INFORMED CONSENT FOR PSYCHOTHERAPY

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about 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.

WAIVER OF LIABILITY

I release Eastside Child and Family Therapy, LLC, its agents, employees, and contractors, of any and all responsibility and liability which may result from:

- An accident or incident which may cause injury to my person or to any and all child(ren) enrolled in treatment at Eastside.
- Any and all responsibility in case property belonging to me is left behind on Eastside premises or damaged, I understand that Eastside Child and Family Therapy, LLC, its agents, employees, and contractors:

- Are here to help me and any and all child(ren) enrolled in treatment with me to achieve wellness.
- There is no guarantee of any particular outcome with treatment.
- The therapeutic process can be challenging and uncomfortable at times.

- I agree to discuss this with the therapeutic professionals I and/or my family is working with or to discuss this with the clinical director should it at any time begin to feel too challenging to work through

This agreement shall remain valid until I am discharged from treatment with Eastside Child and Family Therapy, LLC

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 themselves 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 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.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name	Signature	Date

HIPAA- NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on 10/01/2022

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 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 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 process 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 an 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 counterintelligence 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 an 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 other 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 an 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 email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT 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 HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name	Signature	Date

PRACTICE POLICIES

FINANCIAL RESPONSIBILITY

As a courtesy, we will check with your health plan to verify your benefits. However, this is not a guarantee of payment. It is your responsibility to understand your coverage, including co-pays, co-insurance, and deductibles. This also includes understanding what services are covered or not. It is also your responsibility to let me know if there is a change in your insurance or coverage. We will bill your health plan. You are responsible for payment of fees (co-pays, co-insurance, deductibles, or non-covered services) for services rendered with Eastside Child and Family Therapy and its clinicians. If services are provided that are not covered by your health plan, you will be responsible for payment of these services. Payment of fees are due prior to the start of each appointment. If fees are not paid, services may discontinue. The person who signs the acknowledgment page is agreeing to be the “financial guarantor”, which means this person agrees to pay any of these fees. If we determine there is a balance on your account, (ie, you owe fees), we will send you a statement. We ask that you complete payment within 30 days. If the fees are not paid, we will send your account to a collection agency. You will be responsible for collection fees, as well as any court/legal fees. Checks may be made to Eastside Child and Family Therapy.

FEES

Service rates and corresponding health insurance billing codes (numbers starting with ‘90’ refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

- 90791 Initial Consultation/Assessment – Individual (50-60 min.) $275.00
- 90837 Individual/Play Therapy (50 min.) $225
- 90834 Brief Individual/Play Therapy (45 min.) $200
- 90832 Brief Individual/Play Therapy (30 min.) $180
- 90847 Family Therapy with or without client (50 min) $225

REQUEST OF RECORDS FEES

- A copy of the Assessment and Treatment plan provided at no cost 1x per year.
- Medical Records Requests $50.00 flat fee per request for progress/session notes

- in addition to: (No additional copying fees if sent through the portal)
- Fees for copying documents:
  - $1.00 per page for the first 20 pages
  - $0.50 per page for pages 11 through 50
  - $0.25 for each page copied in excess of 50 pages
  - Additionally there is a $5 Postage and handling fee

CASE MANAGEMENT FEES

- $180.00 (prorated per 15 min.) *Case Management includes indirect services we provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports.
  - On occasion you may request that we testify or be present in court proceedings please see COURT FEES below for those fees.
- $180.00 (prorated per 15 min.) for phone consultations (11-60 min.)

COURT FEES

In the event we are requested to attend court a retainer of $2,000 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice to the court date there will be an additional $300 “express” charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $2,000).

- Preparation time (including submission of records): $225/hr
- Phone calls: $180/hr (prorated per 15 min)
- Depositions: $250/hour
- Time required in giving testimony: $250/hour
- Mileage: $0.40/mile
- Time away from office due to depositions or testimony: $250/hour
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- Filing a document with the court: $100
- The minimum charge for a court appearance: $2000

Finally, all fees are doubled if the subpoenaed clinician had scheduled plans to go out of town and is required to cancel them.

SLIDING SCALE
We believe that therapy should be available to everyone and We strive to make counseling affordable. If finances are a barrier to your family seeking help, we offer a sliding scale. Please let us know if you need a sliding scale application.

PRIVATE PAY/OUT OF POCKET
We offer a same day pay discount of 25% for under-insured, non-insured, out of network, or those not wanting to utilize their insurance.

CANCELLATION/ NO SHOW POLICY
An appointment reserves a specific time for you, your child and/or your family. If you need to cancel or reschedule, please notify our office or your clinician at least 24 hours in advance, via text, email or secure portal message. A $100.00 fee will be assessed for missed appointments or cancellations under 24hrs.

If a family or client late cancels or does not show up for a scheduled session without notice more than 2 times they will be removed from the schedule and asked to move to same day scheduling.

ADDITIONAL FEES
- Non-sufficient funds (bounced) check $45.00
- Past-due accounts – over 30 days $25.00 per month

Payment is due at the beginning of the session, commercial and private pay clients are required to have a credit card on file, at all times.

TELEPHONE ACCESSIBILITY
If you need to contact your clinician between sessions You may utilize the Portal to send a secure message. Due to the nature of our work we are often not immediately available; however, we will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or your local crisis line.

PLEASE SEE YOUR THERAPIST'S DISCLOSURE STATEMENT FOR THEIR CONTACT PHONE NUMBER.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not endorse or accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. If we see your name pop up we may simply just block you. If we do not respect these boundaries it could potentially blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. You are welcome to follow Eastside Child and Family on Instagram and Facebook, where you might see inspirational posts about parenting, self care and self love.

ELECTRONIC COMMUNICATION

We 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, we will do so. While we may try to return messages in a timely manner, we 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, facsimile machines, and e-mail. 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 treatment, better continuity of care, and reduction of lost work time and travel costs. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider'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 provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the provider.

MINORS

If you are a minor, your parents may be legally entitled to some information about your treatment. We 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. We may terminate treatment after appropriate discussion with you and a termination process if We determine that the treatment is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, We will provide you with a list of qualified Counselors or therapists 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, We must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name	Signature	Date

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such

information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

BY SIGNING THIS FORM, I CERTIFY:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name	Signature	Date

CONSENT FOR MINOR USAGE OF SOFTWARE AND SERVICES

Name & relationship to minor client:_____

Name of minor client:_____

If you are the parent or legal guardian of a minor child (herein, “Minor Client”), which means your child is under 18 years old, you must give your written permission and consent for the Minor Client to use the SimplePractice Software and Services. You understand and agree, by signing this form, that the Minor Client’s use of the SimplePractice Software and Services will be governed by the same terms of service that are applicable to your use of the SimplePractice Software and Services.

You agree that the practice listed above has your permission and consent to use the SimplePractice Software and Services to schedule appointments, communicate with you and/or the Minor Client, document and administer the Minor Client’s care and treatment, utilize telehealth services, and all other actions in any way related to being the Minor Client’s provider.

By signing below, you also attest to and certify that you are the Parent/Legal Guardian of the Minor Client, and that you have current and unrevoked legal authority to grant permission and consent to the above listed practice permitting the Minor Client to use the SimplePractice Software and Services.

YOU AGREE, THAT IF AND WHEN YOU NO LONGER HAVE SUCH AUTHORITY, YOU WILL IMMEDIATELY NOTIFY THE MINOR CLIENT PRACTICE IN WRITING.

BY SIGNING BELOW YOU HEREBY AGREE THAT YOU, AS PARENT/LEGAL GUARDIAN OF THE MINOR CLIENT LISTED ABOVE, HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS CONSENT AND THAT PERMISSIONS YOU HAVE GRANTED IN THIS CONSENT ARE WITHOUT LIMITATION.

Print Name	Signature	Date

FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Eastside Child and Family Therapy, LLC for care. We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.

1. I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.
2. I am financially responsible for any services rendered where the insurance company does not pay for services.
3. I am legally responsible and agree to pay to the Provider for all fees, charges and expenses incurred by the below Client or owed to Eastside Child and Family Therapy, LLC in connection to Provider providing care to Client.

I agree to provide all insurance information and keep it up to date with Eastside Child and Family Therapy, LLC.

Client Name	Responsible Party Name	Relationship to client

Print Name	Signature	Date

EMAIL, TEXT AND/OR ALTERNATIVE MEANS OF COMMUNICATION

_____I approve of communication of Protected Health Information by Eastside Child and Family Therapy by the following:

- Email:_____
- Text:_____
- Other:_____
- limitations or comments about this communication:_____

_____I do not approve of communication of Protected Health Information by Eastside Child and Family Therapy Via text or email.

1. _____I do not wish to communicate via text or email.
2. _____I agree to communication through the safety of the Simple Practice Portal

I understand that there may be limits to what can be sent over email or text; they are not for psychotherapy or crisis situations and should be used for appointments and scheduling purposes. I understand I am always welcome to communicate through the safety of the Simple Practice Portal. I will notify Eastside Child and Family Therapy of any change in email or texting number.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name	Signature	Date

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES

There are additional procedures that we need to have in place specific to Telehealth 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, I may determine that you need a higher level of care and Telehealth services are not appropriate.
I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

PLEASE LIST YOUR ECP HERE:

Name:_____Phone:_____

YOU AGREE TO INFORM ME OF THE ADDRESS WHERE YOU ARE AT THE BEGINNING OF EVERY SESSION.

YOU AGREE TO INFORM ME OF THE NEAREST MENTAL HEALTH HOSPITAL TO YOUR PRIMARY LOCATION THAT YOU PREFER TO GO TO IN THE EVENT OF A MENTAL HEALTH EMERGENCY.

PLEASE LIST YOUR PREFERRED HOSPITAL_____

Informed Consent for Mentalyc Recording Software

General Notice

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our psychotherapy sessions. I have chosen to use Mentalyc's note-taking system for psychotherapy as part of my effort to provide the best care to my clients. It provides me with an automatically generated transcript and summarization of our sessions. Mentalyc's system is HIPAA compliant and uses up-to-date encryption methods, firewalls, and backup systems to help keep your information private and secure. You are consenting for me to record our sessions using Mentalyc's system.

Details

Recordings of our sessions will be transcribed and summarized by Mentalyc's HIPAA-compliant technology. Mentalyc doesn't store the recordings and client personal information. I may choose to keep the summarized notes as part of your confidential medical record. Mentalyc only keeps anonymized data to help improve the tool. As with any technology, there are certain risks and benefits, which I will list here:

Risks

- All technology contains a risk of confidential information being disclosed. You can ensure the security of our communications by only using trusted secure networks for psychotherapy sessions and having passwords to protect the device you use for psychotherapy. Mentalyc mitigates this risk by ensuring up-to-date technological security and storing the data with as little identifying information as possible.
- Mentalyc Researchers will have access to your de-personalized transcripts (transcript content with removed names, emails, and other identifying information).
- The system may contain unknown bias in the way it generates the session summary and presents clinical information. This risk is mitigated by your therapist's commitment to review and modify the note as needed using their clinical expertise.

Benefits

- The technology allows the therapist to focus more of their attention on therapy.

- Removes the need for taking notes or trying to remember information during and after the session.
- Mentalyc reduces the therapist's workload and may help with compassion fatigue.
- The technology may provide additional clinical insights for the therapist which helps improve outcomes in the therapeutic process.

By signing this consent, you are agreeing to allow your therapist to use the Mentalyc software.

Print Name	Signature	Date

IN CASE OF AN EMERGENCY

If you feel you might be experiencing a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Multnomah County Crisis Line - CALL: 503-988-4888
- Suicide Prevention Hotline - CALL: 988
- Cascadia Behavioral Health Emergency Walk-In Clinic
    - 4212 SE Division St., Suite 100, Portland, OR 97206
- Unity Behavioral Health - 1225 NE 2nd Ave, Portland, OR 97232
- If outside of Multnomah County, call 211 for your local county mental health support services.
- https://www.linesforlife.org/

LGBTQIA+

- Trans Crisis Hotline CALL: 1-877-565-8860
- The Trevor Project CALL: 1-866-488-7386
- The Q Center CALL: 503-234-7837

YOUTH

- Youthline CALL: 877-968-8491
- Text: teen2teen to 839863

DOMESTIC VIOLENCE AND SEXUAL ASSAULT

- Call to Safety CALL: 1-888-235-5333
- RAINN CALL: 800-656-4673
- Sexual Assault Resource Center CALL: 503-640-5311

HOUSELESSNESS

- Portland Street Medicine CALL: 503-501-1231
- Transition Projects CALL: 503-280-4700

OTHER

- Poison Control CALL: 503-494-8968
- Fire and Rescue CALL: 503-823-3700
- Portland Police CALL: 911