Welcome

Welcome to Holding Hope Therapy,
I appreciate you taking a moment to read this information. I want to thank you for choosing Holding Hope Therapy to provide for your mental health care needs and goals. I appreciate and acknowledge the courage it takes to want to make a change, and I am delighted, honored, and privileged to be working with you through this journey.

I see my clients as individuals who each have specific and personal mental health care needs and goals for treatment. I truly care for all clients and work diligently to help provide the help they need. This packet includes information about me and forms for you to fill out and submit to me via email prior to our first session. Please review it in its entirety. If for some reason you are unable to complete the paperwork before our session, we will use your session time to complete the paperwork.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I look forward to meeting with you.

Should you have any questions prior to our appointment please feel free to email me at admin@holdinghopetherapy.com

Thank you,

Benita Weems, M.A., MDIV, M.A., LMHC

Counselor Training, Counseling Orientation, General Information, and Counseling Fees
Training and Degrees: I have an M.A. in Clinical Mental Health from Midwestern State University, an M.Div. from Reformed Theological Seminary, and an M.A. in education and teaching from The University of Alabama. I have been counseling informally and professionally for the last 15 years. I am credentialed as a Washington State Mental Health Counselor (LH61206717), a Texas State Licensed Professional Counselor (88260), and an Idaho Licensed Clinical Professional Counselor (LCPC 9400).

Counseling Orientation: I have an eclectic approach to counseling in which I draw upon different theoretical orientations depending on the needs of my client. I am rooted in Person-Centered Counseling but will utilize tools from other theoretical orientations such as such as Acceptance and Commitment Therapy, Mindfulness, and Lifespan Integration.
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Fees: The fee for counseling is **$200** per 53-minute session for individuals and **$250** per 53-minute session for couples and families. Fees are adjusted annually on January 1 and will not increase more than 10% per year. Payments (cash, check, or credit) are to be made at the beginning of each session. In addition to your session fee, there will be a fee for using your credit card, which will be the exact amount the credit card company charges **Holding Hope Therapy**. Fees change regularly but will range between 2.5%-4% of your transaction. If you would like to know the exact current rate, please ask at the time of your appointment. A $30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via text or email a minimum of three days (72-hours) in advance. Please provide information with your name and date/time of your appointment. Text messages are not adequate notice. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. If you are more than 15 minutes late; I will assume it is a no-show and will not continue to wait. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Social Media and Telecommunication: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also 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.

Termination of Treatment: When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further

obligation to you once treatment has been terminated. If a Client misses two sessions in a row without explanation or constantly reschedules appointments without proper notice, then I reserve the right to terminate counseling,

Testifying in Court: If you become involved in any legal proceedings requiring my participation, you will be expected to pay for all my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

State-Mandated Disclosure: I have broad discretion to release any information that I deem relevant in situations where I believe my client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Consultations: I regularly consult with other professionals regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

State Registration: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (a) to provide protection for public health and safety, and (b) to empower the citizens of the States of Washington, Texas, and Idaho by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure titled “Counseling or Hypnotherapy Patients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
PO Box 47869
Olympia WA 98504-7869
(360) 664-9098

Texas Behavioral Health Executive Council
333 Guadalupe St. Tower 3, Room 900
Austin, TX 78701
512-305-7700
800-821-3205

Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0063
208-334-3233

Contacting Me by Phone: If you need to contact me between sessions (407) 616-9027, please text or contact me via email at admin@holdinghopetherapy.org. 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 highly preferable to phone sessions. However, in the event that you are out of town, sick, or need additional support, phone sessions are available. Telephone sessions will be billed the same as videoconferencing visits. If a true emergency situation arises, please call 911 or any local emergency room.

Emergencies: If you are in an emergency situation and cannot reach me, please call one of the following numbers for help:

General Emergencies: 911

Crisis Clinic: (800) 244-5767 or (206) 461-3222

Suicide Hotline: 988

Signatures

I have read and understand the information presented in this form.

Client Signature:______________________________________ Date:_____________

Client Signature:______________________________________ Date:_____________

Guardian Signature (if applicable): ______________________ Date:_____________

Counselor Signature: ___________________________________ Date:_____________

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 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 circumstances will change. I can promise to support you and do my very best to understand you and repeat patterns, as well as to help you clarify what it is that you want for yourself.

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/herself 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

Signatures

I have read and understand the information presented in this form.

Client Signature:____ Date:________________

Client Signature:____ Date:________________

Guardian Signature (if applicable): ____________________________ Date:________________

Counselor Signature: ____ Date:________________

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical Records - Health Care Access and Disclosure." Please review it carefully.

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and healthcare operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

Protected health information means individually identifiable health information:

- Transmitted by electronic media.
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations For treatment:

- Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- Written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose (RCW 70.02.030(6)). Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.

- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including medical quality review by your health plan, accounting, legal, risk management, and insurance services, and audit functions, including fraud and abuse detection and compliance programs.

Signatures

Client Signature:____ Date:______________

Client Signature:____ Date:______________

Guardian Signature (if applicable): ________________________ Date:______________

Counselor Signature: ____________________________________ Date:______________

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we create, and store are the property of healthcare providers. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information(“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose is to obtain insurance.
  For help with these rights during normal business hours, please contact our Privacy Officer:
  Benita Weems, M.A., MDIV, M.A., LMHC
  Tel: (407) 616-9027
  Email: admin@holdinghopetherapy.org

Psychotherapy Notes:
Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. *Psychotherapy notes* exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes is required except if used by the originator of the notes for treatment, to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public if the notes are to be used in the course of training students, trainees or practitioners in mental health; to defend a legal action or any other legal proceeding brought forth by the patient; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by law.

Signatures

I have read and understand the information presented in this form.

Client Signature:____ Date:________________

Client Signature:____ Date:________________

Guardian Signature (if applicable): ___________________________ Date:________________

Counselor Signature: ____ Date:________________

OUR RESPONSIBILITIES

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

OUR RESPONSIBILITIES

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by requesting our office or medical records department to email a copy.

Other Disclosures and Uses of Protected Health Information
Notification of Family and Others:

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. This would be limited to your name and general health condition (for example, "critical," "poor," "fair," "good" or similar statements). In addition, we may disclose health information about you to assist in disaster relief efforts.
You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.
We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws -** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.

- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a jobsite.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.
- **To Coroners, Medical Examiners, Funeral Directors**. We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.
- **Organ and Tissue Donations**. If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.
- **Incidental Disclosures**. We may use or disclose PHI incidents to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.
- **Limited Data Set Disclosures**. We may use or disclose a limited data set (PHI that has certain identifying information removed) for purposes of research, public health, or healthcare operations. This information may only be disclosed for research, public health, and healthcare operations purposes. The person receiving the information must sign an agreement to protect the information.

Signatures

I have read and understand the information presented in this form.

Client Signature:____ Date:________________

Client Signature:____ Date:________________

Guardian Signature (if applicable): ___________________________ Date:________________

Counselor Signature: ____ Date:________________

SPECIAL AUTHORIZATION

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse Treatment Records (RCW 70.96A.150)
- Mental Health Services for Minors (RCW 71.05.390-690)
- Communicable and Certain Other Diseases Confidentiality (WAC246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part2)
-

If we need your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most importantly, if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future use and disclosure.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.
Effective Date: 01/01/2022

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT
(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

Benita Weems keeps a record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Written requests should be made to the Privacy Officer at the following address:

Benita Weems, M.A., MDIV, M.A., LMHC
Tel: (407) 616-9027
Email: admin@holdinghopetherapy.org

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT
BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I

want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity shall not be liable for the acts or omissions of others.

AUTHORIZATION TO RELEASE INFORMATION – IF APPLICABLE: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for all charges not paid by insurance. I understand this amount is due at the beginning of the session.

INSURANCE COVERAGE – IF APPLICABLE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company, and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

Signatures

I have read and understand the information presented in this form.

Client Signature:____ Date:________________

Client Signature:____ Date:________________

Guardian Signature (if applicable): ____________________________ Date:________________

Counselor Signature: ____ Date:________________

ONLINE THERAPY INFORMED CONSENT – PART 1

I hereby consent to engage in telehealth (also referred to as online therapy) with Benita Weems, M.A., MDIV, M.A., LMHC for psychotherapy services. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to healthcare practitioners located in Washington.

1. I understand that my healthcare 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.

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

I understand that I have the following rights with respect to telehealth:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or myself; and where I make my mental or emotional state an issue in a legal proceeding. This information is detailed in the Notice of Privacy Practices that I received. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

I accept that telehealth does not provide emergency services. During our first session, Benita Weems, M.A., MDIV, M.A., LMHC and I will discuss an emergency response plan as needed. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273- TALK (8255) for free 24-hour hotline support or call 988.

I understand that I have a right to access my medical information and copies of medical records in accordance with Washington, Texas, and Idaho State law.

I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. Advantages of telehealth include but are not limited to increased access to a broader range or providers, elimination of transportation concerns such as access and cost, easier access for clients whose concerns around travel/anxiety/interaction would have prevented their access to services, reduced risk for medically fragile clients, increased comfort, and familiarity for clients in their own environments.

I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area (as possible at any given time as there may be restrictions on meeting in public based on Washington state laws for various reasons).

I understand that there are potential risks and benefits associated with any form of psychotherapy and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases, may even get worse.

ONLINE THERAPY INFORMED CONSENT – PART 2

I understand that there are technological risks specific to telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I understand that my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto-remember" usernames and passwords, or use my work computer for personal communications; and that I am solely responsible for securing this end of our interaction.
I understand that I am responsible for:

1. Providing the necessary computer, and telecommunications equipment for my telehealth,
2. Personal security and or protection on my computer,
3. Location with sufficient lighting and privacy that is free from distractions or intrusions,
4. Reliable and secure high-speed internet connection.
5. A backup form of communication such as a personal phone number (handy and on record) if the internet connection fails.

After we connect, I will help my therapist complete a check-in to ascertain the immediate suitability of telehealth by verifying my name, location, whether I am in a situation conducive to a private, uninterrupted session, and my readiness to proceed. I will maintain current local emergency contact information with my therapist.

ONLINE THERAPY INFORMED CONSENT – PART 3

Telehealth by SimplePractice and Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. We may also have a phone call with your personal

phone number. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice and Doxy.me 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, Doxy.me, 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 or Doxy.me 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 Doxy.me – 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 or Doxy.me.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.
6.

Telehealth sessions will be held with the use of https://doxy.me or SimplePractice unless you choose telephonic sessions.

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 any questions have been answered to my satisfaction
I have read and understand the information provided above.

Signatures

I have read and understand the information presented in this form.

Client Signature:____ Date:______________

Client Signature:____ Date:______________

Guardian Signature (if applicable): ________________________ Date:______________

Counselor Signature: ____________________________________ Date:______________

CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Holding Hope Therapy** to debit your credit card as listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with authorized **Holding Hope Therapy** and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards will also be debited in the event that you fail to give adequate notice of missing an appointment. A receipt of credit card processing will be sent to the email below.

Please complete the information below:

I, (**print full name:**) authorize **Holding Hope Therapy** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of **$200** per 53-minute session for individuals, and **$250** per 53-minute session for couples and families. In addition to your session fee, there will be a fee for using your credit card, which will be the exact amount the credit card company charges Holding Hope Therapy. Fees change regularly but will range between 2.5%-4% of your transaction. If you would like to know the exact current rate, please ask your therapist at the time of your appointment. (See above for yearly increase to rates).

Billing Address Phone#
City, State, Zip____

Email____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name:
Account Number:
Expiration Date:
CVV2 (3-digit number on the back of Visa/MC/Discover, 4 digits on the front of AMEX):

I authorize **Holding Hope Therapy** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Client/Guardian Signature:____

Date:______________________