TRUTHERAPY

CLIENT IDENTIFYING INFORMATION

CLIENT INFORMATION

Name: _____

DOB: _____

Address: _____

City, State, Zip Code: _____

EMERGENCY CONTACT

Full Name: _____

Contact Number: _____

Full Name: _____

Contact Number: _____

LEGAL GUARDIAN IDENTIFYING INFORMATION FOR MINOR CLIENTS

Please list all person(s) who have legal guardianship over the client.

Legal Guardian Full Name: _____

Relationship to Client: _____

Legal Guardian Phone Number: _____

Legal Guardian Full Name: _____

Relationship to Client: _____

Legal Guardian Phone Number: _____

Foster Agency Case Manager: _____

Foster Agency CM Phone Number: _____

DFCS Case Manager: _____

DFCS CM Phone Number: _____

CONSENT TO RECEIVE APPOINTMENT REMINDERS AND PATIENT PORTAL ACCESS

Cell Number: _____

Email: _____

Do we have your consent to send you text reminders?
☐ YES ☐ NO INITIAL HERE _____

Do we have your consent to send you email reminders?
☐ YES ☐ NO INITIAL HERE _____

Do we have your consent to leave you voicemails?
☐ YES ☐ NO INITIAL HERE _____

By initialing above, I authorize TruTherapy LPC and its affiliates to contact me by automated SMS text message, and email for appointment reminders, other various content, as well as, add me to TruTherapy LPC's patient portal and leave me voicemails when I cannot be reached. I understand that message/data rates may apply to messages sent by TruTherapy LPC under my cell phone plan. I know that I am under no obligation to authorize TruTherapy LPC to send me text messages. By initialing above, I indicate I am the primary user for the mobile phone number and email address listed above, I accept the risk explained above and consent to receive text messages and emails via automated technology from TruTherapy LPC and its affiliates to the phone number that I have provided.

I may opt-out of receiving these communications at any time by calling the front desk at (706) 843-6241. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text or email may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in text messages and emails may include my first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

MENTAL HEALTH COMPLAINTS

Primary Complaints at this Time:

☐ Depression	☐ Substance Abuse	☐ Eating Problems	☐ Anxiety	☐ Behavioral Problems
☐ Panic Attacks	☐ Phobias	☐ Trauma	☐ Relationship Problems	☐ Grief/Loss
☐ Adjustment	☐ ADHD	☐ Suicidal/Homicidal Thoughts	☐ Other _____	

Additional information about why you want to start services:

_____

_____

_____

My signature below shows that the above information is true and correct. I give permission for TruTherapy LPC to contact my emergency contact and/or legal guardian in case of emergency.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

Signer Initial Here: _____

CONSENT TO TREATMENT

This document contains important information about TruTherapy LPC's professional services and business policies. Although these documents are long and sometimes complex, it is very important that I understand them. When I sign this document, it will also represent an agreement between us. We can discuss any questions I have when I sign them or at any time in the future.

CONSENT TO MENTAL HEALTH SERVICES

My signature below indicates that I am seeking and consent to take part in treatment with a TruTherapy LPC licensed LPC, LMFT, LCSW and/or supervised LAPC, LAMFT, master's level clinician, or other related discipline. Clinicians are under the direct supervision of Candice Cruse, LCSW, CPCS and Felisha Lee, LPC, CPCS. If I have a preference(s) regarding licensure, I will relay my request to a TruTherapy LPC front desk staff member or management. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided. I am aware that I may stop my treatment at any time. The only thing I will still be responsible for is any outstanding financial responsibility. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I acknowledge that I have been given the opportunity to have all my questions answered fully. I understand that if I have any questions regarding the Consent for Treatment form, I can contact TruTherapy LPC at: (706) 843-6241.

PSYCHOLOGICAL SERVICES

I understand therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, I have certain rights and responsibilities that are important for me to understand. There are also legal limitations to those rights that I should be aware of. My therapist has corresponding responsibilities to me. These rights and responsibilities are described in the following sections. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of my life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on my part. To be most successful, I will have to work on things my therapist and I discuss outside of sessions.

PSYCHIATRY SERVICES

Psychiatry (medication management) services are available for established therapy clients. If I feel that psychiatry services will benefit me, I will speak to my therapist during my session. My therapist must refer me to psychiatry before I can make an appointment. If therapy services are terminated, psychiatry services will be transferred to my Primary Care Physician (PCP) or another provider of my choice.

CONFIDENTIALITY

TruTherapy LPC's policies about confidentiality, as well as other information about my privacy rights, are fully described in a Notice of Privacy Practices and Limits of Confidentiality. I have been provided with a copy of that document.

APPOINTMENTS

Appointments will ordinarily be 53 minutes in duration. Sessions may be scheduled as frequent as needed. TruTherapy LPC allows clients to schedule up to six (6) appointments in advance if seen weekly and eight (8) appointments if seen multiple times per week. I am encouraged to schedule in advance to ensure they are seen when needed. It is my responsibility to schedule my appointments. If I have not scheduled appointments or contacted the office in sixty (60) days or more will be discharged and will have to go through the intake process again to restart services. The time scheduled for my appointment is assigned to me and me alone. If I need to cancel or reschedule a session, TruTherapy asks that I provide two (2) full business days' notice. If I miss a session without canceling or cancel with less than 24 business hours' notice, TruTherapy LPC's policy is to collect a $50.00 cancellation fee for therapy appointments and $175.00 for psychiatric evaluations and $75.00 for psychiatric follow-ups. EXAMPLE: If my appointment is on Monday at 2 PM, I must cancel by 2 PM on Friday or if my appointment is on Tuesday at 8 AM I must cancel by 8 AM on Monday. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, I

will be responsible for the portion of the fee as described above. In addition, I am responsible for coming to my session on time; if I am more than 15 minutes late, my appointment will be canceled, and I will be charged a cancellation fee. If I exceed three (3) late cancelations within a four (4) month period, I will be placed on stand-by for two (2) months. While on stand-by I can only schedule appointments during the week the services are rendered, and I must be seen at least once per month. If I fail to meet the stand-by status criteria, I will be discharged and will not be able to return to services for six (6) months.

PROFESSIONAL RECORDS

TruTherapy LPC is required to keep appropriate records of the services provided. My records are maintained in a secure location in the office. TruTherapy LPC keeps brief records noting that I was here, my reasons for seeking therapy, the goals and progress we set for treatment, my diagnosis, topics we discussed, my medical, social, and treatment history, records received from other providers, copies of records we send to others, and my billing records. Except in unusual circumstances that involve danger to yourself, I have the right to a copy of my file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, TruTherapy recommends that I initially review them with my clinician or have them forwarded to another mental health professional to discuss the contents. I have the right to request that a copy of my file be made available to any other health care provider at my written request.

CONTACTING CLINICIANS BETWEEN APPOINTMENTS

I understand clinicians are not immediately available by telephone. They do not answer their phone when they are with clients or otherwise unavailable. If I need to speak with a clinician before my next session, please speak to the front desk about moving up my appointment or making an additional one. **If I feel I cannot wait for an appointment or if I feel unable to keep yourself safe, 1) contact Georgia Crisis and Access Line at 1-800-715-4225 or South Carolina Crisis and Access Line at 833-364-2274 or National Suicide Prevention Lifeline at 1-800-273-8255 2) go to my Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call.**

OTHER RIGHTS

If I am unhappy with what is happening in therapy, I will talk with my therapist so that they can respond to my concerns. Such comments will be taken seriously and handled with care and respect. I may also contact the front desk to request a transfer to another therapist.

My signature below shows that I understand and agree with these statements.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

TRUTHERAPY

FINANCIAL AGREEMENT

INSURANCE PROCESSING
TruTherapy LPC participates with a variety of insurance and EAP plans. TruTherapy LPC files my claims to my insurance company as a courtesy. I am financially responsible for all services not paid by my insurance company. It is my responsibility to bring my insurance card to every visit and notify us of any changes in my insurance coverage, and if I have secondary insurance or key demographic changes. In agreement with the services that will be provided by TruTherapy LPC, by signing below I agree and authorize my insurance company to pay TruTherapy LPC in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. By signing below, I authorize TruTherapy LPC to release any information necessary for seeking reimbursement for the services rendered to my insurance company. We will attempt to confirm my insurance coverage prior to my treatment; however, it is my responsibility to know my insurance benefits and eligibility. This includes whether we are a contracted provider with my insurance company, my covered benefits, any exclusions in my insurance policy, and any pre-authorization requirements of my insurance company. If I have any questions, please contact my insurance company.

OUT-OF-POCKET EXPENSES
The following fees are not billed to my insurance and are billed directly to the client:

- No Show/Late Cancellation
- Substance abuse and anger management assessments
- Records Requests (including FMLA forms, other forms, and letters)
- Medication Refills
- Multiple therapy sessions on the same day
- Phone triage with a therapist (calls to a therapist in between sessions)
- Court Appearance Fees
- Other fees not covered by your insurance plan

PAYMENTS
All applicable co-payments, deductibles, or any other out-of-pocket expenses are expected to be paid at the time of the appointment. Substance abuse assessment fees are due at the time of scheduling the appointment and are non-refundable. The copayments, deductibles, and out of pocket expenses are my responsibility and payments are expected at the time of my appointment. Payment is accepted by cash or credit card. TruTherapy LPC reserves the right to increase fees in the future to a reasonable amount and I will be given adequate advanced notice if this should occur.

CANCELED APPOINTMENTS
It is my responsibility to schedule and ensure that these appointments are kept. If I am unable to attend my scheduled appointment, I must call to cancel or reschedule my appointment at least 24 business hours before the appointment. Cancellations are only accepted Monday-Thursday 8:00 AM – 6:00 PM. I will be held responsible for any appointment that is not canceled within more than 2 full business days' notice (cancellations will not be accepted after hours, on the weekends, or through voicemail/email, see Consent to Treatment for additional information). Insurance companies will not pay for canceled appointments and that I will be required to pay $50.00 for each therapy appointment, $175.00 for each psychiatry evaluation appointment and $75.00 for each psychiatry follow-up appointment that is canceled late before I can schedule my next appointment. If I do not notify TruTherapy LPC that I will not be at my substance abuse assessment appointment (no show), I will forfeit my assessment fee and will not be able to reschedule without paying the initial fee again.

My signature below shows that I understand and agree with these statements.

Client Full Name: _____

Client Date of Birth: _____

_____ _____
Signature of Client OR Legal Guardian if Client is a Minor Date

_____
Printed Name of Legal Guardian if Client is a Minor

TRUTHERAPY

INFORMED CONSENT - INTERACTING WITH THE LEGAL SYSTEM

By signing below, I am agreeing to not involve or engage my clinician in any legal issues or litigation in which I are party to at any time either during my services or after services are terminated. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, TruTherapy LPC will provide I a copy of my records, and I will be responsible for charges in producing that record. If I believe it is necessary to subpoena my/my child's clinician to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for a maximum of four (4) hours to be paid five (5) days in advance of any court appearance or deposition. Any additional time that a therapist spends over four (4) hours would be billed at the rate of $375.00 per hour including driving time. If I subpoena my clinician, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my clinician.

My signature below shows that I understand and agree with these statements.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

Signer Initial Here: _____

TRUTHERAPY

LIMITS OF CONFIDENTIALITY

The contents of counseling sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy not to release any information without a signed release of information. Exceptions are as follows:

DUTY TO WARN AND PROTECT
When a client discloses intentions or a plan to harm another person, the healthcare professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. In addition, it may be necessary for the health care professional to take steps for the client to be placed in a restricted hospital environment to ensure the safety of the client and of others.

ABUSE OF CHILDREN AND VULNERABLE ADULTS
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse or neglect, the healthcare professional is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT
Other healthcare professionals must report professional misconduct by a healthcare professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released to substantiate disciplinary concerns.

COURT ORDERS
Health care professionals are required to release records of clients when a court order has been placed. Clients who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the county Juvenile Court may have waived certain rights to confidentiality when entering the treatment program.

MINORS/GUARDIANSHIP
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

AUDIO/VIDEO TAPING
In the event it becomes necessary to audio and/or video tape a client for treatment or supervision purposes, a specific consent form for audio and/or video will be required. No recordings of any kind will be conducted without the expressed consent of the client.

OTHER PROVISIONS
TruTherapy LPC does not conduct research on any of their clients. Outcome measures, as it pertains to the effectiveness or ineffectiveness of the treatment services are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any client is disclosed, nor can any client be identified by any outcome information collected. Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. In some cases, notes

and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couple's sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.
In the event in which the company or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

My signature below shows that I understand and agree with these statements.

Client Full Name: _____

Client Date of Birth: _____

_____ _____
Signature of Client OR Legal Guardian if Client is a Minor Date

_____
Printed Name of Legal Guardian if Client is a Minor

TRUTHERAPY

NON-RECORDING AGREEMENT

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room.

In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court, or governmental agency. Such loss could compromise or nullify my legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give my own recordings all the legal confidentiality they give to a therapist's office notes and may find them self-serving. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Additionally, most users of recording technology lack the technological tools and knowledge required to delete a recording in a way that makes it unrecoverable and unhackable. Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the client(s) and therapist(s). For these reasons and others like them, TruTherapy LPC maintains a strict policy on recording.

Therefore, by signing below, I agree that:

1. Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.
2. Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Therapists at TruTherapy LPC will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them. Violation of this policy by covert recording or non-conformance with this agreement will lead to termination of therapy.

My signature below shows that I understand and agree with these statements of the Non-Recording Agreement.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

Signer Initial Here: _____

TRUTHERAPY

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

To authorize mental health treatment for my child, I must have either sole or joint legal custody of my child. If I am separated or divorced from the other parent of my child, please notify TruTherapy LPC staff immediately. TruTherapy LPC will ask me to provide a copy of the most recent custody decree that establishes custody rights of I and the other parent or otherwise demonstrates that I have the right to authorize treatment for my child. If I am separated or divorced from the child's other parent, please be aware that it is my duty to notify the other parent that TruTherapy LPC is providing services to my child. It is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment. One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapists regarding the child's treatment. If such disagreements occur, the clinician will strive to listen carefully so that he or she can understand my perspectives and fully explain his or her perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables my child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides the services should end, TruTherapy LPC will honor that decision, unless there are extraordinary circumstances. However, in most cases, the clinician will ask that I allow the option of having a few closing sessions with my child to appropriately end the treatment relationship.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATIONS WITH THE CLINICIAN

During treatment with my child, the clinician may meet with the child's parents/guardians either separately or together. Please be aware, however, that, always, the patient is my child – not the parents/guardians nor any siblings or other family members of the child will be identified therapy clients with rights of psychological privilege unless a separate written contract is made to conduct family therapy mutually agreed to by the therapist and the parents. If the clinician meets with I or other family members during my child's treatment, he or she will make notes of that meeting in my child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to my child's treatment record as mandated by law.

MANDATORY DISCLOSURES OF TREATMENT INFORMATION

In some situations, TruTherapy LPC is required by law, to disclose information, whether I have my or my child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child clients tell the clinician that they plan to cause serious harm or death to themselves, and their clinician believes they have the intent and ability to carry out this threat in the very near future. Clinicians must take steps to inform a parent or guardian or others of what the child has told them and how serious the clinician believes this threat to be and to try to prevent the occurrence of such harm.
- Child clients tell the clinician they plan to cause serious harm or death to someone else, and the clinician believes they have the intent and ability to carry out this threat in the very near future. In this situation, the clinician must inform a parent or guardian or others and may be required to inform the person who is the target of the threatened harm [and the police].
- Child clients are doing things that could cause serious harm to them or someone else even if they do not intend to harm themselves or another person. In these situations, the clinician will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child clients tell the clinician, or the clinician otherwise learns that it appears that a child is being neglected or abused physically, sexually, or emotionally – or that it appears that they have been neglected or abused in the past. In this situation, the clinician may be required by law to report the alleged abuse to the appropriate state child – protective agency.
- The clinician is ordered by a Court to disclose information with proper releases or other legal exceptions.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is TruTherapy LPC policy to provide me with general information about my child's treatment, but NOT to share specific information my child has disclosed to me without my child's agreement. This includes activities and behavior that I would not approve of – or might be upset by – but that do not put my child at risk of serious and immediate harm. However, if my child's risk-taking behavior becomes more serious, then the clinician will need to use his or her professional judgment to decide whether my child is in serious and immediate danger of harm. If the clinician feels that my child is in such danger, he or she will communicate this information to me. Even when we have agreed to keep my child's treatment information confidential from me, the clinician may believe that it is important for me to know about a particular situation that is going on in my child's life. In these situations, the clinician will encourage my child to tell me, and the clinician will help my child find the best way to do so. Also, when meeting with myself, the clinician may sometimes describe my child's problems in general terms, without using specifics, to help me know how to be more helpful to my child.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS

Although the laws of the State of Georgia may give parents the right to see any written records TruTherapy LPC keeps about my child's treatment, by signing this agreement, I am agreeing that my child or teen should have a "zone of privacy" in their meetings with me and I agree not to request access to my child's written treatment records unless ordered by a Court or to transfer the record to another therapist who is serving my child.

APPOINTMENTS WITHOUT A LEGAL GUARDIAN ON PREMISE

I understand that if the client is 14 years of age or younger a legal guardian or authorized adult must remain at the same location as the client during the session and must be always available if needed. A legal guardian can authorize an adult by providing written consent to involve them in their treatment. I authorize TruTherapy LPC to provide services to my child who is 15 years of age or older when I am not present.

My signature below shows that I understand and agree with these statements. I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records to respect the confidentiality of my child's/adolescent's treatment. I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

TRUTHERAPY

TELEHEALTH CONSENT

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

- I understand if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
- I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If I am unable to reconnect within 5 minutes, please call our office at (706) 843-6241.
- I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
- I understand that I am responsible for (1) providing the necessary computer, telecommunications, equipment, and internet access for my telemental health sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telemental health session.
- I understand that if the client is 14 years or younger a legal guardian, or authorized[1] adult must be at the same location as the client during the telemental health session and must be always available if needed. If an authorized adult is with the client, then a parent must be on-call[2] during the session.
- I agree to inform my provider of the address where I am at the beginning of each session. I also need a contact person who my provider may contact on my behalf in a life-threatening emergency only. This person will only be contacted to go to my location or take I to the hospital in the event of an emergency.
- I may withhold or withdraw consent to the telehealth consultation at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- I agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

[1] An Authorized adult is any person 18 years or older that has permission from the client's parent or legal guardian to be present. A *Release of Information* legal document will need to be signed by the parent/guardian prior to the appointment to authorize the adult. This form will give TruTherapy LPC permission to discuss information about the client's mental health treatment with the authorized adult.
[2] A parent/guardian must be on-call if an authorized adult is present during the telehealth session. If the parent cannot be reached during an appointment, a warning will be given. If the parent cannot be reached a second time while on-call, then the client will have to come into the office for future services.

I have been advised of all the potential risks, consequences, and benefits of telehealth. My health care practitioner has discussed with I the information provided above. I have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All my questions have been answered, and I understand the written information provided above. My signature below shows that I understand and agree with these statements.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor

TRUTHERAPY

HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose my protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes my rights to access and control my protected health information. "Protected health information" or "PHI" is information about I, including demographic information, that may identify I and that relates to my past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. A new Notice will be effective for all PHI that we maintain at that time. Upon my request, we will provide I with any revised Notice of Privacy Practices. Copies of this Notice are available from our receptionists or by accessing our website http://www.TruTherapyLPC.com.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information for Which My Authorization Is Not Required. My PHI may be used and disclosed without my prior authorization by my provider, our office staff, and others outside our office that are involved in my care and treatment for the purpose of providing health care services to I, to pay my health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose my PHI to provide, coordinate, or manage my health care and any related services. This includes the coordination or management of my health care with a third party. For example, we would disclose my PHI, as necessary, to a home health agency that provides care to me. For example, my protected health information may be provided to a provider to which I have been referred to ensure that the provider has the necessary information to diagnose or treat I.

Payment: My PHI will be used, as needed, to obtain payment for my health care services. For example, obtaining approval for a hospital stay may require that my relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, my PHI to support the business activities of my provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose my PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where I will be asked to sign my name and indicate my provider. We may also call I by name in the waiting room when my provider is ready to see I. We may use or disclose my PHI, as necessary, to contact I to remind I of my appointment.

Other Permitted and Required Uses and Disclosures That May Be Made with My Opportunity to Object. We may use and disclose my PHI in the following instances. I have the opportunity to object to the use or disclosure of all or part of my PHI. If I am not present or able to agree or object to the use or disclosure of the PHI, then my health care provider may, using professional judgment, determine whether the disclosure is in my best interest. In this case, only the PHI that is relevant to my health care will be disclosed.

Others Involved in My Health Care: Unless I object, we may disclose to a member of my family, a relative, a close friend or any other person I identify, my PHI that directly relates to that person's involvement in my health care. If I am unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in my best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for the care of my location, general condition, or death. Finally, we may use or disclose my PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in my health care.

Emergencies: We may use or disclose my PHI in an emergency treatment situation. If this happens, we will try to obtain my consent as soon as reasonably practicable after the delivery of treatment. If my healthcare provider or another healthcare provider in our agency is required by law to treat I and the healthcare provider has attempted to obtain my consent but is unable to obtain my consent, he or she may still use or disclose my PHI to treat I.

Other Permitted and Required Uses and Disclosures That May Be Made Without My Consent, Authorization, or Opportunity to Object. We may disclose my PHI in the following situations without my consent or authorization:

Required by Law: We may use or disclose my PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
Public Health: We may disclose my PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury, or disability.
Communicable Diseases: We may disclose my PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose my PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.
Abuse or Neglect: We may disclose my PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose my PHI if we believe that I have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose my PHI to a person or company required by the Food and Drug Administration (i) to report adverse events, product defects or problems, biologic product deviations, track products; (ii) to enable product recalls; (iii) to make repairs or replacements; or (iv) to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose PHI during any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.
Law Enforcement: We may disclose my PHI, so long as applicable legal requirements are met, for law enforcement purposes.
Coroners, Funeral Directors, and Organ Donation: We may disclose my PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law: We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be disclosed for cadaveric organ, eye, or tissue donation purposes.
Research: We may disclose my PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of my PHI.
Criminal Activity: Consistent with applicable federal and state laws, we may use or disclose my PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel: (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of a determination by the Department of Veterans Affairs; or (iii) to foreign military authority if I am a member of the foreign military services.
Workers' Compensation: We may use or disclose my PHI as authorized to comply with workers' compensation laws and other similar legally established programs. Inmates: We may use or disclose my PHI if I am an inmate of a correctional facility and my health care provider created or received my PHI in the course of providing care to I.
Fundraising: We may contact me to raise funds. We may use and disclose my PHI, including demographic data, dates of health care provided, the department from which I received the services, the name of the treating physician, outcome information and health insurance status, to a business associate or institutionally related foundation for fundraising purposes without my authorization. I have the right to opt out of receiving fundraising communications from us, our business associates, and our institutionally related foundations. Each fundraising communication will provide I with a clear opportunity to elect not to receive further fundraising communications.
Required Uses and Disclosures: Under the law, we must make disclosures to I, and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with requirements of the Code of Federal Regulations, Part 45 Section 164.500 et seq.
Uses and Disclosures of PHI for which My Written Authorization Is Required. Other uses and disclosures of my PHI will be made only with my written authorization, unless otherwise permitted or required by law as described below. I make revoke this authorization, at any time, in writing, except to the extent that my provider or TruTherapy LPC has already taken an action in reliance on the use or disclosure indicated in the authorization. The following uses and disclosures will be made only with my written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.
2. **My Rights.** Following is a statement of my rights with respect to my PHI and a brief description of how I may exercise these rights:
I have the right to inspect and copy my protected health information. This means I may inspect and obtain a copy of my PHI that is contained in a designated record set for so long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that my health care provider and TruTherapy LPC uses for

making decisions about I. Under federal law, however, I may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, I may have a right to have this decision reviewed. Please contact our Office manager if I have questions about access to my medical record.

I have the right to request a restriction of my protected health information. This means I may ask us not to use or disclose any part of my PHI for the purposes of treatment, payment, or healthcare operations. I may also request that any part of my PHI not be disclosed to family members or friends who may be involved in my care or for notification purposes as described in this Notice of Privacy Practices. My request must state the specific restriction requested and to whom I want the restriction to apply. I also have a right to restrict certain disclosures of my PHI to a health plan if I have paid in full out-of-pocket for the health care item or service. My health care provider is not required to agree to a restriction that I may request. If my health care provider believes it is in my best interest to permit use and disclosure of my PHI, my PHI will not be restricted. I then have the right to use another healthcare provider. If my health care provider does agree to the requested restriction, we may not use or disclose my PHI in violation of that restriction unless it is needed to provide emergency treatment.

I have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

I may have the right to have my provider amend my protected health information. This means I may request an amendment of PHI about I in a designated record set for as long as we maintain this information. In certain cases, we may deny my request for an amendment. If we deny my request for amendment, I have the right to file a statement of disagreement with us and we may prepare a rebuttal to my statement and will provide I with a copy of any such rebuttal.

I have the right to receive an accounting of certain disclosures we have made, if any, of my protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to I, to family members or friends involved in my care, or for general notification purposes. I have the right to receive specific information regarding these disclosures that occurred after June 13, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

I have the right to obtain a paper copy of this Notice of Privacy Practices from us. I have a right to obtain a paper copy of this Notice from us, upon request, even if I have agreed to accept this Notice electronically.

I have a right to receive notifications of a data breach. We are required to notify I upon a breach of any unsecured PHI. PHI is "unsecured" if it is not protected by a technology or methodology specified by the Secretary. The notice must be made within 60 days from when we become aware of the breach. However, if we have insufficient contact with I, an alternative notice method (posting on website, broadcast media, etc.) may be used.

3. **Complaints.** I may complain to us or to the Secretary of Health and Human Services if I believe my privacy rights have been violated by us. I may file a complaint with us by notifying our Office manager of my complaint. **We will not retaliate against I for filing a complaint.** We are required by law to maintain the privacy of PHI, to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. If I have any objections to this form, please speak with our Office manager in person or at 706-843-621.

By signing below, I acknowledge I have received a copy of HIPPA Notice of Privacy Practices.

Client Full Name: _____

Client Date of Birth: _____

_____ _____

Signature of Client OR Legal Guardian if Client is a Minor Date

_____

Printed Name of Legal Guardian if Client is a Minor