute a cancellation and this gives us adequate time to offer that time to another client (we often have a waiting list of clients who need appointments). We understand that circumstances arise and that late cancellations are unavoidable. Three 'late cancels' in each two month period of time are allowed. After three, there is a $50 fee

2. All "no shows" will be assessed at a $50 fee.

3. If there is consistently pattern of poor attendance, you and your therapist will review your individual circumstance and clinical needs. All options will be considered including continuing treatment, termination from services or referral to a more appropriate setting.

4. It is also helpful to inform your therapist if you are planning to leave therapy and your reason for doing so. The termination process can be beneficial to both therapist and client.

Please discuss any questions or concerns that you might have regarding this policy with your therapist.

_____ _____
Client Witness

_____
Date

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Payment Policy

Our independent practitioners are paneled with a wide variety of insurance companies. It is the responsibility of the client to determine if your insurance requires preauthorization, has a deductible and amount of copayments. Our support staff can be helpful with this process – However, it is important for you to know your insurance policies and coverage. We will bill your insurance for services rendered. You will receive an Explanation of Benefits (EOB) form your insurance company explaining your financial responsibility and reimbursement rates.

- You are responsible for all copayments, deductibles, and any balance that is not covered by your insurance.
- Payment is expected at the time of service. We ask that you make your copayment **prior** to your session.
- We accept a variety of payment methods: cash, check, Visa, MasterCard, debit, etc.
- We prefer that payments are made in cash or check to keep our banking fees low.

PLEASE MAKE CHECKS PAYABLE TO **YOUR PRACTITIONER**

Our support staff is happy to answer any questions for you regarding billing, insurance, and reimbursement.

We understand that, from time to time, your financial situation may make it difficult to make a payment at time of service. **Please discuss any payment plan with your practitioner – Not with our support staff.**

_____
Client

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NOTICE OF HIPPA POLICY
And Privacy Practices

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

I. Use and Disclosure of Your Protected Health Information for Treatment, Payment, and Health Care Operations:

We may use or disclose information in your records for **treatment, payment, and health care operations purposes with your consent**.

Personal health information (PHI) refers to information in a client's health record that could identify that client.

Use of this information refers only to activities within this office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure of information refers to activities outside of this office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client.

In providing for your treatment, we may use or disclose information in your record to help you obtain health care services from another provider, or to assist us in providing for your care. For example, we might consult with another health care provider, such as your physician or another psychologist. In order to obtain payment for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination).

II. Use and Disclosure Requiring Authorization:

Except as described in this Notice, we may not make any use or disclosure of information from your record for purposes outside of treatment, payment, and health care operations unless you give your written authorization.

You may revoke an authorization in writing at any time, but this will not affect any use or disclosure already completed before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

It is important for you to understand that we cannot control the disclosure of information from your records once your written authorization has been obtained and records have been sent to an outside party. For example, any individual that has obtained your records via your written consent and request (e.g., attorney, other provider) may of their own accord and beyond our control transmit your records to other parties. Please carefully consider the nature of your written consent to disclose any personal documents that originate in our office.

III. Use and Disclosure Without Consent or Authorization:

There are certain circumstances, listed below, in which we are allowed (or, in some cases, required) to use or disclose information from your record without your permission:

• **Child Abuse:** If there is reasonable cause to suspect that a child is or has been abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, or person over the age of fourteen living in the home of the child, the law requires us to report this to the Department of Public Welfare, and/or appropriate governmental agency. The Pennsylvania State Board of Psychology specifically requires that: "psychologists who, in the course of their employment, occupation or practice of their profession, come into contact with children shall report or cause a report to be made to the Department of Public Welfare when they have reasonable cause to suspect on the basis of their professional or other training or experience, that a child coming before them in their professional or official capacity is a victim of child abuse."

• **Adult and Domestic Abuse:** If there is reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we reserve the right to report this to responsible agencies or providers involved with the vulnerable adult (e.g., physician, residential or nursing facility, Office of Aging). Your signature of this form indicates your consent with our right to report elder abuse.

• **Driving Risk:** Pennsylvania law specifically requires that healthcare providers report concern about an individual's ability to operate a motor vehicle safely to the medical department of the Pennsylvania Department of Transportation.

• **Judicial or Administrative Proceedings:** Personal Health Information is privileged by state law. If you are involved in a court proceeding and a request is made for your records, we will not release information without the written authorization of your or your legal representative, including a subpoena. The privilege does not apply if you are being evaluated for a third party, or if the evaluation is court-ordered, or in certain other limited instances. You will be informed in advance if this is the case.

• **Serious Threat to Health or Safety:** If a client presents a clear and immediate probability of physical harm to him or herself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or appropriate authorities.

• **Workers' Compensation and Disability Claims:** If you file a workers' compensation claim or are in the process filing a disability claim, we may disclose information from your record as authorized by applicable laws.

IV. Client's Rights:

• **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected heath information. 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 to have confidential communications of PHI delivered by alternative means and/or at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we may be able to arrange to send your bills to another address.)

• **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, given your written request. This may be subject to certain limitations and fees. Upon request, the details of the request process will be discussed with you. Please understand that older records may be destroyed, and therefore no longer available, in accordance with applicable law or standards.

• **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request must be in writing, and we reserve the right to deny your request.

• **Right to an Accounting:** You have the right to request an accounting of certain disclosures that have been made. Upon request, the details of the accounting process will be discussed with you.

• **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from this office upon request, even if you have agreed to receive the notice electronically. Please see www.centrepsychology.com to review this notice at any time.

• **Right to restrict disclosures associated with marketing:** Disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require client authorization.

• **Right to restrict disclosures associated with out of pocket payment:** Clients have the right to restrict certain disclosures of PHI to health plans or insurance companies if the client pays out of pocket in full for services.

• **Right of notification:** Clients have the right to be notified following a breach of unsecured protected health information.

V. Psychologist's/Clinician's Duties:

• We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

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

• If we make significant revisions to policies and procedures which might affect the privacy of your personal health information, we will provide you with a copy of those revisions. If you are still in treatment at this office, you will be provided with a copy of the revisions in the manner permitted by law, generally by hand delivery at your next appointment. As needed, former clients may be mailed a copy of significant revisions to the most recent mailing address on file at our office. Updated notices of our privacy policies will always be available for review upon request at this office.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact this office in writing or by phone (address and phone number above). We recommend that such inquiries be done in writing.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to our office (address above).

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

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint, in accordance with the provisions of applicable law.

VII. Effective Date, Restrictions and Changes to Privacy Policy

Restriction: In the case of a minor child, age thirteen and under, the child's legal guardian has the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about the child for as long as the PHI is maintained in the record. However, psychotherapy notes including statements made by a child during therapy sessions will not be released, in order to protect the child's right to confidentiality, unless required by law or deemed to be in the best interests of the child.

Restriction: Individuals with legal authorization (Power of Attorney) have the right to inspect or obtain a copy (or both) of PHI in the mental health or billing records used to make decisions about the individual, purpose of evaluation, or purpose of treatment. However, psychotherapy notes and/or written reports will not be released without written documentation of power of attorney that specifies responsibility for health-related issues.

Restriction: This office expressly recommends against the client's use of electronic means of communication. This includes but is not limited to email and social media (e.g., Facebook). We will not initiate electronic communications unless absolutely necessary or no other means exist, and only with your written consent unless this is not possible.

Existing or former clients who decide to initiate electronic communication do so knowing that these communications cannot be protected, and will be discussed with the clinician as an aspect of treatment or evaluation.

Use of our website contact form for changing appointments or other purposes does not require you to include PHI (e.g. state your appointment date and time and our office will contact you).

If other providers or individuals contact this office about you by means of electronic communication (email, texting, etc.) we will not respond without your express written consent. If you anticipate this, please complete a written authorization today.

This notice will go into effect on February 24, 2014

_____

Client Signature Date

_____

Guardian/Power of Attorney Signature Date

_____

Witness Signature Date