PASTORAL INSTITUTE

2022 15th Avenue |Columbus, Georgia |31901

Counseling Center Minor Client Information

For Office Use Only:
Date of Visit:_____
Patient #:_____
Clinician:_____
Payment Type:_____
OQ: Y ◯ N ◯
Portal: Y ◯ N ◯

Name: _____

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Preferred method of contact: ◯ Mobile ◯ Home ◯ Voice ◯ Email

Current Grade_____ Race_____ Ethnicity _____

Religion: _____ Church: _____

Parents' Marital Status: ◯ Single ◯ Live-In ◯ Married ◯ Divorced ◯ Widowed

Parents' Military Status: ◯ Active ◯ Veteran ◯ Disabled ◯ Retired ◯ Dependent

Parents' Name(s): _____

Date of Birth: _____ Age: _____ Social Security #: _____

Employer: _____

Emergency Contact Name: _____ Relation: _____
Home/Cell Phone: _____ Work Phone: _____
Address: _____

Financial and Insurance Information

Primary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Secondary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

In order to file your insurance, we must have a copy of your insurance card(s).

Mental Health Information:

What has happened to cause you to seek counseling for your child? *(continue on back if needed)*

_____

_____

_____

_____

_____ _____

Has your child received previous mental health care? ◯ Yes ◯ No

If so, when and what treatment did your child receive?

_____

_____

____ _____

General Health Information:

Is your child presently under the care of a physician? ◯ Yes ◯ No

Name of physician/psychiatrist: _____

Physician's telephone number: _____

Types and dates of surgeries: _____

_____

Does your child drink alcohol/do drugs? ◯ Yes ◯ No
If yes, which substance(s) and how often? _____

List medication(s) taken regularly: _____

_____

_____

_____

____ _____

_____ _____

Parent/Guardian Initials Date

SOCIAL MEDIA POLICY

Pastoral Institute staff will not accept Friend Requests or contact requests from current or former clients on any social networking site; i.e., Facebook, LinkedIn, etc. Adding clients and/or family members as friends or contacts on these sites can compromise a client's confidentiality and our mutual privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions, please do not hesitate to discuss the issue with your clinician.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the Pastoral Institute or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment necessary for payment of insurance claim. The insurance company is hereby authorized to pay the Pastoral Institute, Inc., basic benefits and/or major medical benefits for medical and/or treatment expenses, or to include their name on the check payable to patient for medical and/or expenses.

For Tricare Beneficiaries: **I consent to the Pastoral Institute, as a Military Treatment Facility (MTF) to send a copy of my Protected Health Information (PHI) to referring MTFs for continuity of care.**

_____ _____

Parent/Guardian Initials Date

FINANCIAL POLICY AND AGREEMENT

For those with health insurance, the Pastoral Institute will assist in filing claims and seeking reimbursement. The Pastoral Institute cannot guarantee insurance reimbursement. It is the responsibility of the patient to follow up with the insurance company to make sure they pay the claims correctly. If the insurance company does not pay within 90 days, the unpaid balance is due from the Guarantor. Some insurance coverage for mental health services requires pre-authorization. The patient must call for authorization. The insurance company will not pay for services that have not been authorized. All fees charged are the direct responsibility of the client. Payment of any and all services rendered will be expected from the guardian that escorts the patient to his or her appointments. It is the policy of the Pastoral Institute to bill for any appointment cancelled without a 24-hour notice.

Payment for co-pay or deductible is due at the time service is rendered. Accounts that become more than ninety (90) days past due may be forwarded to a collection agency. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

Financial Agreement:

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that the statements are correct unless questioned within thirty (30) days in writing or by telephone contact with the Pastoral Institute Business Office.

_____ _____

Parent/Guardian Initials Date

PASTORAL INSTITUTE BROKEN APPOINTMENT POLICY

Your appointment time has been reserved just for you. If you find it impossible to keep your appointment time, please call us at least 24 hours in advance. Failure to call our office and cancel your appointment 24 hours in advance will result in a charge of half of the standard session fee or more for testing appointments. We offer appointment reminder phone calls and/or texts 48 hours prior to your appointment. However, this is a courtesy and you are still responsible for cancelling your appointment at least 24 hours in advance.

_____ _____

Parent/Guardian Initials Date

COUNSELING, CONFIDENTIALITY, PRIVACY PRACTIVE AND NON-RECORDING AGREEMENT

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand that the PI is committed to quality care. I may contact the Clinical Director regarding any questions about my therapist or concerns about quality of care. I understand that the PI may call my home or other designated location and leave a message on voice mail or in person to assist the practice in carrying out health care operations, such as appointment reminders, insurance concerns, and any call pertaining to my clinical care. I have read the above and give my consent to the counseling process of the PI. I have also read and understand the Pastoral Institute's statement regarding the limits of confidentiality. In addition, I have had an opportunity to review the Pastoral Institute's Notice of Privacy Practices and have had an opportunity to obtain a copy and ask questions to seek clarification I needed about these important materials.

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

_____ _____

Parent/Guardian Initials Date

SECURE MESSAGING WITH THERAPIST CONFIDENTIALITY RELEASE AGREEMENT (CLIENT PORTAL)

_____

E-mail Address

I agree to setting up a patient portal for email and record communication. I understand that confidentiality of e-mail communications with my therapist cannot be guaranteed. I further agree that I will not attempt to extend therapy via e-mails. Any therapeutic issues I will handle either during the therapeutic face-to-face meeting or as appropriate, by telephone in emergencies.

E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail will be read and responded to within a particular period of time. Possible e-mail-related concerns can include, but are not limited to the following:

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the e-mail and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to Pastoral Institute to set up a patient portal.

_____ _____

Parent/Guardian Initials Date

INFORMED CONSENT FOR COUNSELING SERVICES AGREEMENT

It is important to Pastoral Institute's leadership and staff that we are culturally competent and aware of needs of different population groups. We strive to be respectful and inclusive of spiritual beliefs and attitudes, healing practices, and cultural/linguistic diversities. We believe as PI practitioners that this brings about positive change as we understand differing cultures among various communities and are able to work with everyone within his/her context.

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute's (PI) staff members. I agree to collaborate with my therapist and other appropriate professional staff members of the PI for the purpose of assessment and evaluation of my current situation to work together to identify appropriate goals and methods of achieving them.

- In the event of a group session, a written waiver of all participants shall be received by the Pastoral Institute prior to any disclosure. In the event the patient involves a minor child and the request is in connection with a divorce or child custody proceeding, you agree that a guardian ad litem shall be appointed by the court to make the determination as to whether the minor child should waive the privilege, and that you, as the parent and/or legal guardian, shall not retain the right to waive any privilege on behalf of a minor child under such circumstances;
- Any and all medical records retained by the Pastoral Institute are subject to the applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") laws and regulations. Any requests for medical records of a patient shall be HIPAA compliant, and the Pastoral Institute will not disclose any medical records in its possession that would be in conflict with the applicable HIPAA requirements.

Informed Consent for Therapy with Parents/Guardians Divorce, Custody or Legal Issues

As a mental health treatment practice, our primary focus, responsibility and goal is the treatment and well being of our identified patients. In the case of a minor child as the primary patient, it is essential that parents and legal guardians are in agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. This Consent states that you, as the parent and/or any legal guardian with authority over the health care decisions of the child, agree to the terms contained herein and to communicate effectively with any other parent and/or legal guardian as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible for the patient.

Although our responsibility to your minor child, as the primary patient, may require our involvement in conflicts between parents and guardians, you hereby acknowledge that the Pastoral Institute's involvement will be strictly limited to those actions which will benefit and be in the best interest of the patient. Additionally, you agree to the following:

- Anything that is said in any individual or group therapy session is and shall remain at all times strictly confidential;
- The Pastoral Institute's role is limited to providing treatment to the patient, and you shall not attempt to utilize any information related to your minor child's treatment to your benefit or for your advantage in any legal proceeding relating to a divorce or to the custody of your child that is derived from the treatment of your child by the Pastoral Institute. You acknowledge and agree that the use of any such information shall be determined by a court appointed guardian ad litem or by an order from a court with competent jurisdiction.

You shall not request or require the Pastoral Institute, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child. Any communications between the minor patient and the clinician, whether during an individual or group session, are treated by the Pastoral Institute as privileged communications under applicable law. **You acknowledge that, prior to any clinician being required to testify or disclose any confidential and/or privileged communications between a patient and the clinician, a written waiver of the privileged communications shall be delivered to the Pastoral Institute. If you decide to subpoena your therapist, you will be responsible for his/her expert witness fees in the amount of a deposit of $300.00 to be paid at the time we are notified of a subpoena to provide a deposition or appear in court. Any additional time the therapist spends would be billed at the rate of $200.00 per hour including travel time. If your therapist is a licensed psychologist, the fees are $250.00 per hour including travel time. You understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.**

In order for the Pastoral Institute to disclose privileged communications pursuant to any court order, such court order shall explicitly require the disclosure of any privileged communications of the patient.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my minor child under these terms and conditions set forth above by signing below.

I accept the responsibility of communicating with my child's therapist after every appointment to be updated regarding any change in the treatment plan related to my child's therapy. However, I acknowledge that I am not entitled to all of the communications and disclosures made by my minor child during any treatment sessions, and that such communications may consist of privileged communications which are afforded protection under applicable law.

I understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, I acknowledge that the Pastoral Institute will look to me as the sole party responsible for the financial obligations of the account.

I, _____, attest that I am the legal guardian or have power of attorney of _____ (child), and have full legal rights to make. Medical decisions for my child and there are no current court orders that would prohibit me from making medical decisions for my child.

Name of Child/Client (Printed): _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

EMPLOYEE ASSISTANCE PROGRAM (EAP) OR COVENANT CONGREGATION PROGRAM (CCP) UTILIZATION

I would like to use Employee Assistance Program (EAP) or Covenant Congregation Program (CCP) benefit if I am eligible:

☐ Yes ☐ No

_____ _____

Name Employee/Member Name of Company or Congregation

_____ _____

Department Name Relationship to Employee/Member

_____ _____

Client Initials Other Congregation

_____ _____

List any Other Employer(s) Date

Consent for Minor Child Participation with OQ outcome measures

The Pastoral Institute is committed to providing quality care to our clients. As a part of this commitment, we are implementing the use of outcome surveys to measure the effectiveness of treatment and the quality of the therapeutic relationship. All survey information will be maintained in a confidential, HIPAA-compliant web server and can only be accessed by your therapist.

The process would involve your agreement to receive emails prior to an appointment which will ask you to rate your child's progress and then discuss the information with your child's clinician in session. The email will give you the unique log-in information you need to go to the OQ server and complete a short survey. We will request you to do the assigned survey the evening prior to your scheduled appointment.

For minors under age 4, the measure is completed on paper.

You are able to withdraw consent for participation at anytime.

☐ Yes, I _____, the legal guardian of my child under age 12, _____, wish to participate in the OQ outcome measures process and agree to receive emails. My email address is _____.

☐ Yes, my child is between 12 & 17 years old and I give permission for _____ to participate in the OQ outcome measures process. I understand this measure could at times be sent to my child in addition to or instead of my participation. My child's email address is _____.

☐ No, I do not wish to participate in the OQ outcome measures process at this time.

_____ Parent/Guardian Initials

_____ Date

Pastoral Institute's Child and Family History Client #_____

Child's Name: _____ Birthdate: _____

(Does child Sign?_____) Race: _____ Handedness: ☐ Right ☐ Left

Referred by: _____ Form completed by_____ (Relationship?_____)

PLEASE CHECK CURRENT CONCERNS ABOUT YOUR CHILD

☐ Academic/Learning Difficulties
☐ Adoption Issues/Problems
☐ Suspected Alcohol/Drug Abuse
☐ Allegations of Abuse
☐ Anger Issues
☐ Anxiety
☐ Attention/Hyperactivity Difficulties
☐ Autism Spectrum Disorder
☐ Behavior Difficulties
☐ Depression
☐ Eating Problems
☐ Language Difficulties
☐ Health Concerns _____
☐ Home Schooling Issues
☐ Hearing Difficulties
☐ Gifted Assessment
☐ Suspected Intellectual Difficulties
☐ Family Difficulties
☐ Grief Issues
☐ Gross Motor Delays/Clumsiness
☐ Memory Difficulties
☐ Self-Harm
☐ Suicidal
☐ Visual Motor Coordination Difficulties/Writing; Difficulties
☐ Social Skills Difficulties
☐ Traumatic Brain Injury
☐ Violent Behaviors
☐ Other _____

Living Arrangements:

The Child currently lives with _____

How many other children live with child?_____ Ages: _____

How long has the child lived in the present living arrangements? _____

Does the child have pets? ☐ Yes ☐ No; what types? _____

PARENT/GUARDIAN INFORMATION

Highest Educational Level:

Mother	
Father	
Step Parent	
Adoptive	
Guardian	

Events Producing Family Stress:

☐ Death of a family member
☐ Incarceration of a family member
☐ Custody disagreement
☐ Parent emotionally/mentally ill/ substance abuse
☐ Abandonment by parent
☐ Parental deployments #_____
☐ Serious illness of a family member
☐ Loss of employment of a major wage earner
☐ Unsafe home environment
☐ Birth/Adoption of another child
☐ Parental disagreement about child-rearing
☐ Involved with Social Services/Child Protective Services/Juvenile Court
☐ Loss of home
☐ Parental separation
☐ Parental divorce
☐ Sibling conflict
☐ Child neglect/abuse
☐ Financial problems
☐ Single-parent family

Prenatal/Birth History

- ☐ Child was born with no complications
- ☐ Experienced anoxia at birth/assistance breathing
- ☐ Experienced in utero exposure to drugs/alcohol
- ☐ Experienced in utero trauma (e.g. cord wrapped)
- ☐ Was born past due date
- ☐ Gestational diabetes
- ☐ Toxemia
- ☐ Was born via C-section
- ☐ Was born premature
- ☐ Weighed less than 5 ½ pounds at birth
- ☐ Weighed over 9 lbs at birth
- ☐ Birth weight_____
- ☐ Rh incompatibility

Which of the following applied to the infant? (Check all that apply)

- ☐ Required Oxygen/Breathing problems
- ☐ Required incubator
- ☐ Sleeping problems
- ☐ Infections
- ☐ Placement in the NICU, if so how long? _____
- ☐ Feeding problems
- ☐ Rash
- ☐ Bleeding into brain
- ☐ Excessive crying
- ☐ Seizures/convulsions

☐ Did the infant require: ☐ X-rays ☐ CT scans ☐ Blood Transfusion

☐ Unusual appearance, describe: _____

☐ Jaundice (were bilirubin lights used?) ☐ Yes ☐ No How long: _____

☐ Length of stay in the hospital:_____Mother:_____Infant: _____

☐ Other concerns_____

Developmental Milestones	Early	Typical	Late	Not Yet
Sitting Alone	◯	◯	◯	◯
Crawling	◯	◯	◯	◯
Fed Self	◯	◯	◯	◯
Fed Self With Spoon	◯	◯	◯	◯
Gave Up Bottle	◯	◯	◯	◯
Started Solid Foods	◯	◯	◯	◯
Standing Alone	◯	◯	◯	◯
Walking Alone	◯	◯	◯	◯
Speaking First Words; Age_____	◯	◯	◯	◯
Speaking Short Sentences; Age_____	◯	◯	◯	◯
Using Toilet When Awake	◯	◯	◯	◯
Staying Dry at Night	◯	◯	◯	◯
Dressed Self	◯	◯	◯	◯
Rides Tricycle	◯	◯	◯	◯
Rides Bike	◯	◯	◯	◯

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

☐ Time out ☐ Loss of allowance/privileges ☐ Physical Punishment ☐ Yelling

☐ Ignoring ☐ Grounding ☐ Other, describe:_____

Who is mainly in charge of discipline? _____

What do you find most difficult about raising your child? _____

_____

_____

Sensory Motor Skills:	**Date of Last Testing**	**Results Normal Y/N**
Vision Testing		Yes
Hearing Testing		YES

Medical/Psychiatric/Neurological Concerns:

☐ No major medical/psychiatric concerns ☐ Asthma ☐ Depressive disorders

☐ Attention deficit/hyperactivity disorder ☐ Diabetes ☐ Fetal alcohol syndrome

☐ Chronic ear infections ☐ Lead poisoning ☐ Severe allergies

☐ Seizure disorder ☐ Spina bifida ☐ Stomach problems

☐ Surgeries ☐ Other_____

☐ Family History of Mental or Emotional problems _____

☐ Food allergies _____

Neurological Status:

☐ No signs of neurological concerns ☐ Episodes of head banging ☐ Seizures or convulsions

☐ A serious head injury ☐ A motor tic ☐ Periods of unconsciousness

☐ An unusual number of accidents ☐ Other_____

Medication:

Is he/she currently on any medications? ☐ Yes ☐ No If so, names of all medications: _____

_____

_____

Education:

Did he/she attend a formal pre-kindergarten? ☐ Yes ☐ No | ☐ Fulltime ☐ Halftime

Did he/she attend a formal kindergarten? ☐ Yes ☐ No | ☐ Fulltime ☐ Halftime

Has he/she been in the same school since initial enrollment? ☐ Yes ☐ No

Has he/she ever been held back? ☐ Yes ☐ No If yes, what grade(s)?_____

He/she is currently in:

Attendance:

☐ full time classes ☐ part time classes ☐ regular classes

☐ gifted/talented courses ☐ special education classes ☐ homeschooled

He/she has:

Attendance:

☐ an excellent attendance record ☐ no significant attendance problem

☐ frequent excused absences ☐ frequent un-excused absences

Conduct:

☐ exemplary conduct record ☐ only minor disciplinary problems ☐ frequent disciplinary problems

☐ enrolled in correction program ☐ severe disciplinary problems ☐ suspension from school

Academic Performance:

☐ an outstanding academic record ☐ no serious academic difficulties

☐ some academic difficulties ☐ many academic difficulties

Academic Testing:

	Above Average	Average	Below Average
Reading			
Math			
Language			

Describe School Issues:

_____

_____

Services Received:

☐ Speech ☐ Occupational Therapy ☐ Physical Therapy ☐ ABA Therapy ☐ Social Skills ☐ Early Child Special Edu.

Extracurricular Activities

☐ Sports Clubs/Hobbies: _____

☐ Spiritual Affiliation/Church: _____

How does your faith impact these concerns? _____

_____

Strengths: What are the child's greatest assets? _____

_____

What are the family's strengths? _____

Level of family stress related to child's condition:

Low Moderate High

1	2	3	4	5	6	7	8	9	10

RESET FORM

PASTORAL INSTITUTE

2022 15TH AVENUE • COLUMBUS, GEORGIA 31901
(706) 649-6500 • WWW.PASTORALINSTITUTE.ORG

INFORMED CONSENT FORM FOR TELEMENTAL HEALTH

Client Name | *Date of Birth (mm/dd/yyyy)*

This Informed Consent is an agreement, intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together, and does not amend any of the terms of that agreement. Your signature below indicates agreement with these additional terms and conditions. This document contains important information focusing on providing counseling/therapy via telecommunications – internet or phone.

We, the Pastoral Institute, offer counseling via traditional in person on-site sessions, video conferencing, and telephone formats. Telemental health is considered any of those methods other than on-site. If your counseling needs are appropriate for telemental health, you may participate in counseling, either in person, through telemental health formats, or in any combination of services.

Client responsibilities for participation in telemental health counseling:

The client should:

- ☐ **Verify** with your insurance or EAP providers to make sure telemental health sessions are covered under your plan.
- ☐ **Be** in the state in which the clinician is licensed to practice. Clinician will ask and notate your location.
- ☐ **Be** in an area that is **safe** and **provides privacy**.
- ☐ **Be** in an area that is **appropriate** for a video session, such as a home office.
- ☐ **Refrain** from the use of alcohol, illicit drugs, or any mind-altering substances prior to session.
- ☐ **Dress appropriately** as you would if you were attending a session in office.
- ☐ **Do not** have anyone else in the room unless you **first** discuss it with your clinician.
- ☐ **Do not** record sessions without **first** obtaining your clinician's agreement.
- ☐ **Do not** conduct other activities, such as driving, while in session.
- ☐ **Do not** bring weapons of any kind to session.
- ☐ **Minors** should have a parent or guardian with them at the location of the web-based session, unless otherwise agreed upon with their clinician.

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To prevent unnecessary hardship, if you are troubled by anything your clinician may have said during a video or phone based session, it is important to remember that clinicians of the Pastoral Institute are highly trained professionals who have only the highest positive regard for you and your concerns. If you have any ill feelings or misunderstandings that may have arisen during your session, please make sure to discuss your concerns with your clinician as soon as possible.

Confidentiality and Records:
All of your Protected Health Information (PHI) is retained, as it would be for any in person session. The Notice of Privacy Practices (**click here to view**) that was given to you at intake provides detailed information on how private information about your health care is protected, and under what circumstances it may be shared. Although it is not guaranteed that these methods will prevent all possible confidentiality breaches, they are designed with the intention of protecting the privacy of your clinical record. Your information is stored via Greenway Intergy Electronic Health Record Systems, (**Intergy**) (which is designed for healthcare providers) and includes a Business Associate Agreement for HIPAA compliance. Intergy uses federally approved, point-to-point encryption and will retain your records indefinitely.

Risks / Client's Responsibilities / Client's Protection:
When using telecommunication technology, there is a risk that it may be forwarded, intercepted, circulated, stored, or even altered, and the security of the devices used may be compromised. We take every reasonable precaution to protect the privacy and security of all electronic communication. However, it is not possible to guarantee complete security of the information. If you use any methods of electronic communication with your clinician, other than recommended secure messaging through the client portal, there is a chance that a third party may be able to intercept that communication.

It is important to be aware that family, friends, co-workers, employers, and hackers may gain access to any technology, devices, or applications that you use. We encourage you to communicate only through a computer, phone, or any other device that you know to be safe. You are responsible for reviewing and maintaining the privacy and permission settings of any applications or technology you use.

Possible Limitations of Telemental Health:
Telemental health should not be viewed as a substitute for in person counseling or medication management. It is an alternative form of counseling with possible benefits and limitations.
By signing this document, you agree that you understand that telemental health:

- ☐ May lack visual and/or audio cues, which may cause misunderstanding.
- ☐ May have disruptions in the service and quality of the technology used.
- ☐ May not be appropriate if you are having suicidal or homicidal thoughts, acute psychosis, or another emotional crisis.
- ☐ When using secure email through the portal, there might be a delay in your clinician receiving and responding to your message. It is also possible that technical difficulties may prevent the message or response from being delivered.

Email:
We, the Pastoral Institute staff, **strongly discourage** the use of email because this format is not considered a secure form of communication and does not meet HIPPA compliancy standards. However, you can use secure messaging with your clinician through the **client portal for non-emergency issues**. These correspondences become part of your clinical record. You simply send a portal email to your clinician and within two business days you will receive a response. Examples of appropriate use of the client portal include, but are not limited to, scheduling appointments or asking questions about mental health benefits.

Texting:
To protect your privacy, we, the Pastoral Institute staff, **DO NOT** use SMS or MMS texting with clients.

Cost of Sessions:
The same fee rates will apply for telemental health as apply for in-person therapy; however, insurance or other managed care companies may not cover sessions conducted via telecommunication. If your insurance, HMO, managed care, EAP/CCP provider, or other third-party provider does not cover telemental health sessions, you will be solely responsible for the entire session fee. It is **strongly** recommended that you contact your insurance company prior to engaging in telemental health sessions to determine whether these sessions are covered.

You are responsible to pay any co-payment and/or deductible at the time of your session. You are also responsible for any payments in which your insurance provider refuses to reimburse. If you have insurance with a company in which your clinician is not paneled, an invoice and receipt can be provided to you to submit to your insurance company.

Cancellations and No Shows:
Your appointment time has been reserved just for you. If you find it impossible to keep your appointment time, **please call us at least 24 hours in advance**. Failure to call our office and cancel your appointment 24 hours in advance will result in a **late cancelation fee, which is 50% of the standard session rate**. We offer appointment reminder phone calls 48 hours prior to your appointment; however, this is **a courtesy** and you are still responsible for canceling your appointment at least 24 hours in advance.

If you do not initiate the meeting at your scheduled time, or contact your clinician within **five (5) minutes** of your session start time, it will be considered a **no show** and you will be **charged** for the session. By not canceling your appointment as stated in the cancellation policy above, you are agreeing to pay the **no show fee, which is 50% of the standard session fee**. Inform your clinician if you would like him/her to contact you in the event you do not initiate your session within the first five minutes of the start time of your session.

Video conferencing counseling sessions are held via OTTO Health. You will be sent an email **one day** prior to your session and **thirty (30) minutes** prior to session as reminders. It is recommended that you sign on to your OTTO Health account initially at least **twenty (20) minutes** prior to your start time to complete a short questionnaire. Subsequent appointments, please sign in at least **five (5) minutes** prior to your session start time. You are responsible for initiating the connection with your clinician at the time of your session. Once you initiate the session, you will be placed in a virtual waiting room and the clinician will join you shortly.

Privacy Protocol During Telemental Health Sessions:
Always use a private and safe environment for your sessions. If someone enters your space during your session at your location, simply acknowledge their presence by saying hello and your clinician will automatically disconnect from the session. This is to protect your privacy. Inform your clinician if you would like to establish a different procedure for handling interruptions.

Verification of Identity:
If sessions are requested via phone, you will have to have a brief interaction either on-site, or via video conferencing in order to verify your identity by matching you with your picture ID. During this initial verification, you will choose a phrase or number that you will use for all future sessions. This process protects you from another person posing as you.

Emergency Management for Telemental Health:
For your safety, and so that we can get you help in case of an emergency, the following points are important and necessary. Therefore, by signing this agreement form you are acknowledging that you understand and agree to the following:

- ☐ You, the client, will inform your clinician of the location where you will be consistently located during your sessions, and will inform your clinician if this location changes.
- ☐ You, the client, will identify on your client information form the name of a person who your clinician is allowed to contact in the event that he/she believes you are at risk of harming yourself or others.
- ☐ Depending on your clinician's assessment of risk, you, the client, or your clinician may be required to verify that your emergency contact person is able and willing to go to your location in the event of an emergency, and if your clinician deems necessary, call 911 and/or transport you to a hospital. In addition, your clinician may assess, and therefore require that you create a safe environment at your location during the entire time that you are in treatment with the Pastoral Institute.

Backup Plan in Case of Technology Failure:
The most reliable backup is a telephone. It is recommended that you always have a phone available and that your clinician knows the phone number you intend to use as a backup.

If you get disconnected from a **video session**, you should end and attempt to restart the session. If you are unable to reconnect within five minutes, call your clinician at the Pastoral Institute 706-649-6507, ext .

Unless you request otherwise, if your clinician does not hear from you within ten (10) minutes, he/she will call you at the number you provided on the client information form.

If you are disconnected during a **phone session**, call your clinician back immediately. If you and your clinician are unable to reconnect via the phone, your clinician will send you a message via the client portal.

Client Full Name

Date (mm/dd/yyyy)

Full Name of Person Filling Out Form

Relationship to Client

☐ *I accept the terms of this agreement and I affirm that I, am responsible for executing this agreement on the date of*

Complete/signed forms may also be faxed to our secure fax at (706) 649-6521

SAVE & PRINT RESET FORM