Gloria Dove LPC, NCC
Phone • (469) 670-2548
gloriadove@sbcglobal.net • www.gloriadove.com

Therapist: _____

AGREEMENT FOR PAYMENT AND FINANCIAL RESPONSIBILITIES

Gloria Dove works with a mission to improve emotional, and relational well-being through quality and affordable counseling, professional training, and community education. The standard fee for a first evaluation appointment is $175 and the standard fee for ongoing counseling is $125 per 60-minute session. We also have sliding scale for those whose income cannot support the standard fee. Annually we review fees and renew the agreement for payment. There is a cost of living increase typically 1-2% each year. Please complete the following and return to your counselor.

Client's Name:_____ **Date of Birth:**_____ **Age:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____ **County:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone**: _____

Email:_____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: _____

Employer/School:_____ **Occupation/Year in School:**_____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_____

Spirituality:_____ **Importance to You:**_____

Parent or Guardian (if under 18)_____

Who Referred You? Name:_____ Phone:_____

May your therapist acknowledge the referral? ☐ Yes ☐ No

Emergency Contact: Spouse/Partner/Other: **Name:**_____ **Relationship:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Permission to Call: ☐ **Yes** ☐ **No** **Restrictions?**_____

Secondary Client's Name:_____

Date of Birth:_____ **Age:**_____ **Email:**_____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: _____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_____

Please list any additional people who will be attending the counseling session

Additional Name (As needed):______________________________________

DOB:____________**Age:**________________**Email:**____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: ____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other________

Additional Name (As needed):______________________________________

DOB:____________**Age:**________________**Email:**____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: ____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other________

Additional Name (As needed):______________________________________

DOB:____________**Age:**________________**Email:**____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: ____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other________

Additional Name (As needed):______________________________________

DOB:____________**Age:**________________**Email:**____

Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender**: ____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other________

Party responsible for payment: Self:________Other/Relationship:____

Please Print Name of Insured

Insurance (The office will need a copy of both sides of your insurance card.)

Primary Insurance:____Phone:____________________________________

Insured Name:_____________________________________DOB:_______________SSN #:__________________________

ID #:_____________________________Group:________________Employer:_____________________________________

**Authorization # (if required by insurance company):____

****If I fail to obtain authorization, I am responsible for payment to Gloria Dove. for the denied session.**

Secondary Insurance:_______________________________Phone:____

Insured Name:_____________________________________DOB:_______________SSN #:__________________________

ID #:_____________________________Group:________________Employer:_____________________________________

**Authorization # (if required by insurance company):_____

****If I fail to obtain authorization, I am responsible for payment to Gloria Dove. for the denied session.**

1. I am responsible for obtaining all authorizations and for all charges not covered. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose).

2. My therapist may discuss accommodations in special circumstances (i.e. video therapy, phone sessions); it is my responsibility to determine insurance coverage for these sessions or to cover the cost of the service at the agreed-upon rates.

3. I authorize Gloria Dove staff to communicate with my insurance company for the purpose of claim verification and authorization for services, including a diagnosis code, and for my insurance carrier to release information regarding my coverage to Gloria Dove. I authorize the release of any medical or other information necessary to process this claim.

4. My right to payment for all services are hereby assigned to Gloria Dove. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Gloria Dove.

5. I understand that I have a right to request and receive a Notice of Privacy Practices from Gloria Dove.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Based upon my coverage, contract, and/or subsidized fee plan, I agree to pay the following for my services:

$_____for each office visit (deductible/co-pay/co-insurance or self-pay fee)

$_____for appointments cancelled with less than 48-hours' notice (unless an exception is granted by my therapist)

$_____for Video Therapy sessions not covered by insurance (at the discretion of my therapist)

$_____for phone consultations/sessions longer than 15 minutes (at the discretion of my therapist)

I have read the above statements and accept the terms.

Client Signature or Authorized Persons Signature **Date/Time** AM or PM (circle one)

Responsible Party Signature **Relationship** **Date/Time** AM or PM (circle one)

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HEALTH HISTORY

1. Name_____ Date of Birth _____
   Occupation_____
   In Case of Emergency Contact _____
   Phone Number_____ Relationship_____
   Children and Ages _____
   _____
2. Primary Care Physician_____ Phone Number _____
3. Serious Medical Illness/Accidents (Identify and give dates) _____
   _____
   _____
4. Are you currently on any medications? □ Yes □ No
   If yes, please list _____
   Any past medications? (May use back of form) _____
5. Surgeries or operations (Identify and give dates)_____
   _____
6. Any hospitalizations? □ Yes □ No
   If yes, when and for what reason _____
7. Have you ever been treated for depression/anxiety? □ Yes □ No
   If yes, by whom?_____ □ Internist □ OB/GYN □ Psychiatrist
   Please list any medications prescribed _____
8. Have you had any previous counseling? □ Yes □ No
   If yes, with whom and when? _____
9. Are you or have you been in the care of a psychiatrist? □ Yes □ No
   If yes, with whom and when?_____
10. Have you ever been treated for alcohol or drug abuse? □ Yes □ No
    If yes, when and where?_____
11. Have you been the victim of physical or sexual abuse? □ Yes □ No
12. Do you have suicidal thoughts? □ Yes □ No
13. Have you had a suicidal attempt? □ Yes □ No If yes, when? _____
14. Do you or have you had an eating disorder? □ Yes □ No
15. Do you have a history of infectious diseases? □ Yes □ No If yes, please describe _____

16. Do you have any allergies? □ Yes □ No
    If yes, please describe any adverse reactions _____
17. Is there past or present nicotine use? □ Yes □ No

Client Signature:_____ **Date:** _____

Legal Guardian Signature:_____ **Date:** _____

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CONSENT FOR SERVICES

Gloria Dove works with a mission to improve emotional, and relational well-being through quality and affordable counseling, professional training, and community education. This document contains important information about the services and policies of Gloria Dove. Please review the information carefully, sign the document, and discuss any questions with your therapist.

Confidentiality
Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. It is the policy of Gloria Dove to protect the privacy of every client to the maximum extent possible. Generally, information about you or services furnished to you will not be released without your prior written consent. There are, however, some circumstances which require the disclosure of information without your consent, such as when:

a) mandated by state or federal law due to suspicion or knowledge of child abuse and/or neglect or elder abuse and/or neglect,
b) there is an imminent risk or serious threat of physical harm to self or to others, and
c) specifically ordered by a court of law.

In accordance with the quality assurance standards set by Gloria Dove's licensing board, The Texas State Board of Examiners of Professional Counselors, your file may be reviewed to ensure record keeping compliance. Also, your therapist may anonymously discuss your treatment with a supervisor to ensure the provision of quality care. All Gloria Dove supervisors and staff are obligated to follow laws of confidentiality.

Cancellation Policy
Gloria Dove requires 48-hour notice in the event you need to cancel or reschedule your appointment. To cancel or reschedule your appointment contact your therapist by calling their direct dial phone number, or you may contact the front desk at 469-670-2548 between 8:30am and 4:30pm, Monday through Friday. After hours, you may contact the front desk and leave a detailed message.

Appointments that are cancelled or missed without the 48-hour notice will be billed to your account in the amount that Gloria Dove would collect if the service had been provided as scheduled. Insurance does not reimburse for missed appointments; therefore, you are responsible for full payment of this fee. Please discuss with your therapist any questions about the cancellation policy.

Messages
If you need to contact your therapist outside of your scheduled appointment, you may contact them by calling the direct dial phone number, please call 469-670-2548 between 8:30am and 4:30pm, Monday through Friday. After hours, you may contact the front desk at 469-670-2548. Messages are reviewed by the following business day. If you experience a mental health crisis, please review the section on emergencies below. Please discuss with your therapist any questions about how she handles messages.

Emergencies
Please discuss with your therapist how to handle emergencies. If you experience a mental health crisis outside of a session there are several resources for help. These resources are available 24 hours per day, 365 days per year. Alternatively, you may go to the nearest Emergency Room or call 911.

Fees and Insurance
The fee for your first appointment is determined during the intake process. At the first appointment, you and your therapist will establish the ongoing appointment fee. Payment is expected at the time of your appointment. Gloria Dove accepts cash, checks, MasterCard, Discover, and Visa.

Gloria Dove accepts Medicare and some insurance as in-network, and other insurance as out-of-network. This varies per the individual therapist / provider, so please discuss this further with your therapist. If you select to use your insurance, we will assist you in answering basic questions about your benefits, as well as submit claims on your behalf. You will need to provide

your current insurance identification care at the time of your initial appointment. Your plan may include deductibles, co-insurance, and co-pays. Ultimately, you are responsible for payment and understanding your insurance policy.

The standard fee is $175 for an initial appointment, and $125 for ongoing appointments. For those whose household income does not support the standard fee, a sliding-fee scale may be available.
Eligibility for these adjustments depends on case by case situation. Please discuss this information further with your therapist.

Gloria Dove is a for-profit counseling center, and timeliness of payments is important. Overdue accounts may result in formal collection procedures.

Client Rights
All clients of Gloria Dove. maintain their rights to the following:

Personal Rights
1) The Client must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
2) The Client has the right to have staff make fair and reasonable decisions about treatment and care.
3) The Client may not be filmed, taped, or photographed unless he/she agrees to it.

Treatment and Related Rights
1) The Client must be provided prompt and adequate treatment and services appropriate for them.
2) The Client must be allowed to participate in the planning of their treatment and care.
3) No treatment may be given to the client without written, informed consent, unless it is an emergency to prevent serious physical harm to self or others, or a court orders it.
4) The Client must be informed in writing of any costs of care and treatment for which he/she or relatives may have to pay.

Record Privacy and Access
1) See HIPAA Privacy Practices notice.

Grievances
Gloria Dove aims to provide all our clients with high-quality mental health care that will offer hope and healing. In the event you are dissatisfied with the services you or your loved one receive; you retain the right to advocate for on your/their behalf.

For clinical complaints, the procedures are as follows:
Step 1: Clients are encouraged to talk with the counselor to see if the complaint can be responded to and resolved at that level.
Step 2: If the client and counselor cannot achieve satisfactory resolution to the complaint, the client may request a referral for another therapist.

For administrative or financial complaints:
Step 3: The client may present a written statement describing the complaint to Gloria Dove, and we will respond to the complaint within 30 days.

Termination of Services
Clients have the right to end treatment at any time. Please notify your therapist of your desire to complete therapy. She/he may request to have a final session with you to allow for therapeutic termination and to provide aftercare planning. Services through Gloria Dove may be terminated for a variety of other reasons, including but not limited to:

- there is mutual agreement by the client and counselor to end counseling
- the client does not return for counseling or reschedule for 60 days
- the counselor decides to discontinue counseling because it is no longer effective or because the client does not comply with treatment recommendations
- the client is engaged in residential or inpatient treatment (i.e. hospitalization) and does not expect to return to counseling
- Gloria Dove therapists may use their clinical judgment to determine a client needs to be referred to another clinician or to another provider organization to ensure appropriate treatment
- Gloria Dove reserves the right to terminate with a client who has violated cancellation policies to the point that it has become disruptive to their treatment and/or to the therapist's schedule

Please note that clients are still responsible for making payments on all balances after they have ended treatment, no matter the circumstances. Clients are welcomed to return to treatment with Gloria Dove.

Client Consent

My signature below indicates that I reviewed this document, agree to the policies, and authorize the services. I accept financial responsibility for payment of services received, and for payment of late cancellations. If I use insurance to pay all or a portion of the charges, I hereby authorize the release of information necessary to process insurance claims filed on my behalf. I acknowledge that I am financial and legally responsible for the full payment of charges for services received in the event my health insurance policy does not cover my claim. I am 18 years of age or older or I have legal custody of this minor child(ren).

Client Name (Print): _____

Client Signature: _____ **Date:** _____

Custodial Parent or Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Notice of Privacy Practices/HIPPA

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- **Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- **Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

- **Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Get a list of those with whom we've shared information**

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting the U.S. Department of Health and Human Services Office for Civil Rights by:
1.Sending a letter to 1301 Young Street - Suite Dallas, TX 75202;
2.Calling (214) 767-4056; (214) 767-8940 (TDD); (214) 767-0432 FAX
or,
3.Visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/
We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**

We can share health information about you for certain situations such as: Preventing disease, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

- **Do research**

We can use or share your information for health research.

- **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

- **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

This notice is effective 05/19/2020. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Gloria Dove LPC, NCC
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gloriadove@sbcglobal.net • www.gloriadove.com

This is to acknowledge that I have received

Gloria Dove's Privacy Notice HIPPA

Name _____

Signature _____

Date _____

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Appointment Reminders

Gloria Dove is now offering the option for "Appointment Reminders." You can receive an appointment reminder to your cell phone (via a text message), your email address, or your phone (via a computer-generated voice message) the day before your scheduled appointment.

Please select **ONE** of the following options:

☐ **Text Message:** I authorize Gloria Dove to send text message appointment reminders to me on my provided cell phone number. Text message charges from my cell phone provider may apply.

Example of text message: "Do not reply-reminder-You have an appointment MON 01/11 at 4:00 PM – If you have any questions please call us at 469-670-2548 – Name of Counselor

Cell phone number to send text messages to: (_____)_____- _____

☐ **Email message:** I authorize Gloria Dove to send an email message appointment reminders to me on my provided email address.

Example of email message from ValantApptReminder@reminderXchange.com
Hello,
This is a reminder of your appointment on Monday – 01/11/2016 scheduled for 4:00 PM with NaTasha C. Jones. If you have any questions regarding your appointment, please feel free to contact us at: 469-670-2548.
Thank you.

Email address to send reminder messages to: _____

☐ **Automated Voice Messages:** I authorize Gloria Dove to send computer generated voice phone message appointment reminders to me on my provided phone number.

Hello. This is a reminder of your appointment on Monday, January 11, scheduled for 4 PM with Name of Counselor. If you need to reschedule or have any questions, feel free to call us at 469-670-2548. Once again, your appointment is scheduled for Monday, January 11, at 4 PM with Name of Counselor. Thank you.

Phone number for the automated system to call: ()_____- _____

☐ **None of the above:** I will remember my appointments on my own.

I understand that Late Cancellation and No-Show appointment fees will still apply.

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am giving my permission to receive appointment reminders as I have noted above. My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

_____ _____ _____
Printed Name Signature Date

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EMAIL CONSENT

CLIENT INFORMATION	
CLIENT NAME:	DATE OF BIRTH:
EMAIL ADDRESS:	

Gloria Dove will use and disclose Protected Health Information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA). Gloria Dove will use reasonable means to protect the confidentiality of PHI sent and received through email. However, because of the risks outlined below, Gloria Dove cannot guarantee the security and confidentiality of email communications and will not be liable for improper disclosure of confidential information that is not caused by Gloria Dove's intentional misconduct.

The risks of email communication include, but are not limited to:

- Email can be copied, circulated, forwarded, and stored in electronic files;
- Email, whether accidentally or intentionally, can be broadcast worldwide immediately and received by many unintended recipients;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the provider or client has deleted his or her own copy;
- Employers and online services may have a right to archive and inspect emails transmitted through their systems;
- Passwords providing access to email can be stolen and misused, or host systems can be compromised, leading to unauthorized disclosure of personal information;
- Email can be intercepted, altered, forwarded, or used without written authorization or detection;
- Email may not be answered in the time frame expected by the sender.

After reviewing the risks of email communication, you may authorize:

_____Unencrypted email communication, an unsecure method.

By authorizing the above method of email communication, you acknowledge and agree to the following:

- I understand that Gloria Dove will read and respond to email communication as promptly as possible; however, a specific turnaround time is not guaranteed. Thus, I will not use email for emergencies or other time-sensitive matters.
- I acknowledge that some or all information sent or received via email may concern my diagnosis and/or treatment. Email may be included in my medical record or forwarded internally to other Gloria Dove staff as necessary for diagnosis, treatment, payment, and other business purposes. Electronic information will not, however, be forwarded to independent third parties without my prior written consent, except as authorized or required by law.
- I understand that communication via unencrypted email is not secure and, therefore, Gloria Dove cannot guarantee the confidentiality of electronic PHI.
- I understand that Gloria Dove and its representatives are not liable for breaches of confidentiality caused by any third party or myself.
- I understand that I may, at any time, revoke my consent for email communications.
- Unless revoked in writing, this authorization will expire upon the later of the following events: 1) one (1) year after the date of my signature, or 2) the date on which I terminate care by Gloria Dove and its providers.

I hereby acknowledge that I have read and fully understand the information provided in this Email Consent.

_____ _____

Client Signature Date

RIGHT TO REVOKE

I request that my provider no longer use email to communicate with me.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

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CLIENT GUIDE TO TELEHEALTH SERVICES

"**Telehealth Services**" encompasses Video Therapy and Telephone Counseling. Telehealth involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with Gloria Dove. ("**Provider**") and a client who are not in the same physical location. Telehealth Services may be used for diagnosis, treatment, follow-up and/or education. Please note that prior to beginning Telehealth Services, new clients will be screened by phone by their Provider to ensure suitability for this treatment modality.

SATORI Family Services, LLC is dedicated to ensuring you receive the best possible care with minimal interruptions. Many clients and Providers are moving to Telehealth services during a national crisis and to ensure health, safety, and continuity of care. For most clients, services will return to meeting in the same physical location (Gloria Dove office) when possible and agreed upon between the client and Provider. Please discuss the duration of Telehealth Services with your Provider.

This guide is intended to help you successfully participate in Telehealth Services. It is not exhaustive and should not replace conversations with your Provider.

SETTING UP FOR VIDEO THERAPY

- To participate in Video Therapy, you will need the following technology:
  - A secure internet connection with at least 1mb of bandwidth
  - A computer or tablet with a video camera and microphone
- SATORI Family Services, LLC is utilizing Zoom to provide secure, confidential video therapy to our clients.
  - You can learn about Zoom at: www.zoom.us
- Once your appointment is scheduled, a SATORI Family Services, LLC staff member will send you a link to your Zoom session along with confirmation of your Provider's name, the appointment date, and time.
  - You will use the same URL for all future sessions unless your Provider tells you otherwise.
- Prior to your appointment, please check your bandwidth to ensure compatibility with the platform
  - Zoom requires 1megabyte per second (1mbps) bandwidth to operate
  - This free website can help you test your internet bandwidth: www.speedtest.net
- Please log in to the session a few minutes prior to your start time to ensure your connection is working
- Turn on your video and microphone
- Please ensure your Provider can see you
  - it is ideal to sit in a well-lit room and to have your face illuminated
  - please position the camera so that your Provider can clearly see your face

SETTING UP FOR TELEPHONE COUNSELING

- Your Provider will call you at a designated phone number at the start of your session time. Please be sure your Provider knows the best number to reach you.
- Have your phone and ringer turned on to ensure you hear your Provider's call.
- If you have not heard from your Provider within 10 minutes of the session start time, please contact her/him directly.

PRIVACY

- Gloria Dove values your confidentiality. To ensure your privacy in Telehealth Services, your Provider will connect with you from a space where she/he can reasonably ensure confidentiality and lack of interruption. Your Provider may use headphones and/or sound machines to enhance your privacy.
- To ensure your confidentiality, please set up in a private space where others will not be able to hear your conversation. Using headphones/earbuds with a microphone may help minimize what other people nearby can hear.

- Your Provider should be informed either in advance of or at the beginning of each session if someone else is in the room or will be participating in the session. Your Provider has the right to exercise her/his clinical judgment and decline to continue a session.
- To ensure the productivity of the session, please do your best to avoid interruptions. We suggest meeting privately in a room with a closed door. It is ideal to leave pets and other household members out of this space during the session.
- For Video Therapy:
    - Only use a secure internet connection. Using public Wi-Fi may mean that other people can access your information during your session.

WHAT TO EXPECT IN YOUR TELEHEALTH SESSIONS

- Your provider is obligated to confirm your location, as she/he is typically only authorized to serve clients in a state she/he is licensed in.
    - Please check with your provider prior to the session if you will be participating in sessions while located in a different state than your residence.
- Your Provider will work with you to ensure you have access to local crisis resources in case of an emergency and should discuss this plan with you as part of your Video Therapy treatment
- VIDEO THERAPY SESSIONS:
    - When you connect via the link sent to you, you will enter your Provider's virtual waiting room. Your Provider will be able to see when you have entered, but no other clients can see you or your information.
    - At the start of the session time, your Provider will connect with you and you should see and hear her/him.
    - If this is your initial session with this Provider, she/he will need to see your drivers license or other state-issued ID to confirm your identity. In subsequent sessions, your Provider can visually confirm your identity.

TROUBLE SHOOTING TECHNICAL ISSUES IN VIDEO THERAPY

- Your Provider can't hear you or see you?
    - Check that you have unmuted your microphone and enabled video capabilities
- You cannot connect via the link sent?
    - Ensure you are connected to the internet and have adequate bandwidth
    - Double check the link sent and try again. Call your Provider if you still cannot connect.
- Is the image pixelated or is there a delay in the video/sound?
    - Usually this clears up in a moment. If not, check that you have adequate internet bandwidth.

BACK UP PLAN

- Prior to your initial Telehealth session, your Provider should establish a backup plan with you in the instance that the video therapy platform is not operational, or there is no connection for Telephone Counseling
- Typically, the backup plan may include your Provider calling you at a pre-determined phone number and/or sending you a new link for Video Therapy session.
- If you cannot connect and have not heard from your Provider within 10 minutes, you may call your Provider directly at the number provided.
- If you still are unable to reach your Provider, you may call Gloria Dove's office M-F 8:30am-4:30pm for assistance at (469) 670-2548.

ACCEPTING PAYMENT DURING TELEHEALTH SERVICES

- Your Provider will discuss Video Therapy and/or Telephone Counseling fees with you in advance and keep you updated on any changes to fee structure or billing practices.
- If utilizing health insurance, you are responsible for confirming coverage of Video Therapy and/or Telephone counseling prior to the sessions and for covering the cost of sessions that are not reimbursed by your insurance plan.
- Payment for Telehealth Services will be collected at the time of service by a credit card on file.

Thank you for allowing SATORI Family Services, LLC to support your mental health needs.

Gloria Dove LPC, NCC
Phone • (469) 670-2548
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CONSENT TO TELEHEALTH SERVICES

Client's Name:_____ **DOB:**_____

Client ID:_____ **Therapist:** _____

INTRODUCTION

"**Telehealth**" (also known as "Video Therapy" and "Telephone Counseling") involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with SATORI Family Services, LLC. ("**Provider**") and a client who are not in the same physical location.

Telehealth may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- **Video Therapy:** counseling sessions provided via video conferencing
- **Telephone Counseling:** counseling sessions provided via telephone
- Electronic transmission of clinical records, photo images, personal health information or other data between a client and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of Video Therapy Services (Zoom) has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

STATEMENT OF POTENTIAL RISKS AND BENEFITS

Potential Benefits of Telehealth Services

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Potential Risks of Telehealth Services

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment foryou.
- Your Provider may not able to provide clinical treatment for your particular condition via Video Therapy or Telephone Counseling. You may be required to seek alternative care. In this case, your Provider would offer you referral suggestions and resources to the best of her/his ability.
- Delays in clinical evaluation/treatment could occur due to failures of the technology.
- Security protocols or safeguards could fail causing a breach of privacy. If this were to occur, SATORI Family Services, LLC would notify you promptly.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.

By accepting this Consent to Telehealth Services, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via Telehealth is an evolving field and that the use of Video Therapy or Telephone Counseling in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of Telehealth Services may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using Telehealth Services, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these Telehealth services. My Provider cannot ensure my privacy at my location.
7. I agree that I will not record my sessions without prior written consent. Instructions for accessing my medical record have been outlined for me in the Center's Privacy Practices.
8. I agree and authorize my Provider and Center to share information regarding my Telehealth treatment with other individuals for treatment, payment and health care operations purposes as allowed by law.
9. I agree and authorize Gloria Dove and/or Zoom to provide me with technical support if I request it.
10. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment.
11. If my health insurance provider does not reimburse for provision of Telehealth Services, I may be solely responsible for covering the costs of my Video Therapy or Telephone Counseling, as outlined in the form "Agreement for Payment and Financial Responsibilities."
12. I understand that my Provider may only utilize Video Therapy for my treatment when I am located in the state of my residence and/or in which the Provider has authorization or licensure to practice. As such, my Provider will ask to verify my location at the beginning of sessions.
13. I understand the need to participate in Telehealth Services from a secure, private location to the best of my ability. I will communicate any privacy limitations to my Provider at the beginning of the session.
14. My Provider has shared a Client Telehealth Guide with me, which can help me set up for video therapy and trouble shoot potential technical issues. My Provider and I have discussed a back-up plan if the technology fails to work during a session.

CLIENT CONSENT TO THE USE OF VIDEO THERAPY

By signing below, I indicate agreement to the following:

- I have read this Consent to Telehealth Services form and Client Guide to Telehealth carefully and understand the risks and benefits of the use of Video Therapy and/or Telephone Counseling in the course of my treatment.
- I have discussed Telehealth Services with my Provider, and all my questions have been answered to my satisfaction.
- I hereby give my informed consent for the use of Video Therapy and/or Telephone Counseling in my mental health care.
- I hereby authorize my Provider to use Video Therapy and/or Telephone Counseling in the course of my diagnosis and/or treatment.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Client (or Authorized Person) Signature **Date/Time**

Therapist Signature **Date/Time**