Child Intake Form

General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May we contact you via email? ☐ Yes ☐ No

Would you like to be added to our email list? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Spirituality

Insurance Information

Primary Insurance | Phone Number

Insured Name | DOB | SSN #

Member Number | Group Number | Employer Name

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Siblings | Age | Lives with child? ☐ Y ☐ N

How satisfied are you with their relationship? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

List family members below

Family Memeber | Age | Lives with child? ☐ Y ☐ N

Family Memember | Age | Lives with child? ☐ Y ☐ N

Family Member | Age | Lives with child? ☐ Y ☐ N

Family Memember | Age | Lives with child? ☐ Y ☐ N

Family History

Who helped raise child?

Any one else in the family neurodivergent?

Please describe your child's relationship with their parents/caregivers:

Please describe any issues within the family dynamic (i.e. sibling rivalry, parent child conflict)

If there are any circumstances from your child's childhood that you'd like to elaborate on, please do so here: (i.e.any emotional, physical or sexual abuse; did you move; adoptions, births of new siblings)

Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, pease explain why:

Employment/Education Status

Employer/School

Occupation/Years in School

Does your child work? Please select the best that describes their work.

☐ Disabled ☐ Employed Part Time ☐ Unemployed
☐ Employed Full Time ☐ Retired ☐ Student

Select type of school and classroom; please select IEP/504 if your child has one. I will need a copy of this report from the school:

☐ Self Contained ☐ IEP/504 ☐ Public
☐ General Education ☐ Charter ☐ Private

Mental Health History

Has your child experienced any of the following? Please check all that apply: if yes please state the month and year

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming Others
- ☐ Violence
- ☐ Weight Gain/Loss

Does your child have an Autism Diagnosis? ☐ Yes ☐ No

If yes, please provide me a copy of the diagnostic report

Have your child ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist Dates seen

Medical History

Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Has your child had any surgeries or operations? ☐ Yes ☐ No

If yes, please list:

Does your child currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Does your child experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician Phone Number

Permission to contact physician? ☐ Yes ☐ No

Family or Personal Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Abuse
- ☐ Attempted Suicide
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Unemployment
- ☐ Frequent Relocations
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Autism Symptoms _____

Personal History

What symptoms are your child dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Thoughts of Self-harm/Suicide
- ☐ Trouble Sleeping
- ☐ Autism Symptoms: _____

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Neurodivergent Issues

Does your child have difficulty with transitions? ☐ Yes ☐ No

If yes, how often:

is your child making friends? ☐ Yes ☐ No

If yes, please explain:

Does your child struggle with emotional regulation? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

How does your child deal with any substance abuse? ☐ Yes ☐ No ☐ Unsure

Does your child exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do your child have any hobbies or interests? ☐ Yes ☐ No

If yes, what are they and how often do they do them or talk about them?

What does your child do for fun?

Legal Summary

Has your child or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Fraud
- ☐ Substance Abuse
- ☐ Driving Offenses
- ☐ Immigration
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here: Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?

Payment Informaton & Authorization

Scheduling Information

Please check all the appointment days and times that are ideal for you:

☐	Monday	☐ AM	☐ PM	☐	Thursday	☐ AM	☐ PM
☐	Tuesday	☐ AM	☐ PM	☐	Friday	☐ AM	☐ PM
☐	Wednesday	☐ AM	☐ PM	☐	Weekend	☐ AM	☐ PM

Payment Information

Amount

☐ Cash ☐ Check ☐ Credit Card

Credit Card Authorization

Please complete all of the fields below if you plan on paying by credit card. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Name on Card

Zip Code

Credit Card Number

Card Expiration

Card Type ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other

By signing below, I authorize Chapter & Page Counseling LLC to charge the credit card above for agreed-upon purchases and fees. I understand that my information will be saved for future transactions on my account.

Name Printed

Signature

Date

Cancellation & No Show Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 48 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone at _____

ALL NO-SHOWS AND ANY APPOINTMENTS CANCELLED, RESCHEDULED, OR CHANGED WITHOUT 48 HOURS' NOTICE WILL BE BILLED TO YOUR ACCOUNT IN THE AMOUNT WE WOULD HAVE COLLECTED IF THE SERVICE HAD BEEN PROVIDED AS SCHEDULED.

Please keep in mind that insurance does not reimburse for missed appointments; therefore, you will be responsible for the full payment of the appointment fee. For example, if a therapy session is $100, and you have a $35 copay you would be responsible to pay $100 for a late cancellation or missed appointment.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

ARRIVAL TIME

Please arrive at your appointment at least 5 minutes prior to your scheduled appointment time. All therapy has a specific time schedule. An early arrival allows for a relaxed experience. If you arrive late, your therapy may be shortened in order to maintain our schedule.

LATE ARRIVAL POLICY

All appointments begin and end on time in order to maintain our schedule. If the therapy does not start on time due to client tardiness, the therapy time will be reduced accordingly and you will still be required to pay full price. If a client is more than 15 minutes late, the appointment will be considered a cancellation.

I have read and understood the cancellation and refund policy and agree to abide by the above conditions.

Name Printed	Signature	Date

Informed Consent for Counseling and Psychotherapy

This informed consent document is intended to provide general information about the counseling services provided by Chapter & Page Counseling LLC. This is a legal document; please read it carefully before signing.

Mental Health Services

Chapter & Page Counseling LLC recognizes that it may not be easy to seek help from a mental health professional. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result

Nature of Therapy & Risks

It is important to understand that there are both benefits and risks associated with participation in therapy. Therapy may improve the ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. However, clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. Therapy can lead to unanticipated feelings and change, which might have an unexpected impact on you, and your relationships. For example, marital therapy may lead to the possibility of exercising the divorce option.

Relationship

The relationship you have with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. It is not appropriate to share gifts, barter, or trade services with your therapist.

Confidentiality

Discussions between you and your therapist are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist when you and the therapist discuss this matter further.

After-Hour Concerns & Emergencies

As a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, you may contact your therapist in between sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Communication

By signing the Informed Consent for Counseling and Psychotherapy document, you are consenting for Chapter & Page Counseling to communicate with you by phone, e-mail, and at the address provided on your client intake form. You agree to notify us if you need to opt out of any form of communication.

Fees

- The fee for individual therapy sessions are $100 per session and are approximately 45 minutes in length.
- The fee for conjoint (marital /family) therapy sessions are $100 per session and approximately 45 minutes in length.
- The fee for Play Therapy therapy sessions are $120 per session and approximately 50 minutes in length.
- The fee for AutPlay Therapy sessions are $150 per session and approximately 60 minutes in length.
- The fee for Parent Training Sessions are $150 per session and approximately 55 minutes in length.
- Fees are payable at the time that services are rendered.
- If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Insurance

Please talk to your therapist if you plan to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Ultimately, the financial responsibility is yours and you will be required to pay for services in the event that your insurance does not cover them. Please discuss any questions or concerns that you may have about this with your therapist.

Notice to Clients

The Az Board of Behavioral Health Examiners receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at https://azbbhe.us, or by calling 602-542-1882.

Consent to Treat

By signing the Informed Consent for Counseling and Psychotherapy, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services and that you may stop such care, treatment, or services at any time. By signing the Informed Consent for Counseling and Psychotherapy document you acknowledge that you have both read and understood all the terms and information contained herein. You also agree that you have had the opportunity to ask questions and seek clarification of anything that remains unclear and that those questions have been answered satisfactorily.

Your signature below indicates that you have read this agreement for services carefully and understand its contents.

Name Printed	Signature	Date

Informed Consent for Telehealth

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as: "... the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means store and forward transfers." (Tennessee Code 56-7-1002)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) requires an extra level of protection. Additionally, there are other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or intercept your conversations with special technology. Individuals who have access to your telephone, or telephone bill, may be able to determine with whom you have spoken, who initiated that call, and how long the conversation lasted. If you have provided me with your landline phone number, I may contact you on this line from my own office landline or cell phone; typically to set appointments. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone, or cell phone bill, may be able to see with whom you have spoken, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have cell phones. I may also use a cell phone to contact you, typically to set appointments. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my password protected cell phone by your initials only. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, we realize that texting is a quick way to convey information. Nonetheless, please know that it is our policy to use text messaging strictly for appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. Additionally, we are required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:
We utilize a secure email platform hosted by outlook. We have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. If we choose to utilize emailing as part of your treatment, I encourage you to also utilize this software on your end. Otherwise, when you reply to my emails, creating an email chain, that chain will no longer be secure. My encrypted email service only works to send information and does not govern what happens on your end. We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).
Email (other than setting up and canceling appointments) is billed at your individual therapist's hourly rate for the time they spend reading and responding to them. If you are in a crisis, please do not communicate this to your therapist via email as your therapist may not see it in a timely manner. Instead, please see below under "Emergency Procedures." Finally, we are required to keep a copy or summary of all email communication that addresses your therapy as part of your clinical record.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:
It is our policy not to accept "friend" or "connection" requests from any current or former client on our personal social networking sites (e.g.,Facebook, Twitter, Instagram, Pinterest, etc.) as it may compromise your confidentiality and blurs the boundaries of our relationship.

Video Conferencing (VC):
Video Conferencing is an option for us to conduct remote sessions over the internet where we can speak to and see each other on a screen. I utilize ZOOM. This platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA BAA. If we choose to utilize VC, we will give you detailed directions regarding how to log-in securely through an email invitation received from your individual therapist. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure the session begins promptly. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps):
During the course of your treatment, we may recommend that you visit certain websites for pertinent information or self-help, or that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may utilize automated software or other entities to know that you've visited these sites or applications. They may even use your information to attempt to sell you other products. Additionally, anyone who has access to the device may be able to see that you have been to these sites by viewing your device history. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let us know by checking (or not checking) the appropriate box at the end of this document.
Electronic Record Storage:
Your communications with me will become part of a clinical record of treatment and PHI. Your PHI will be stored electronically with TherapyNotes, a secure storage company who has signed a HIPAA BAA.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology with which you are interacting. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time

Each therapist is required to make sure that you're aware that we are located in the Western US and abide by Mountain Standard Time. Our practice is considered an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers, nor are we available at all times. If at any time this does not feel like sufficient support, please inform your individual therapist, and we can discuss additional resources or transfer your case to a therapist or clinic with 24- hour availability. We will return phone calls, texts, and emails within 24 hours. However, we do not return calls on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of Technology Failure

During a TeleMental Health session, technological failures are possible. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and your therapist has that phone number. If you are disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call your therapist.

If you are on a phone session and get disconnected, please call your or contact your therapist to schedule another session if necessary. If the issue is due to your therapist's phone service, and we are not able to reconnect, you will not be charged for that session.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from your individual therapist, but do one or more of the following:

- Call Mobile Crisis at 602-222-9444
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, your therapist may determine you need a higher level of care and TeleMental Health services are not appropriate.
- Your therapist requires an Emergency Contact Person (ECP) that can be contacted on your behalf in a life threatening emergency. Please provide the ECP's name and contact information below. Either you or your therapist will verify that your ECP is willing and able to go to your location in the event of an emergency and transport you to a hospital, if necessary. Your signature at the end of this document indicates that you understand your therapist will only contact this individual in the extreme circumstances stated above.
- ○ Please list your ECP contact information here:
- You agree to inform your therapist of your location at the beginning of every TeleMental Health session.
- You agree to inform your therapist of the nearest mental health hospital to your location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session).

Please list this hospital and contact number here:

Structure and Cost of Sessions

We offer primarily in-person counseling. However, based on your ability to make in-person sessions, we may provide phone, text, email, or video conferencing if these services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you. The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in my general "Information, Authorization, and Consent to Treatment" form. A credit card is required ahead of time for TeleMental Health therapy for ease of billing. No Telehealth services will be provided before a billable credit card is on file. Please sign the Credit Card Payment Form, which was sent to you separately and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable, and we will provide you with a receipt of payment and a description of services provided upon request. This receipt may also be used as a statement for insurance if applicable to you (see below). Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to determine your insurance company's policies and to file for insurance reimbursement for TeleMental Health services. As stated above, we will gladly provide you with a statement for your insurance company and assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location, this includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either an in-person or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be responsible for the session you missed at a $45 rate. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, with its own limitations. Primarily, there is a risk of misunderstanding one another due to a lack of visual or auditory cues. For example, if video quality is lacking, your therapist might not see a tear in your eye. Or, if audio quality is lacking, your therapist might not hear the crack in your voice that they would otherwise notice. There may also be a disruption to the service (e.g., call ends unexpedly or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let your therapist know if something they have done or said has upset you. We invite you to keep our communication open at all times to reduce any possible harm.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. You may withdraw your authorization for any of these services at any time during the course of your treatment by notification in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

☐ Texting ☐ Email

☐ Video Conferencing ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are possible implications not anticipated at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modes of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

Name Printed	Signature	Date