Christian Therapy and Mediation Services, LLC
Mark D. Glover
4290 N. Monroe, Hutchinson KS 67502
620-662-1283 x 15

Informed Consent for Psychotherapy

General Information - The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding of how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Working with you to identify presenting issues and develop a plan of care is the goal. However, it is your commitment to identifying personal goals towards which you desire to move and obstacles that may prevent that movement that will, in large part, determine the success of the therapy. If you have a crisis situation develop after hours, call the suicide prevention hotline at (800) 273-8255 or go to your local emergency room.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if the information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally, I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

For Questions, Concerns, and Complaints

As a mental health professional licensed by the State of Kansas through the Behavioral Sciences Regulatory Board (BSRB), I am committed to practice according to the ethics of my profession. You may contact the BSRB at 785-296-3240 and/or the secretary of the United States Department of Health and Human Services with questions or to register complaints about any licensed mental health professional.

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS Please, remember to cancel or reschedule 48 hours in advance. You may be responsible for the entire fee if cancellation is less than 48 hours.

The standard meeting time for psychotherapy is 45 minutes. It is up to you, however, to determine the length of your sessions. Requests to change the 45-minute session must be discussed with the therapist in order for time to be scheduled in advance.

A $35.00 service charge will be charged for any checks returned for any reason.

Cancellations and re-scheduled sessions may be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are the best practice. However, in the event that you are out of town, sick, or need additional support, virtual sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the internet, fax, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine.

Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the

client. Therapists may make clinical assessments, diagnoses, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also on direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as your physical condition including deformities, apparent height, and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming, and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

MINORS
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

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EFFECTIVE DATE OF THIS NOTICE This notice went into effect on January 1, 2021,

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures, I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have a direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in the diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the

coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.
Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter- intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health-related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or another person that you indicate is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the

existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgment of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of the Informed Consent & Confidentiality Policies of this clinic.

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FINANCIAL POLICY

Fee. Counseling sessions are 45 minutes long. The fee for a 45-minute session is $110. Payment is due at the beginning of the session unless arrangements have been made previously.

Insurance Patients. As a courtesy to you, the office is willing to file your insurance claim. Deductibles and co-pay/co-insurance are your responsibility and are to be paid prior to each session. If no payment is received from your insurance within 60 days of filing, we will bill the session charge to you. If a payment is received from the insurance company on this claim, your payment will be applied to co-pays or be refunded. If you want to see a provider who is out-of-network, you agree to turn over any payments paid to you by the insurance company, or those amounts will be billed to your credit card on file.

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered. If for some reason payment is not made at the time of the appointment, it is expected to be made prior to the next.

Methods of Payment. Cash, checks, money orders, and credit cards are accepted. Checks returned for insufficient funds will incur a $35.00 fee.

MISSED APPOINTMENT POLICY

Forty-eight-hour notice is required for the cancellation or rescheduling of an appointment. Appointments changed with less than 48-hour notice may be charged your full fee, unless the reason was inclement weather or other major problem that was excused by your therapist. The charge will be due prior to your next appointment and insurance cannot be billed.

For your convenience, a card can be kept on file and charged to keep your balance from inhibiting your ability to schedule appointments. If provided, this card will be charged as amounts are accrued on your account.

Patient Portal User Agreement and Consent

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal.

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason. All messages sent to you will be electronically secure. Messages and emails from you to any staff member should be sent through the Patient Portal for security and confidentiality reasons. The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled.

Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If you do not receive a response within two business days, please feel free to call our office. You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of access to your login links. Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks. Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication. Online communications are admissible as evidence in court just as medical records are in the event the physician/patient privilege is waived or if a court orders disclosure.

Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions. Responses to online communications are limited by the information provided and your question

may necessitate a follow-up phone call or a request to meet with you in person to gain further information. Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications.

Applicable law may allow a health care professional to determine that a minor patient is “mature” to keep a portion of the minor’s medical information confidential. If the minor patient is determined “mature” by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor’s email address will be required. Applicable law may also permit confidential communication with a minor patient in regard to treatment. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor’s email address will be required. The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you. The Practice will not forward online communications with you to third parties except as authorized or required by law.

Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools. Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your account confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications

Take steps to keep your online communications to and from the Practice confidential, including Do not store messages on your employer-provided devices (e.g., computer, cell phone, tablet, etc.); otherwise, personal information could be accessible or owned by your employer. Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your account safe and private. Do not allow other individuals or third parties access to the devices(s) upon which you store medical communications. Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third parties.

Access to Online Communications

The following pertains to access to and use of online communications: Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

Patient Intake Form

Name:_____ Phone: _____ ☐Cell ☐ Home ☐ Work
E-mail address:_____ 2nd Phone: _____ ☐Cell ☐ Home ☐ Work
Address:_____City:_____ State:_____ Zip:_____
Date of Birth:_____ Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widow(er)
Spouse (or Parent if patient is minor):_____ Names and Ages of Children:_____
_____
Emergency Contact:_____ Phone:_____
How were you referred to our office?_____
Family Medical Doctor (Name and Phone number): _____
FINANCIAL

☐I plan to use my insurance to cover the cost of my therapy. (Provide insurance card to be copied.)
Primary Insured if different than patient: ☐Spouse ☐Parent Name _____
Date of birth _____ Phone Number: _____

☐I want to pay for my therapy.

☐My EAP has authorized ____ visits. Authorization number _____

Portal Use or Refusal

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my account confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information.

☐ I **do** want to use the portal. ☐ I do **not** want to use the portal.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THE INFORMED CONSENT, THE PRACTICE POLICIES, THE PRIVACY PRACTICES, AND THE FINANCIAL POLICY.

_____
SIGNATURE DATE

If patient is a minor, the parent or guardian must sign to consent for the minor.