Albuquerque Family Counseling
Rescuing your most important Relationships

8500 Menaul Blvd NE, Suite B-455
Albuquerque, NM 87112
(505) 974-0104

CLIENT INFORMED CONSENT

Thank you for choosing us for your counseling needs. We realize that starting counseling is a major decision and you may have many questions. This document represents your informed consent and an agreement between us. By signing it, you acknowledge that you have received the information necessary to make an informed and voluntary decision to participate in counseling as provided. Please read this document carefully and feel free to ask any questions that you may have.

- SERVICES
  Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Consistent therapy has been shown to have huge 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. Psychotherapy requires a very active effort on your part and in order to be most successful, you will have to work on things that we discuss outside of sessions.

- APPOINTMENTS
  Sessions are 45-60 minutes long unless scheduled otherwise. When you make an appointment at AFC, we are designating time just for you.
  If you need to cancel or reschedule a session, it is required that you provide at least 24 hours notice. **If you miss your appointment or cancel your appointment without 24 hours notice, you will be responsible for a cancellation fee of $65.** In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time.

- FEES/PAYMENTS
  The full fee per session is $100.00, which includes the GRT. **All payments are due at the time services and are rendered in the form of cash or credit card**. You agree that all session fees and insurance co-payments will be settled at the time of each session. If you are using your insurance benefits, you are responsible for any and all claims that may be denied. **All clients are required to have a valid credit card on file with AFC. This card will be used for billing purposes only, such as cancellation fees or if a claim is denied by your insurance carrier**. A statement will be issued to you with itemized charges if this occurs.

DOCUMENTATION/ CONSULTATION FEES

All documentation or consultation outside of the therapy session is billed at the rate of $30.00 per 30 minute increment, with a $30.00 minimum. This may include but is not limited to: reports, case consultations with other professionals, or client requested court documents. Client requesting these services will be required to submit the appropriate fee prior to receiving any documents.

- **EMERGENCIES:**

We do not provide emergency services. Messages left for us after 5pm or on the weekends may not be received by us until the following business day. Should you need immediate intervention by an emergency service, please arrange to visit your nearest hospital emergency room for evaluation or call 911.

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The following refers to limits of confidentiality. The law protects the privacy of all communications between counselor and client ***except*** in the following situations.

- If we suspect abuse or neglect of a child under the age of 18, or is said child discloses abuse or neglect directly to us, we am required by law to inform the appropriate authorities, usually the Department of Child, Youth and Family Services (CYFD).
- If we believe that a client presents a substantial and imminent risk of serious harm to another person or himself, we are required by law to take protective action which may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. We are required by law to contact family members who can help provide protection and to facilitate hospitalization for the client. Once notified, it is the family member's responsibility to provide this protection.
- If you are involved in a court proceeding and we are ordered by the court to disclose information, we are required by law to do so. We do not and will not participate or testify in divorce court or child custody proceedings.

<u>COORDINATION OF TREAMENT:</u>

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no inform will be shared.

____You may inform my physician(s) ____we decline to inform my physician(s)

PHYSICIAN NAME: _____
PHONE: _____

MARRIAGE/COUPLES THERAPY:
We acknowledge that if your therapist sees either member of the couple for individual sessions as part of couple treatment, the therapist will not keep "secrets" and will encourage each partner to share information openly and honestly with each other. There may be times when your therapist appears to be on either person's side but is really on the side of the marriage/relationship.

We understand that by entering into marriage/couples therapy there are no guarantees for an outcome of the couple staying together. We agree not to subpoena the therapist to testify for or against either party or to provide records in a court action.

TECHNOLOGY CONSIDERATIONS AND PRIVACY:
In attempt to protect confidentiality we ask that all cell phones be turned off while here. If you need to make a call or a text, please do so in the waiting room or outside. Please be aware that pictures, videos or voice recordings are NOT allowed in these offices during or out of session.

Confidentiality via text or email correspondence cannot be guaranteed. Although text and email communication can be very efficient and expedite the transmission of information, AFC cannot guarantee that they will confidential or remain private due to the unsecure nature of them both.

Cell phone and smart device usage is prohibited…Due to the nature of all technological advancements and the use of "smart" devices, cell phone and smart device usage will be restricted to the waiting room, unless prior approval is given by the therapist.

Recording of sessions is strictly prohibited. Session recordings will only be allowed if all parties involved agree to such recordings and sign a release authorizing such recordings. This policy will be firmly followed due to confidentiality concerns.

THANK YOU FOR YOUR RESPECT OF CONFIDENTIALITY AND THIS POLICY.

CHILDCARE POLICY:
Children are not allowed in session or left unsupervised in the waiting area. In order to maximize your time with your therapist please make sure you have made arrangements for childcare prior to your appointment.

(If you are scheduled after 5:00pm on the weekdays or on a Saturday please wait for your therapist to let you in the main lobby doors)

We have read and understand the above information. Any questions or concerns have been answered.
Signature/Client_____Date_____

Signature/Client_____Date_____

This permission is valid for a period of one year from the date signed.

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 505-974-0104 or from Kelly Chicas, our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Signature of client or his or her personal representative Date

I authorize the billing of any and all transactions incurred at Albuquerque Family Counseling including claims denied by my insurance carrier or late cancelation/no show fees. These will be charged to the credit card listed below anytime after charge being incurred or claim being denied. I understand that my credit card will only be charged in the event of a late cancellation/no show, or claims denied by my insurance carrier.

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I understand that Albuquerque Family Counseling checks my initial quote of benefits and bills for services as a courtesy, but that it is not a guarantee of payment from my insurance carrier. I understand that I am responsible for knowing and understanding my insurance benefits and that I am ultimately responsible for the balance due of any claim that my insurance plan denies or does not pay.

- Copayment: This is a set amount by your insurance carrier and is your responsibility. If this amount changes you will be responsible for the difference and will be charged to the credit card on file.
- Coinsurance: This amount will be determined by whatever your coinsurance percentage is for these services (20% = $20) and will be due at the time of each visit. If this amount changes you will be responsible for the difference and will be charged to the credit card on file.
- Deductible: You will be responsible for paying out of pocket, per visit, at the time of service, until your deductible is met. If your insurance applies anything to your deductible for any services billed and we have not collected at the time of service you will be balance billed to the credit card on file.

I understand that if any charges are applied to my credit card, Albuquerque Family Counseling will provide an itemized statement to me regarding those charges upon request. I agree to all terms and conditions set forth by Albuquerque Family Counseling and understand that by signing this agreement, I relinquish the right to dispute any charges.

Type of Credit Card: (Circle One) □**Visa** □**MasterCard**

Account Number:_____

Expiration Date:_____

3 digit Verification Code Number:_____

Card Holder's Name as it Appears on the Credit Card:_____

Credit Card Billing Address:_____

City, State, Zip_____

Print Name:_____

Authorized Signature:_____

Client Name: _____
Date of Purchase: _____
Amount: _____ Sessions: _____
Counselor: _____

By signing this I agree to the terms of the package that I am purchasing. I agree that I have 60 days from the date of purchase to use any and all sessions included in this package. I understand that this is a non-refundable package and if I do not use the sessions allotted in this package within 60 days from purchase date I forfeit the remaining session(s). I understand that under no circumstance are any sessions in this package refundable for any reason.

Client Signature: _____ Date: _____

Informed Consent for Distance Counseling Services

The purpose of this document is to inform you, the client, about many aspects of online and telephone counseling services: the process, the counseling, the potential risks and benefits of services, safeguards against those risks, and alternatives to online services. Please initial next to each paragraph to acknowledge that you have read and agree to these terms.

_____ **1) Possible misunderstandings**
The client should be aware that misunderstandings are possible with online counseling devices because nonverbal cues are relatively lacking. Even with video software,
misunderstandings may occur due to connection problems causing image delays or less than optimal image quality. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact, and other non-verbal cues. If you have never engaged in online counseling before, please have patience with the process and clarify information if you think your counselor has not understood you well. Also, please be patient if your counselor asks for periodic clarification.

_____ **2) Privacy of the counselor**
Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. Albuquerque Family Counseling has chosen to use HIPAA compliant VSee as the software provider for web conferencing. The client is responsible for securing his or her own computer hardware, internet access points, and password security. Clients must seek the written permission of the counselor before recording any portion of the session. Clients are prohibited from posting any portion of said session on internet websites such as Facebook or YouTube or any other form of social media.

_____ **3) Potential risks** There are various risks related to electronic provision of counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. Confidentiality could be breached in transit by
hackers or Internet service providers or at either end by others with access to the client's account or computer. People accessing the internet from public locations such as a library, computer lab, or café should consider the visibility of their screen to people
around them. Position yourself to avoid others' ability to read your screen. Using cell phones can also be risky in that signals are scrambled but rarely encrypted.

_____ **4) Safeguards** Your counselor has selected an account with VSee for video communications to allow for the highest possible security and confidentiality of the content of your sessions. In order to benefit from these safeguards, the client is required
to download, register and utilize the chat and video software from VSee.com. Your personal information is encrypted and stored on a secure server in compliance with HIPAA regulations. Using Skype for video conferencing is not a HIPAA compliant platform. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping their email IDs and passwords secret,
and maintaining security of their wireless internet access points.
Please discuss any additional concerns with your counselor early in your first session so as to develop strategies to limit risk.

_____ **5) Records** The counselor will maintain records of online counseling and/or consultation
services. These records can include reference notes, internet communication and session summaries. These records are confidential and will be maintained as required by applicable legal and ethical standards according to the American Counseling Association and the National Board of Certified Counselors.

_____ **6) Disconnection of Services** If there is ever a disruption of services on the internet then the client will need to call their respective counselor to discuss how to proceed with the session.