**Privacy Rights and Informed Consent for Integrative Therapeutic Services**

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us.

**Psychological Services** Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing difficult aspects of your life.  However, psychotherapy has been shown to have benefits for individuals who undertake it.  Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.  But, there are no guarantees about what will happen.  Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me.

**Yoga/Mediation/Breathwork** Part of our work together may include gentle yoga poses, mediation and/or breathwork. It is your responsibility to inform me about any medical concerns or injuries prior to engaging in the practice. Any adjunct therapies will be done at your pace and comfort level.

**Appointments**  Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. **If you miss a session without canceling, or cancel with less than 48 hour notice, my policy is to collect the session fee.** In addition, you are responsible for coming to your session on time; if you are late, your appointment will still end on time.

**Professional Fees**  The standard fee for a 50-minute session is $190.00. You are responsible for paying at the time of your session. Payment is accepted through Venmo. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me.

**Insurance** I do not accept insurance, but will provide the appropriate information to file a claim your self. You should be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems.  All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that I can provide requested information to your carrier if necessary.

**Professional records** I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records regarding each session along with records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. I recommend that you initially review your file with me or have them forwarded to another mental health professional to discuss the contents.

**Confidentiality** There are some important exceptions to this rule of confidentiality. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child and Adult Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Texas law to report the matter immediately.

· Serious Threat to Health or Safety: Under Texas law, if you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

**Telephone** I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. If you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call.

**Email**: If you choose to communicate via email, remember that email communications are not private. Email is, by its nature, subject to pass through a variety of email servers and thus subject to interception by unknown parties. To further protect your confidentiality, **email is used solely to communicate about basic information, such as appointment times**. I will not respond to requests for any therapeutic guidance over email (this would be done over the phone or in session).

**Other Office Policies**

I am not allowed to accept gifts from clients. While I appreciate your thoughtfulness, I am prohibited by the canons of my profession from accepting gifts from clients.

Similarly, our profession practice standards prohibit me from accepting requests to connect or to be “Friends” on internet sites such as FaceBook, LinkedIn, Instagram and other electronic and social media platforms.

**Your signature below indicates that you have read this Agreement and agree to the terms.**

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Signature of Client

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Printed Name of Client

**Consent to Integrative Therapeutic Services and**

**Acknowledgement of Privacy Rights**

**Yoga/Meditation/Breathwork Liability Waiver:** I understand that I will be practicing gentle yoga poses and that I have informed the instructor, Carter Townsend, PsyD, of any and all injuries or medical concerns prior to my engaging in the practice. I acknowledge that I have discussed any medical concerns fully with Carter Townsend, PsyD. I understand that participating in this practice is voluntary and I will not hold Carter Townsend, PsyD liable for any injury that I might sustain during the course of or as a result of the practice sessions.

**Client Agreement:** I hereby consent to integrative therapeutic services and certify that I understand the nature of these services, including possible risks. I assume responsibility for those risks, which are outlined in the Privacy Rights and Informed Consent for Integrative Therapeutic Services. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking integrative therapeutic services in order to further my own well-being and for no other reason and do not represent a third party. I am aware that I may withdraw this consent and terminate services at any time. I am also aware that there are no guarantees of any specific outcome.

By my signature below, I authorize your office to send emails to the following email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below indicates my agreement that if I miss a scheduled appointment, and do not call within 10 days to reschedule that your office will accept that as my notice of my intent to terminate counseling with your office.

I agree to pay the fee of $180 at the time of service. I agree to pay with either cash, check or Venmo.

By my signature below, I authorize your office to name an appropriate custodian of my record in the event of my psychologist’s death or disability. In the event of Dr. Townsend’s death or disability, contact notice will be posted on Dr. Townsend’s website.

I also understand and have been provided a copy of Dr. Townsend’s Privacy Rights Document, which provides a detailed description of the potential uses and disclosures of my protected health information as well as my rights on these matters.  I understand I have the right to review this document before signing this acknowledgment form.

**Your signature below indicates that you have read this Agreement and agree to integrative therapeutic services.**

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Signature of Client

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Printed Name of Client

**Consent for Telepsychological Services**

Prior to starting **video-conferencing services**, we discussed and agreed to the following:

* There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
* Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
* We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
* You need to use a webcam or smartphone during the session.
* It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
* It is important to use a secure internet connection rather than public/free Wi-Fi.
* It is important to be on time. If you need to cancel or change your tele-appointment, you must notify Dr. Townsend 48 hours in advance by phone or email.
* We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
* We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
* If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
* You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
* As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

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Signature of Client

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Printed Name of Client