The Counseling Center of Florence, LLC

PHONE: (843) 673-0054
FAX: (843) 667-1549
616 S. COIT ST.
FLORENCE, SC 29501

☐ THE COUNSELING CENTER OF FLORENCE, LLC ☐ J.G. MARTIN ENTERPRISES

PATIENT INFORMATION

Date: ________________ ☐ NEW PATIENT ☐ UPDATE

Patient: ______________________________________
LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:
____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME
____
SCHOOL/LOCATION

Patient Date of Birth: ________________ Patient SSN: ________________

Mailing Address: ______________________________
ADDRESS
____
CITY STATE ZIP CODE
____
EMAIL

HOME: ________________
CELL: ________________
WORK: ________________

Referral? ☐ Yes ☐ No Referred by: ______________________________

PRIMARY INSURANCE CARRIER: ______________________________

Group No.: ________________ ID No.: ________________

Is insurance subscriber same as patient? ☐ Yes ☐ No (If no, complete Insurance Information below.)

INSURANCE INFORMATION

Subscriber: ______________________________________
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: ________________ Subscriber SSN: ________________

Subscriber Address: ______________________________
CITY STATE ZIP CODE

Subscriber Phone No: ________________ Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Subscriber Employer: ______________________________

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the staff at the next appointment without fail. I hereby authorize payment directly to The Counseling Center of Florence, LLC or J. G. Martin Enterprises. If I have provided my insurance information in the box above, I hereby authorize The Counseling Center of Florence, LLC or J.G. Martin Enterprises to bill my insurance for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: ______________________________ Date: ______________________________

Patient Name: ____________________________________ Insurance ID: ___________________________________

This page is completed for minors only

*Our office recognizes that often extended family members and friends help many of our families with minor children. A legal guardian is required to sign all forms for a minor client to enter counseling with our office. This information is provided to help us better protect your privacy. Please **ONLY** fill out the information below that pertains to your case:*

_______________________________________ _______________________________________
Biological Mother's Name Phone Number

_______________________________________ _______________________________________
Biological Father's Name Phone Number

Biological Parents Are: ☐ Married ☐ Separated ☐ Divorced ☐ Cohabitating ☐ Not married, living separately

If living separately, please tell us who child lives with the majority of the time: ________________________________

If biological parent(s) are divorced and still have custody, please tell us if either parent has remarried and enter the stepparent's names below:

_______________________________________ _______________________________________
Stepmother's Name Phone Number

_______________________________________ _______________________________________
Stepfather's Name Phone Number

Has there been a termination of rights for either or both biological parent: ☐ **YES** ☐ **NO**

If yes, please enter parent name(s):____

Was there an adoption for this client: ☐ **YES** ☐ **NO** If yes, please enter the date of adoption: ______________

_______________________________________ _______________________________________
Adoptive Mother's Name Phone Number

_______________________________________ _______________________________________
Adoptive Father's Name Phone Number

Is this child currently in foster care: ☐ **YES** ☐ **NO** If yes, please complete the following:

_____________________________ _____________________________ _____________________________
Caseworker's Name Agency Phone Number

_______________________________________ _______________________________________
Foster Mother's Name Phone Number

_______________________________________ _______________________________________
Foster Father's Name Phone Number

Is there a current DSS kinship agreement in place? ☐ **YES** ☐ **NO** If yes, please complete the following:

_______________________________________ _______________________________________
Kinship Caregiver's Name(s) Phone Number

Is there a current court order in place giving anyone **other than** the biological parents guardianship, custody or rights to client mental health information: ☐ **YES** ☐ **NO**

- ❖ **Our office requires a copy of any current custody, visitation, guardianship orders or active DSS kinship agreements to be on file prior to the client seeing the counselor.**

By signing this form, I am agreeing that all the information provided is correct to the best of my knowledge. I further understand that this sheet is only for informational purposes for this office. If I wish to sign a release for anyone listed on this form, I will complete a separate release of information form. ***Please ask the front office staff for an additional release form should you require one.***

_______________________________________ _____________________
Parent/Guardian Signature Date

_______________________________________ _____________________
Staff Signature Date

Outpatient Behavioral Health Consent for Treatment Form

*The majority of this document is mandated by both South Carolina State Law and Public Law 104-191; it is provided for **your** protection. The Counseling Center of Florence, LLC and J.G. Martin Enterprises has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with The Counseling Center of Florence, LLC and J.G. Martin Enterprises.*

Contact Information
The Counseling Center of Florence, LLC is located at 616 S. Coit St. in Florence, SC 29501. This is also our mailing address. Our usual office hours are Monday through Thursday 7:30 am to 7:30 pm. Our clients are seen by appointment only. Our telephone number is (843) 673-0054 (the voicemail is secure and confidential) and our fax number is (843) 667-1549.

Please understand that any relationship that you have with counselors and staff at The Counseling Center of Florence, LLC is considered a professional relationship. Therefore, any communication between you and any staff member may become part of your or your child's permanent file. This includes, but is not limited to, information pertaining to scheduling, insurance, billing and clinical information.

Counseling Services
Counseling has both benefits and risks. Risks may include uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of counseling often requires discussing the unpleasant aspects of your life. However, counseling has been shown to have benefits for individuals who undertake it. Counseling often leads to a significant reduction in feelings of distress, increase satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss *outside* of sessions. The first 1-2 sessions will involve a diagnostic assessment for your needs. Based on the presenting symptoms, you may be diagnosed with a mental illness. Diagnoses are required for insurance and billing purposes, but it may follow you or affect your life. If you choose to not have an identified diagnosis, you may choose to self-pay. By the end of the assessment, your counselor will be able to offer you some initial impressions of what work might include. At that point, treatment goals will be discussed, and an initial treatment plan will be created. You should evaluate this information and make your own assessment about whether you feel comfortable working with your designated counselor. If you have questions about treatment, discuss them with your counselor whenever they arise. Please understand that in no way will there be any sexual relations between you and your counselor during or after treatment. Counselors are also not allowed to receive gifts of any kind. No blogs or public writings created by any counselor from this office represent any specific client. ***Counselors cannot have contact through any or all forms of social media including but not limited to Facebook, Facebook Messenger, Instagram, Twitter or Yahoo Messenger. We currently do not permit contact through electronic means, such as email or text.***

Fees
It is customary to pay for professional services at the time they are rendered. The billing rate for face to face and telehealth services are $155 for an initial assessment and thereafter will be billed at $105 for individual 45-minute therapy, $112 for 50-minute family and couples' therapy and $120 for 60-minute extended individual therapy. Each 45-60-minute session that is missed may accrue a missed appointment fee. If your counselor accepts your insurance, you will only be required to pay a copay and/or coinsurance unless your deductible has not been met. Patients with insurance are responsible to pay their co-pay and/or coinsurance at the beginning of each session. If you do not know whether your deductible is met, you will be charged the full insurance contract rate, then refunded when your insurance company pays. Legal services that include talking with an attorney, writing reports and/or court time will be billed at a session rate per hour. Please see the front office for explanation of or questions regarding legal fees. By signing this form, I give permission for my insurance to be billed and payments to be collected by The Counseling Center of Florence, LLC or J. G. Martin Enterprises. I understand that clinical information may need to be shared in order to obtain eligibility, authorization for services and to file claims on my behalf. There may be other instances that my clinical information will be shared with my insurance company on my behalf.

Payments
Payment is due at the time of the session unless other arrangements have been made. Our office will file your in-network insurance claim(s), but you are responsible for deductibles, co-insurance, and co-payments. We do not file secondary insurance(s). If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, we will refer you to another counseling practice or facility. It is your responsibility to familiarize yourself with your insurance benefits. If your claims are denied and you are responsible for the payment, or your coverage had been terminated, or if you are in your HIX grace period due to lack of premium payments with your insurance company, you are responsible to pay your account in full. Our administrative staff will be happy to assist you with any questions, comments or concerns that you may have.

Services Provided by

- ☐ **David Kahn, Ph. D., LPC, LPCS** (License #2173, #3847) is a Licensed Professional Counselor, Licensed Professional Counselor Supervisor, and is the Clinical Director of The Counseling Center of Florence, LLC
- ☐ **Laura Smith, MS, LPC, LPCS** (License #5073, #6448) is a Licensed Professional Counselor, Licensed Professional Counselor Supervisor, and is the Clinical Supervisor of The Counseling Center of Florence, LLC
- ☐ **Leslie McCall, MA, LPC** (License #2882) is a Licensed Professional Counselor
- ☐ **Erick Lownsberry, MA, LPC** (License #7358) is a Licensed Professional Counselor
- ☐ **Jackie Griffin, M.Ed., LPC** (License #7669) is a Licensed Professional Counselor
- ☐ **Carisa Gerald, MA, LPC** (License #7838) is a Licensed Professional Counselor
- ☐ **Tai Yancey, MA, LPCA** (License #7490) is a Licensed Professional Counselor Associate and is supervised by Laura Smith, Clinical Supervisor and David Kahn, Clinical Director
- ☐ **Jazz Washington, MS, LPCA** (License #7532) is a Licensed Professional Counselor Associate and is supervised by Laura Smith, Clinical Supervisor and David Kahn, Clinical Director

- ☐ **John Gary Martin, M.Ed., LPC** (License #326) is a Licensed Professional Counselor. John G. Martin Enterprises is managed by The Counseling Center of Florence, LLC

******Full Professional Disclosure Statements for each counselor are available upon request.******

Other Rights

If you are unhappy with what is happening in therapy, we hope that you will speak with your counselor so a response can be given to your concerns. Such comments will be taken seriously and handled with care and respect. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your counselor's specific training and experience. Our office has interns from various colleges. You may be asked for interns to observe your session. You have the right to say "no". Please note that interns follow the same confidentiality regulations of our office.

Telehealth

If you are interested in telehealth your counselor will determine if you are appropriate for this service and we can tell you if your insurance will cover these services.

Consistency in Treatment

During counseling it is common to have a temporary increase in problem behaviors. Consistency is key to recovery. It is crucial that you be on time for your appointments and consistent with your scheduling in order for you to meet your treatment goals. If you fail to show for sessions, you may be asked to sign a consistency agreement. Your counselor will help you address the need for consistency as it pertains to your treatment. If you fail to comply with your consistency agreement, you may be referred back to your referral source to find alternative care.

Emergency Protocol

You hereby authorize The Counseling Center of Florence, LLC to take any reasonable steps on mine or my child's behalf in case of an accident, injury or illness during counseling sessions, including but not limited to: emergency first aid, nurse and/or ambulatory services. You agree to be liable for the cost of any such action taken on my behalf and hereby release The Counseling Center of Florence, LLC from liability thereof. You assume risk, by this consent, of any illness, accident, or injury to yourself while attending at The Counseling Center of Florence, LLC and release The Counseling Center of Florence, LLC from any liability thereof.

Confidentiality

Each parent, whether the custodial or non-custodial parent of the child, has equal access and the same right to obtain all educational and medical records of the minor child (SC Law 20-7-100). Additionally, according to South Carolina Law, confidentiality may be breached in an attempt to collect unpaid fees for services rendered. In the event that there are unpaid fees, client's accounts are sent to a collection agency and a 30% service charge is added to the bill. A 10% late charge may be added to each month the payment is late, including late payments on previously arranged payment plans. Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." Information can only be shared with outside professionals after written consent is given by the patient. The information you share in counseling is protected health information and is generally considered confidential by South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. However, there are limits to the privilege of confidentiality. These situations include: (Continued on following page)

1. When you sign a release for a person or office.
2. Suspected abuse or neglect of a child, elderly person, or a disabled person.
3. When it is believed you are in danger of harming yourself or another person or you are unable to care for yourself.
4. If you report that you intend to physically injure someone, the law requires this practice to inform that person as well as the legal authorities.
5. In an emergency, where your life or health is in immediate danger.
6. If our office is ordered by a court to release information as part of a legal involvement. This includes a Guardian ad Litem (GAL) (A GAL routinely has a court order to access records.)
7. When you are being seen for court-ordered evaluations or treatment.
8. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
9. In natural disasters whereby protected records may become exposed.
10. Children under the age of 18 (We do maintain a reasonable right to privacy.).
11. Treating couples and families (We have a mixture of responsibilities to different family members.).
12. During a malpractice case or a disciplinary board hearing against a counselor.
13. If you use your mental condition as a defense in court.
14. In workman's comp cases.
15. As required by the Patriot Act.
16. As required by the Partner Notification Act.
17. When otherwise required by law.
18. Consultation, Supervision: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service. If you are working with a Licensed Professional Counselor Intern or Licensed Clinical Social Worker Intern, your clinical mental health counselor is required to discuss your case on a regularly scheduled basis with his/her Supervisor which will include your name, diagnosis, and content of therapy. The Supervisor is also required to maintain your confidentiality under the same legal guidelines as your clinical mental health counselor.
    If applicable, your clinical mental health counselor will complete the following for your information:

    I am being supervised by:

    ☐ Laura L. Smith, MS, LPC, LPCS

    ☐ David A. Kahn, PhD, LPC, LPCS

    ☐ ______________________________

    ☐ ______________________________

IF THERE HAS BEEN A DIVORCE OR THERE IS A PERMANENT OR TEMPORARY COURT ORDER PERTAINING TO CUSTODY OR VISITATION, WE WILL NEED A COPY OF THAT ON FILE TO PROTECT THE RIGHTS OF ALL PARTIES INVOLVED.

Appointments

Appointments are usually scheduled for 45-60 minutes. The practice's hours are by appointment only. Clients are generally seen weekly or more/less frequently as awareness dictates. You may leave a voicemail 24 hours a day, but calls are ONLY returned during regular office hours, Monday through Thursday. In the event of an emergency, you need to call or go to your primary care physician, your psychiatrist, or the local emergency room.

Record Keeping
A clinical chart is electronically maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Ethics
Counselors follow the Code of Ethics of the following organizations:

- The South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-educational Specialists.

  Website: https://www.llr.sc.gov/POL/Counselors/

Consent for Counseling
You will be asked to sign the last page of this document. By signing below, you are stating that you have read and understood this policy statement, and you have had your questions answered to your satisfaction. You accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. You understand that you may withdraw from counseling at any time.

You further understand that:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- We have no physician's on staff, and no one here can prescribe medications to anyone.
- Your counselor may need to consult with your physician, attorney, or other counselor.
- Your counselor is not available 24 hours a day.
- Appointments may be successfully canceled as late as 24 hours prior to the scheduled time.
- Your counselor is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, SC at (803) 896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).
- The Administrative Director for The Counseling Center of Florence, LLC is Marlena Hanna Lownsberry. She is a confidential administrator under state and federal law. She will be your major contact for problems, complaints and commendations.

I acknowledge that I have received and read The Counseling Center of Florence, LLC or Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with my counselor.

I agree that I will be financially responsible for 100% of replacement or repair costs if myself or my minor child/family member damage or destroy any property of TCC or the counselor.

PLEASE PRINT: ____
Client or Parent / Guardian if Client is Under 18

____ ____________________
Client or Parent / Guardian Signature Date

____ ____________________
Staff Signature Date

Patient Name: ____________________ Insurance ID: ____________________

Missed Appointment Agreement

Effective January 1, 2019

Our office wants to work with you and your family to meet your treatment goals and gain the most out of your therapy sessions. Your time is important, and your appointment time is for you only. Our office does not double book clients. If you miss your appointment there is an automatic consequence for the counselor as they do not get paid for their time. There are fees when you miss an appointment.

As of 1/1/2019 missed appointment fees are $40.00 for the 1st missed appointment and will increase by $40.00 for each one thereafter. Example: 1st missed appointment is $40.00, 2nd missed appointment is $80.00, 3rd is $120.00, and so on. Our office **CANNOT** bill your insurance company for a missed appointment. You are responsible for missed appointment fees and **CANNOT** be rescheduled until the missed appointment fees are paid. *Medicaid clients can not be charged for missed appointments. Medicaid clients may be referred back to their referral source after missing two appointments.*

If you miss an appointment and fail to contact the office, our system removes any future scheduled appointments. It will also remove any appointments from accounts which you are the guarantor on.

The following are ways to avoid missed appointment fees:

1) Be on time and at each scheduled appointment.
2) Schedule appointments that you know will work for you and your family.
3) Give 24 hours' notice if you will have to miss an appointment. Our system counts down to the very minute. Providing 23 hours and 59 minutes is still a missed appointment. **You may call our office 24 hours a day, 7 days a week, and leave a message on our secure and confidential voicemail system if it is outside of normal business hours.**

Your counselor nor the front office can waive your missed appointment fee. Please contact the office and ask for the Director if you have any questions.

______________________________ ______________

Client or Parent/Guardian Signature if Client is Under 18 Date

______________________________ ______________

Staff Signature Date

INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES
The Counseling Center of Florence, LLC and
J.G. Martin Enterprises, LLC

This Informed Consent for Telemental Health Services contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telemental Health: Telemental Health refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Telemental Health is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telemental Health, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telemental Health, there are some differences between in-person psychotherapy and Telemental Health, as well as some risks. For example:

- <u>Risks to confidentiality</u>. Because Telemental Health sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. Also, if other people may walk through the area where you are, you may want to ensure they are appropriately attired to avoid embarrassment!

- <u>Issues related to technology</u>. There are many ways that technology issues might impact Telemental Health. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- <u>Crisis management and intervention</u>. Usually, I will not engage in Telemental Health with clients who are currently in a crisis requiring high levels of support and intervention. In any event, we will have an emergency response plan to address potential crisis situations that may arise during our Telemental Health work.

- <u>Efficacy</u>. Most research shows that Telemental Health is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications: I use the Doxy.me platform for video conferencing, and there is no additional cost to you for using this service. You will need to have a computer that has audio and video capabilities for us to use video conferencing. You will also need a reliable internet service and it is better if you are as close to your WiFi router as possible. For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality: I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our Telemental Health. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telemental Health sessions and having passwords to protect the device you use for Telemental Health).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Professional Disclosure Statement and Confidentiality in Psychotherapy forms which were/are provided to you at the inception of therapy. These still apply in Telemental Health. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telemental Health: From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that Telemental Health is not a good option for us to engage in; if this is the case, we would discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology: Assessing and evaluating threats and other emergencies can be more difficult when conducting Telemental Health than in traditional in-person therapy. To address some of these difficulties, we are creating an emergency plan before engaging in Telemental Health services. You must identify an emergency contact person who is near your location who I will contact in the event of a crisis or emergency to assist in addressing an emergent situation. By executing this document, you are authorizing/allowing me to contact your emergency contact person as needed during such a crisis or emergency.

Patient Name: ____________________________________ Insurance ID: __________________________________

My emergency contact person is: ____

This person can be reached at: ____

If the session is interrupted for any reason, such as the technological connection fails, *and you are having an emergency,* do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services. Another option in case of an emergency might be to call the National Suicide Prevention Hotline 1-800-273-8255. We can also discuss other local resources.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will attempt to re-contact you via the Telemental Health platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me at (843) 834-673-0054. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time. TIP: If you are not plugged in, be sure your device is fully charged and/or be close to somewhere you can plug in. If you are tethering to get the internet, be sure your phone is also fully charged and that you are ready to plug in if it starts to go dead.

Fees: The same fee rates will apply for Telemental Health as apply for in-person psychotherapy. We have already confirmed that your insurance will cover this service. If your insurance lapses you will be billed at my regular rate for these services.

Records: The Telemental Health sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

____ ________________
Client or Parent/Guardian Signature if Client is Under 18 Date

____ ________________
Staff Signature Date