Online Therapy Services
Intake Package

https://OnlineTherapy.co
Email: info@OnlineTherapy.co Phone: 1-833-835-7792 Fax: 866-299-2424

Guidelines for Online Therapy

Please go through the following guidelines to get the maximum benefit from your online therapy sessions:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for online therapy services, and the therapist will not record the session without the permission from the others person(s).
- We agree to use the HIPAA compliant video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You will need either a computer, a phone or a tablet with a camera, microphone, and a speaker and internet connection to attend online therapy sessions.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a safety plan that includes at least one emergency contact in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in online therapy sessions.
- You should confirm with your insurance company that the teletherapy sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

CHILD/ADOLESCENT INTAKE FORM

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

IDENTIFYING INFORMATION

Client's Name (*Last, First*) ____

Age_____ Date of Birth *(mm/dd/yyyy)* ________________ Place of Birth (*City, State*)__________________

Education __________________School ____

Home Street Address____

City ____State__________________ Zip______________

Name of the person completing the form (*Last, First*) _____________________________________

Relationship to the client____

CONTACT INFORMATION

Primary Phone Number______________________ Can we leave message: Yes No

Mother's Phone Number_____________________ Can we leave message: Yes No

Father's Phone Number______________________ Can we leave message: Yes No

Guardian's Phone Number____________________ Can we leave message: Yes No

Preferred mode for contact: Phone Text Voicemail Email

Emergency contact person's Name__________________________________ Phone__________________

FAMILY INFORMATION

Mother's Name (*Last, First*) ____

Age______ Date of Birth *(mm/dd/yyyy)* _______________ Occupation_____________________________

Phone: Primary___________________ Work _________________________ Cell ___________________

Email Address ____

Age at the time of marriage _______________ Age at the time of birth of child ______________________

Home Street Address____

City ____State__________________ Zip______________

Father's Name (*Last, First*) ____

Age______ Date of Birth *(mm/dd/yyyy)* _______________ Occupation_____________________________

Phone: Primary___________________ Work _________________________ Cell ___________________

Email Address ____

Age at the time of marriage _______________ Age at the time of birth of child ______________________

Home Street Address____

City ____State__________________ Zip______________

If living away from biological parents, information about foster parents / guardian:

Name	Age	Relationship	Education	Occupation

Siblings:

Name	Age	Relationship	Education	Get along well or not

History of mental health diagnosis in family: Yes No

Details____

CURRENT MEDICAL AND HEALTH INFORMATION

Current Height ___________________________________ Current Weight __________________________

Pediatrician's Name (*Last, First*) ____

Psychologist's/Psychiatrist's Name (*Last, First*) ____

Any medical conditions: Yes No

Details____

Any surgery, serious illnesses or accidents: Yes No

Details____

Asthma / respiratory problems: Yes No

Details____

History of abuse: Yes No

Details____

Allergies: Environmental_____________ Food______________________ Other____________ None

Last Evaluation	Date	Outcome
Vision		
Hearing		
Ear, Nose, Throat		
Neurologist		
Psychologist		
Medical Specialist		

Does the child wear eyeglasses or contact lenses: Yes No

Vision problems: ____

Does the child wear hearing aids: Yes No

History of childhood ear infection: None Rarely 1-2 times a year 3-4 times a year 5+ times a year

History of ear tubes / ear surgery: Yes No

Does the child take prescription medication: Yes No

Date onset _________________Reason ________________________ Outcome_____________________

PRE NATAL-HISTORY

While pregnant did mother have:

High Blood Pressure: Yes No Excessive Vomiting: Yes No

Bleeding / Spotting: Yes No Kidney disease: Yes No

Toxemia: Yes No Gestational Diabetes: Yes No

Threatened Miscarriage: Yes No German Measles (Rubella): Yes No

Illness other than Cold or Flu: Yes No Hospitalization required: Yes No

Premature labor: Yes No

History of substance abuse in mother during pregnancy: Yes No

Details ____

History of medication in mother during pregnancy: Yes No

Details ____

BIRTH HISTORY

Where was the baby born ____

Was labor induced: Yes No Helped by med: Yes No

Duration of labor ____

Was baby born: early (less than 38 weeks): Yes No late: (after 42 weeks): Yes No

Method of delivery: Spontaneous Vaginal Forceps / Suction Breech Cesarean

Reason ____

During hospital stay did baby have:
Jaundice: Yes No Antibiotic: Yes No Rash: Yes No Blue Spells: Yes No
Convulsions: Yes No Infection: Yes No Incubator Care: Yes No
Remain in hospital longer than normal: Yes No

DEVELOPMENTAL HISTORY

Approximate age at which the child reached these developmental milestones:

	Age	If exact age not known; it occurred		
		Early	**Late**	**Normal**
Hold up head				
Roll over				
Sit unsupported				
Respond to Own Name				
Crawled				
Stand alone				
Walk				
Talk				
Toilet train				
Feed her/himself				
Dress her/himself				
Jump				
Ride a Tricycle				
Read				
Throw & Catch a Ball				
Name Colors				

Please mark any areas which constitute a problem for the child:

Eating: Yes No
Sleeping: Yes No
Nightmares: Yes No
Thumb sucking: Yes No
Nail biting: Yes No
Bedwetting: Yes No
Getting along with friends: Yes No
Self-help skills (dressing, bathing, etc.): Yes No
Understanding Directions: Yes No
Unusual fears: Yes No

Details: ____

____

SCHOOL AND EDUCATIONAL INFORMATION

Age started: Daycare ___________ Nursery ___________Pre-school ___________Kindergarten ____________

Does the child refuse to go to school: Yes No Does the child enjoy school: Yes No

Is the child in special classes: Yes No

If yes, please specify____

Has the child ever repeated a grade: Yes No

If yes, which grade____

Is there family history of learning difficulties : Yes No

If yes, who and what kind/type: ____

Is the child making progress at school: Yes No

Are you satisfied with the school program for the child: Yes No

Does the child face trouble in these specific learning areas:

Math: Yes No Reading: Yes No Writing: Yes No
Verbal/Oral Expression: Yes No Understanding instructions: Yes No

SOCIAL AND EMOTIONAL INFORMATION

Child's major interest and hobbies____

____

Is the child involved in extracurricular activities: Yes No

If yes, what kind____

Does the child have Friends: Yes No

If yes, how many ____________________ Age range____

Does the child have difficulty making friends: Yes No

Does the child have difficulty maintaining friendship: Yes No

Does the child have behavioral problems at school: Yes No

Details ____

Does the child have behavioral problems at home: Yes No

Details ____

Does the child have any of the following psychological symptoms:

Sad / depressed mood	Anger	Panic
General Anxiety	Social Anxiety	School Anxiety
Insomnia	Inattention	Restlessness
Family Stress	Suicidal thoughts	Self-harm
Homicidal thoughts	Bullying	Substance Use
Elopement	Sexuality Concerns	Other

Has the child experienced any traumatic events (e.g., death of a close relative/friend, accident): Yes No

If yes, please describe ____

Any other comments that will help us understand the child better: ______________________________

____

____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Online Therapy Services for myself and/or my family members.

By signing this consent form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

☐ By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name)_______________________________________
Printed Name: ____
Date:____

HIPAA NOTICE OF PRIVACY AND HEALTH INFORMATION PRACTICES

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

This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective January 17, 2008, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the State and/or Nation;
- a source for public safety;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

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

Online Therapy Services may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes, as long as you *consent to receive evaluation or treatment services from the clinic.* To help clarify these terms, here are some definitions:

"Treatment, Payment, and Health Care Operations" Treatment is when a therapist provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a therapist consults with a clinical faculty member who has expertise in a clinical problem. Payment is when Online Therapy Services obtains reimbursement for your healthcare. An example of payment is when Online Therapy Services discloses your PHI to a health agency such as the Department of Social Services so Online Therapy Services may obtain reimbursement for your health. *Health Care Operations* are activities that relate to the performance and operation of Online Therapy Services. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination, conducting training and educational programs or accreditation activities.

"Use" applies only to activities within Online Therapy Services such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of Online Therapy Services, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

Online Therapy Services may use or disclose PHI for purposes outside treatment, payment, or healthcare 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 Online Therapy Services is asked for information for purposes outside of treatment, payment or healthcare operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that Online Therapy Services has relied on that authorization for your ongoing treatment and/or payment of services.

Uses and Disclosures with Neither Consent nor Authorization

Online Therapy Services may use or disclose PHI without your consent or authorization in the following circumstances:

- *Abuse* – If we have reason to believe that a minor child, elderly person or disabled person has been abused, abandoned, or neglected, Online Therapy Services must report this concern or observations related to these conditions or circumstances to the appropriate authorities.

- *Health Oversight Activities* – If the Virginia Board of Psychology is investigating a clinician that you have filed a formal complaint against, Online Therapy Services may be required to disclose protected health information regarding your case.

- *Judicial and Administrative Proceedings as Required* – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, we may be compelled to provide the information. Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order Online Therapy Services to disclose personal health or treatment information. Online Therapy Services will not release information without your written authorization, or that of your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a

third party (e.g. Law enforcement agency or Social Security) or where the evaluation is court ordered. •

- *Serious Threat to Health or Safety* – If you communicate to Online Therapy Services personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s) including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

- *Worker's Compensation* – Online Therapy Services may disclose protected health information regarding you as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- *National Security*- We may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may be required to disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances. *Research*- Under certain limited circumstances; we may use and disclose health information for research purposes. All research projects, however, required prior approval by the Department of Psychology Human Subjects Committee and an institutional review board.

Your Health Information Rights:

Although your health record is the physical property of the Online Therapy Services, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

Online Therapy Services is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice

- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact Online Therapy Services at Phone: (833) 835-7792 Fax (866) 299-2424.

If you believe your privacy rights have been violated, you have the right to complain to us at the above address or to the Secretary of Health and Human Services. We support your right to the privacy of your health information. You will not be penalized, retaliated against, or otherwise treated differently for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I have received a copy of the Notice of Privacy Practices from Online Therapy Services

By signing this form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

☐ By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name) ______________________________________
Printed Name: ____
Date:____

PATIENT-THERAPIST AGREEMENT

This document contains important information about our professional services and business policies. It also contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal Law that provides privacy protections and patient 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. HIPAA requires that we provide you with a Notice of Privacy practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. 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 represent an agreement between us.

Therapy Services are provided by lot of different professionals including Psychiatrists, Psychologists, Licensed Professional Counselors (LPC), Marriage and Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), or Marriage, Family, and Child Counselors (MFCC). For this agreement purposes "Therapist" will refer to any or all but not limited to this set of professionals.

Therapy services include all types of Psychological Therapy, Counselling, Life-coaching and other similar techniques and methodologies. For this agreement purposes, "Therapy" will refer to any or all but not limited to this set of services.

Confidentiality

Your therapy will include talking over very private things with the Therapist. To some extent their ability to help you will depend on how open you can be about yourself – your ideas, feelings, and actions. So that you can feel free to talk openly with a Therapist and so that your right to privacy is protected, the law makes it a therapist's duty to keep patient information confidential. This means that, with some very limited exceptions (some noted below), they cannot reveal information about you to anyone else or send out information about you without your permission. If you are in family or couple's therapy (where there is more than one client), and you want to have my records of this therapy sent to someone, all of the adults present will have to sign a release.

If you ever want the Therapist to share information with someone else (for example, your physician), you will need to sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require you to provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

Minors:

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, the Therapist will provide them only with general information about their work with you, unless they feel there is a high risk that you will seriously harm yourself or someone else. In this case, they will notify them of their concern. However, before giving them any information, therapist will, if possible, discuss the matter with you.

Exceptions to Confidentiality

There are exceptions to confidentiality that you should know about. Please note that while most of these situations are rare, they are important for you to understand. Exceptions to confidentiality include, but are not limited to, the following:

1. If you threaten to harm someone else, the Therapist is required under the law to take steps to inform the intended victim and appropriate law enforcement agencies.
2. If you threaten to cause severe harm to yourself, the Therapist is permitted to reveal information to others if they believe it is necessary to prevent the threatened harm.
3. If you reveal or the Therapist has reasonable suspicion that any child, elderly person, or incompetent person is being abused or neglected, the law requires that the Therapist report this to the appropriate county agency.
4. If a court of law orders the Therapist to release information, they are required to provide that specific information to the court.
5. If you have been referred to the Therapist by a court of law for therapy or testing, the results of the treatment or tests ordered may have to be revealed to the court.
6. If you are or become involved in any kind of lawsuit or administrative procedure (such as worker's compensation), where the issue of your mental health is involved, you may not be able to keep your records or therapy private in court.
7. If you see the Therapist in couples, group, or family therapy, each member of the therapy promises to keep whatever happens in treatment confidential. However, the Therapist cannot guarantee that others will keep this agreement.
8. In order to provide you the best treatment, there will be times when the Therapist may seek consultation from another licensed mental health professional. In these consultations, they make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well.

The laws and rules on confidentiality are complicated. If you are in a situation in which you need advice regarding special or unusual concerns, we strongly suggest that you talk to a lawyer to protect your interests.

Special Situations: Separation, Divorce, and/or Custody Disputes

If you are considering bringing your child for therapy, then the Therapist will always ask whether you are separated or divorced and whether a legal decision has been made about legal custody and physical custody of the child. Except in an emergency, if parents have joint legal custody then the Therapist shall contact the other parent and obtain their consent before they begin to see the child in therapy. In most states, this is a legal requirement - when parents have joint legal custody then both parents must consent to the treatment. Furthermore, in most circumstances having both parents involved in the child's therapy is beneficial to the child and their therapy. The Therapist may contact the other parent in situations in which one parent has sole legal custody of the child because it is beneficial to the child when both parents support the treatment. Of course, all situations are not the same and you will have an opportunity to talk about your specific family before the Therapist contacts anyone else.

If you are in therapy and you are involved in a divorce or custody dispute, the Therapist will not provide testimony in court on any subject other than your therapy. You must hire a different mental health professional for any evaluations you require. This position is based on the following: (1) The Therapist's statements may be seen as biased in your favor because you have a therapy relationship; (2) most, or even all, of the information the Therapist has about you has been provided by you and the Therapist does not have independent information about parenting or custody; and (3) the Therapist's testimony might affect the therapy relationship.

We encourage you to ask any questions you have about therapy, about the Therapist's professional background, and about what you have read in this agreement. In the unlikely event that problems arise during treatment that we cannot resolve together, we can refer you to other therapists for a consultation.

Therapy Services and Process

Therapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the concerns that are being addressed in Therapy. There are many different methods that therapist may use to deal with the problems that you hope to address. Therapy is not like a medical doctor visit; it calls for an active effort on the part of the patient. Therapy can aid you in discovering tools and techniques that can be utilized to improve the quality of your life and your relationships. Therapy involves change, which may feel threatening not only to you but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel very vulnerable. The process can include experiencing feelings like sadness, guilt, anxiety, anger, and fear and making changes that you did not originally intend. Like any professional service, therapy may not work, and for a relatively small number of people, problems may get worse. Even so, many people find that therapy is worth the discomfort they feel. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

As the patient involved in this process, you have the right to ask the Therapist about their professional experience, background, and theoretical orientation.

The Therapy Process

Initially, the Therapist will hold a session with you to evaluate the concerns that bring you to therapy and will give you some initial impressions of the kind of treatment that would be helpful to you. During the first few sessions, you should be thinking about whether you feel comfortable working with them. Because therapy may involve a substantial commitment of time, money, and energy, it is important that you feel comfortable with the therapist you choose. If you decide that you are not comfortable working with them, we would be happy to help you find another therapist. When you do decide to work with a therapist, they will develop goals and a treatment plan together. Once Therapy is initiated the Therapist will decide on a regular schedule of meetings; usually at least one session a week. If they decide that group therapy is appropriate, they will give you a separate group contract. You may discontinue therapy at any time, though we strongly encourage you to discuss it with them first. They can provide you with referrals to other therapists if that seems needed.

If you cancel or miss scheduled appointments and do not contact us for more than 30 days, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further obligation to the client.

Fees and Payments

The fee for initial intake session for an individual is $125 for a 45-50-minute session. The initial intake session for a couple is billed at $150 for a 45-50-minute session; or $225 for 75-minute session. Fee for subsequent sessions varies by the Type of Service and the Type of Therapist. Payment must be made by credit card or check when the session is scheduled, unless we agree otherwise. There is a $30 charge for returned checks/credit card payments. Regardless of payment option, credit card information will be maintained confidentiality on file for any missed or cancelled sessions within 48 hours of your appointment

time. Your credit card information will not be used for any other purposes unless you indicate therapy services can be billed to your credit card. If you would like your sessions to be automatically billed to your credit card, please authorize by initialing in the credit card authorization form.

If your account is overdue (unpaid), we may use legal or other means (courts, collection agencies, etc.) to obtain payment. Your account may be turned over for collection and you will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. If you fail to make any of the payments for which you are responsible in a timely manner, you will be charged a 1.5% service charge monthly on the remaining balance.

We reserve the right to change our fees at any time with a 30 days advance notice. You will receive an updated payment agreement.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is your responsibility to find out exactly what mental health services are covered for you by your insurance policy, and whether treatment needs to be pre-authorized. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require us to provide them with a code number that indicates a clinical diagnosis. The insurance company will sometimes ask for more information including symptoms, diagnoses, degree of impairment, and treatment methods. This will become part of your permanent medical record. Please understand that we have no control over how these records are handled at the insurance company.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

Once you have the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available, and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

Please note that the insurance contract is between you and your insurance company and the responsibility for your fees is yours. Consequently, disputes concerning coverage must be resolved by you with your insurance carrier. Further, even though payment may be sent from the insurance company directly to us, it is your responsibility for any balance not covered by your insurance. Unpaid bills may be turned over to a collection agency and/or an attorney and, if so, you will also be responsible for collection and/or legal costs.

Missed or Canceled Appointments

Please notify us two (2) business days in advance if you need to cancel or reschedule your appointment. Insurance companies cannot be billed, and will not pay, for missed or late-cancelled

appointments. Unless you give us two (2) business days in advance notice, and without exception, missed or canceled appointments will incur the usual charge.

If you cancel or miss scheduled appointments and do not contact us for more than 30 days, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further obligation to the client.

Telephone Calls and Text Messages

Telephone calls and text messages are not directly received by a Therapist, but are managed by the customer service response team. The response team forwards the message to the respective Therapist who will contact you as soon as possible. Please do not provide any confidential or private information as part of the message.

If you have an emergency, go to your nearest emergency room or call 911. We can not guarantee an immediate response from your therapist.

We do not charge for brief telephone conversations with the Therapist; however, extended phone calls (excess of 15 minutes) are billed at the prorated 45-minute session rate per 15-minute increments.

Email

Unfortunately, we have no way to ensure confidentiality over the Internet so, if you choose to contact by email, you are assuming all risks regarding the confidentiality of any information you send by email. Our communications to you via email will be for scheduling and billing only.

Please do not use email for emergencies. If you communicate confidential or private information via e-mail, we will assume that you have made an informed decision, and will honor your desire to communicate on such matters via e-mail.

E-mails from clients and former clients along with any responses that are related to treatment and diagnosis may be kept in respective treatment records. Emails also become a part of your legal records and may be revealed in cases where your records are summoned by a legal entity. Please be assured that current and former client e-mail information is always kept secure and not shared with any third parties.

ELECTRONIC SIGNATURE

By signing this agreement, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name) ______________________________________
Printed Name: ____
Date ____

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

Patient Information

Client's Name (*Last, First*) ____
Age_________ Date of Birth *(mm/dd/yyyy)* ____________ Place of Birth (*City, State*)___________________
Marital Status________________Education__________________Occupation__________________________
Home Street Address____
City ____State_________________ Zip_________________
Primary Phone Number__________________ Alternate Phone Number______________________________
Name of the person completing the form (*Last, First*) ____
Relationship to the client____

Primary Insurance

Name of Insurance Subscriber (*Last, First*) ____
Date of Birth (*mm/dd/yyyy*) __________________Relationship to Patient______________________________
Address______Same as above____
City ____State__________________ Zip__________________
Subscriber Employed By ____
Employer's Address____
City ____State__________________ Zip__________________
Insurance Co. _________________________Group #______________Member #________________________

Secondary Insurance

Is patient covered by additional insurance? Yes No
Subscriber's Name (*Last, First*) ____
Date of Birth (*mm/dd/yyyy*) __________________Relationship to Patient______________________________
Address______Same as above____
City ____State__________________ Zip__________________
Subscriber Employed By ____
Employer's Address____
City ____State__________________ Zip__________________
Insurance Co.__________________________ Group #______________Member #________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage. I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and copayments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Online Therapy Services. I authorized the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Online Therapy Services of the insurance benefits otherwise payable to me for all professional services.

Electronic Signature

By signing this form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name) ____
Printed Name: ____
Date: ____