CLIENT INTAKE SHEET

Provider: Francine Owens, LCSW, RPT Facility: Owens Family Counseling

Client Name_____
Client Address_____City_____State_____Zip _____
Client Phone (day)_____ (night)_____email_____
Date of Birth_____ SS#_____ Sex: Male or Female
Full time Student Yes or No---------- Marital Status: S M D W
Employer_____ Full Time Part Time
Address_____
Phone_____Ext._____Position_____

May we contact you at work regarding your appointment?_____In the event we are unable to contact you whom may we leave a message with regarding your appointments?_____Phone_____

Spouse Name_____SS#_____
Date of Birth_____Spouse's Employer _____
Address_____City_____State_____Zip_____
Phone_____Ext._____Position _____

Primary Insurance_____
Mailing Address_____
Subscriber's Name_____Social Security #_____
Date of Birth_____ID#_____Group#_____

Secondary Insurance_____
Mailing Address_____
Subscriber's Name_____Social Security_____
Date of Birth_____ID#_____Group#_____
Client Relationship to Subscriber _____

Please provide us with your insurance cards for claims filing.

Emergency contact:_____Phone _____
Family Physician:_____Phone_____
Who referred you to this office?_____

My signature below authorizes:

1. **Provider to release treatment and apply for benefits.**
2. **Payment of medical benefits directly to the Provider.**
3. **The release of any medical or other information necessary to process this claim.**
4. **Payment of all fees for services regardless of the fact that insurance may cover such fees; further the undersigned agrees that payment for services shall be made at the time of the services unless an alternate arrangement has been made.**
5. **Permits copy of the authorization to be used in place of the original.**

Client/Parent/ Guardian:_____**Date**_____

Owens Family Counseling
Medical History Form

Chart #_____

Name_____ **Age** _____ **M**_____ **F**_____

Medical History:

Please CHECK those, which you have had or now have. If past history, please give date.

EAR, NOSE, THROAT
- Sinus infection
- Strep throat by culture

RESPIRATORY
- Asthma
- Bronchitis
- Chronic cough
- Hay Fever
- Mononucleosis
- Pneumonia
- Positive tuberculin test
- Tuberculosis

HEART
- Heart problems/murmur
- High blood pressure
- Rheumatic fever

GASTROINTESTINAL
- Gallbladder problems or gallstones
- Hepatitis or jaundice
- Hernia
- Intestinal problems
- Pilonidal cyst
- Rectal problems
- Severe or recurrent Abdominal pain
- Ulcer (duodenal or stomach)

SKIN
- Hives or Eczema
- Serious skin disease

URINARY
- Frequent or painful urination
- Kidney or bladder infection
- Kidney stones
- Prostate infection
- Protein, blood or sugar in the urine
- Urethral discharge

SEXUAL TRANSMITTED DISEASE/INFECTION
- Chlamydia
- Gonorrhea
- Herpes
- Syphilis
- Venereal warts

WOMEN'S HEALTH
- Abnormal Pap smear
- Breast problems
- Menstrual problems
- Pelvic inflammatory disease
- Pregnancy

NEUROLOGICAL
- Headaches
- Migraines
- Paralysis
- Seizure disorder or epilepsy
- Severe head injury or concussion

MENTAL HEALTH
- Alcohol or drug treatment
- Anorexia or bulimia
- Depression
- Excessive worry and anxiety

ORTHOPEDICS
- Dislocations of _____
- Fractures, of _____

OTHER PROBLEMS
- Diabetes
- Thyroid
- Other hormone imbalance
- Tumor, growth or cancer
- Chicken pox
- Measles
- Mumps
- Rubella
- Other_____

Do you have DRUG ALLERGIES? Yes No If yes, list_____

Any other allergies: _____

List any medications that you take: _____

List any CURRENT DISEASES OR DISABILITIES which you have and any treatment which you are now receiving:

Are you current on all immunizations? Yes No

Have you taken the vaccine for COVID-19? Yes No

Give dates of your most recent immunizations: Tetanus _____ Tuberculin _____ Skin Test _____

OPERATIONS

Have you ever had surgery? Yes No

List: Appendectomy
Ovaries Removed
Gallbladder
Other_____
Hysterectomy, (If so, reason_____)
Joint Replacement
Bypass (if so, what _____)

Do you have a Living Will? Yes No

Foreign travel within the last year _____

Do you smoke? Yes No If yes, _____ per day/wk, How long _____
(NUMBER) (CIRCLE ONE)

Do you chew tobacco? Yes No If yes _____per day/wk, How long_____
(NUMBER) (CIRCLE ONE)

Do you drink alcohol? Yes No If yes _____per day/wk, How long_____
(NUMBER) (CIRCLE ONE)

Recreational drug usage? Yes No

Do you have any problems with sexual function Yes No

CHILD/ADOLESCENT ONLY:

Do you have any concerns regarding your child's use of drugs or alcohol? Yes No If yes, explain_____

Do you have any concerns about your child being sexually active? Yes No If yes, explain _____

Has your child been sexually abused? Yes No If yes, explain_____

Vision:

Vision Problems Yes No If yes, explain _____

Dental:

Dental Problems Yes No If yes, explain_____

_____ _____

Client/Guardian's Signature Date

OWENS FAMILY COUNSELING

Household Composition

(List all in your house at this time)

Confidential:

Client Name: _____ Case # _____

Name	Age	Relationship

I give my permission to contact the following in case of emergency:

Name: _____ Relationship _____

Address _____ Phone _____

Client/Guardian Signature: _____

Date: _____

Confidential Report of Primary Care

Patient Name: **Date of Birth**	**From: Francine Owens, LCSW, RPT**
To:	**26 Lamar Circle Suite 5** **Jackson, TN 38305**
City: **State:** **Zip:**	**Phone: (731) 660-5279**

The above named patient was recently referred to me at Owens Family Counseling for mental health services.

I hereby request and authorize the named provider/facility to release the medical information described below to my PCP/Center.

_____

Patient's Signature

Note: If patient requests information not to be released to PCP/Center, patient must sign here:

_____

My findings include the following:
Date of Visit: _____

DSM-V-TR Diagnosis:

_____

_____

_____

_____

Treatment Plans/Recommendations:

☐ Individual
☐ Group Counseling
☐ Family Counseling
☐ Substance Abuse Counseling
☐ Medication Management
☐ Other

Medication: _____

_____

_____

Other Pertinent Information: _____

_____

_____

Owens Family Counseling

Francine Owens, LCSW, RPT
26 Lamar Circle Suite 5
Jackson, TN 38305

Consent to Treatment

You have decided to embark on a powerful journey known as psychotherapy, a decision of strength and courage. Know that we consider the psychotherapeutic relationship to be one of sacred trust. This letter serves to inform you about the therapeutic process, give you some information, and answer questions about the professional relationship between therapist and clients.

Psychotherapy cannot insure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience as therapists that most people can gain some value from the therapeutic process. Know that as we journey together new, often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work, and other areas of life. Here are alternatives and many adjuncts to psychotherapy. These include, but are not limited to, medications, support groups, and complimentary modalities. I will be happy to discuss any alternatives you want to consider at any time.

We have a number of client expectations about the professional relationship we embark on with each client. We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients, their obligations, relations and your therapist the courtesy of a 24-hour notice if you must cancel an appointment; otherwise you will be charged for this time. We always consider broke appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments.

Our current fee is $130 for the intake and $100 for follow up sessions. The rates of other services such as co-joint therapy, family therapy, medical records, court reports, and court appearances may be requested. Payment for your session due at the time of service. We accept cash, personal checks, and credit cards. There is a 5% charge on all credit cards when used as payment. We work with a number of insurance companies via managed care contracts, and we are responsible for filing claims for our services; you must pay your copay at the time services are rendered. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference. Payment arrangements are discussed during your initial session. A collection agency will be utilized when warranted to collect delinquent accounts. This requires the release of identities to the collection agency. Collection costs will be the responsibility of the delinquent account.

We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $35. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence. We do not charge a customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Sessions are 45 to 50 minutes in length. Our therapist takes a few minutes of an hour between clients to relax, let go of the last session and prepare for the next one.

Our appointment times are generally on the hour from 8 AM to 5PM. We do make earlier and later appointments, but these are reserved for long standing clients. Our front office staff will schedule our next appointment at the end of each session. We are in the office Monday through Friday. You may reach us via telephone/voicemail during regular office hours. As our therapists are in session most of the day, they do often check voice mail and return messages several times a day. If your call is non-urgent, we will respond as soon as possible. Calls left for me after 5PM will be returned the following business day at the earliest. **If you are in a life and death emergency dial 911 for assistance or go immediately to your local emergency department**.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in the office. If you should encounter your therapist outside of the office the therapist will speak with you only if you initiate the contact; this allows you to maintain the privacy of your psychotherapeutic relationship. Please do not invite your therapist to social gatherings (including, but not limited to, parties, weddings, business meetings, etc.), offer gifts, or ask them to relate to you in any way other than the professional context of our therapy sessions. Although this may seem artificial and/or awkward, it is the best way to promote a good psychotherapeutic relationship.

Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; our therapist may occasionally share experiences and struggles with some regularity as models for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely. Our therapist will keep confidential anything you say with the following exceptions: a) you direct the therapist to speak about you with someone, b) the therapist determines that you are danger to yourself or others, or c) there is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DCS, and/or law enforcement authorities to attempt to prevent harm from coming to anyone.

Our therapists attend peer consultation with colleagues as needed. They may discuss the work occurring in your session in these sessions while maintaining your anonymity.

Our therapist uses an eclectic approach to therapy, meaning that they utilize a variety of therapeutic models. Our therapist works diligently to use what is most helpful for each individual rather than take any one approach exclusively. We hope this information is helpful to you. If at any time during your relationship with your therapist you have, any questions please feel free to ask.

I do hereby seek and consent to take part in the treatment provided by OFC. I understand that developing a treatment plan with Francine Owens, LCSW, RPT and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to be results of treatment or of any procedures provided by this therapist.

I am aware that I (or my child) may stop treatment with this therapist at any time. 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 am aware that an agent of my insurance company or other third-party may be given information about the type(s), cost(s), and provider of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____

Signature of Client (or person acting for client) Date

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client) and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date

Client Name_____ C.I.D. #_____

Owens Family Counseling

Francine Owens, LCSW, RPT

Policies and Practices to Protect the Privacy of Your Health Information

HIPPA and CONFIDENTILITY INFORMATION

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

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

Effective/Last Revised Date: June 15, 2008

Consultation and Counseling is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse health care administered by this agency. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it in our agency office or on the website.

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

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

II. Uses and Disclosures Requiring Authorization

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- Where required by law.

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

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **To process** claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFCS, Psychiatric Hospital, CMHC, etc., we may share summary information, admission, and discharge information with the referral source. In addition, we may share other health information with the referral source for case management purposes if the referral source agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical or mental health care to you.

We may use or disclose PHI ***without your consent*** or authorization in the following circumstances under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies. If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority. If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations. If we are the subject of an inquiry by the Georgia Composite Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena. If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent, subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **Serious Threat to Health or Safety.** If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws relating to job-related injuries. We 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.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then we will obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you have given us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based upon your authorization. To revoke an authorization, contact the phone number listed below on this notice.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.
- *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise these policies and procedures, we will notify you by mail or on your next session. You may obtain a copy of this notice at the local office or website.

V. Complaints

- **Contacting Francine Owens If** you have any questions about this notice or want to exercise any of your rights, please call 845-473-4939. Please specify that your question or concern is in reference to your mental health and/or substance abuse protected health information.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

Compliance Department – Privacy Complaints
Francine Owens
26 Lamar Circle, Suite 5
Jackson, TN 38305

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any adverse action against you for filing a complaint.**

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by clinic staff at least 24 hours prior to the scheduled session will be billed at the session rate. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

_____ _____will assist you in completing and filing any insurance forms, which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered.

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

This notice will go into effect on October 1, 2006. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

IX. Patient's Consent

I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of practices and policies and I both understand and approve of its content.

_____ _____
Printed Name of Client Witness

_____ _____
Signature of Client and/or Guardian Date

Owens Family Counseling

Francine Owens, LCSW, RPT
26 Lamar Circle Suite 5
Jackson, TN 38305

TELEHEALTH CONSENT FORM

I, _____ (Client) hereby consent to engage in Telehealth with Francine Owens, LCSW, RPT (Therapist).

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 client's health care.

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

I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.

I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

I understand that miscommunication between myself and my therapist may occur via Telehealth.

I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person

services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance clients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the client's responsibility (i.g. co-payments)], and I have been provided with this information in the Informed Consent Form.

I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint or family therapy, clients may sign individual consent forms or sign the same form.]

_____ _____

Client/Parent/Guardian Signature Date

_____

Client's Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with Client/Parent/or Guardian. Client, Guardian or other representative understands and agrees to the above advisements, and Client has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____ _____

Therapist's Signature Date

Owens Family Counseling
Authorization For Release Of Confidential Information

Chart#:_____

Client Name:_____ **DOB:**_____ **SS#**_____

Information is being released between **Owens Family Counseling** and

_____ _____ _____
Specify individual or organization | Address (city, state, zip code) | Telephone/Fax#

_____OFC is authorized to **release** information _____ OFC is authorized to **receive** information

Purpose of Disclosure: ___Continuing Care ___Court ___Family Involvement ___Insurance
___At the request of the Individual ___Other, please explain: _____

Choose From the Following:

___Psychological Assessment
___Verbal Communication
___Entire Chart
___Clinical Progress Notes
___Discharge Summary
___Lab
___Medical Assessment
___Letter
___Nursing Notes
___Treatment Plan
___Medical Progress Notes
___Other, specify_____

I understand that: I may revoke this authorization in writing any time prior to its expiration date by notifying the releasing agency in writing. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/agency providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that disclosing person/agency or receiving organization has taken action in reliance on this authorization.

I am not required to sign this form in order to receive services from OFC. The receiving person/agency is released from any liability and the undersigned will hold the receiving person/agency harmless for requesting or seeking my confidential health information.

The authorization will expire in six (6) months unless I provide an alternative date or event. This authorization will not apply to any dates of services that occur after the date this authorization is signed.

Expiration date: _____unless specified alternative date/condition of expiration:
_____

My signature also means that I have read this form and/or have had it read to me and explained to me in a language that I can understand. I authorize the release of the above requested health information.

_____ _____
Client signature | Date | Client's Authorize Representative /Relationship | Date

_____
Witness | Date