

**Required form for Online Therapy**

**Confidentiality Policy in Emergencies**

Given we will not be meeting in person, it is important that I know your location so I am able to get you help should a medical or psychological emergency arise. Please share the location from which you will be conducting our sessions.

Physical Location of Client Receiving Services:

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Your signature below confirms that you agree to share your location with me prior to or at the beginning of your session should it be different from the location listed above. \_\_\_\_\_

Please provide me with two emergency contacts just in case you need emotional assistance that doesn't meet the criteria of needing to be hospitalized. Please name two emergency contacts, their relationship to you, their phone numbers, and email address. By signing below, you agree that I may, but am not required to, contact either of these people if I am concerned for your safety. In the case that I have dire concerns for your safety, I will do all that I can to protect you, including calling 911 or other emergency responders.

_____	Name, Relationship
_____	Phone number, Email
_____	Name, Relationship
_____	Phone number, Email

**International Clients**

Please ensure that your emergency contacts speak both English and the native language of the country you are living in so that I am able to get help to you. Please also list below major country contacts I may need to get help to you (e.g. medical transportation process/contact information; mental health resources you or I could use in case of emergency, etc.). Please provide context about each.

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**Methods of communication**

Reminders sent via text or email, paying invoices via email, or sharing information electronically can sometimes be helpful and convenient for clients. Given the

limitations of security for electronic communication, I would like to know which of the following you are comfortable with. Please sign next to each that you are comfortable using for administrative issues like scheduling, invoicing and collecting paperwork if not submitted through my client portal.

\_\_\_\_\_ Email  
\_\_\_\_\_ Cellular Phone using Internet (VOIP) (my secure  
business phone line) \_\_\_\_\_ Text via Cellular Phone above  
\_\_\_\_\_ Voicemail via Cellular Phone above  
\_\_\_\_\_ Other methods. Please list.  
\_\_\_\_\_

Please list your preferred email and phone number:

\_\_\_\_\_ Email  
\_\_\_\_\_ Phone Number

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material. Please initial next to each item you consent to.

I consent to allow **Howard Lane, LMHC** to use unsecured email, cell/VoIP phone text messaging, calls, faxes, or voicemail to transmit to me the following protected health information:

\_\_\_ Information related to the scheduling of meetings or other appointments  
\_\_\_ Information related to billing and payment  
\_\_\_ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

\_\_\_\_\_ Signature

Are there limitations about what you would want me to share via text, email, voicemail, etc.? Please share below. I want to ensure we are on the same page!

\_\_\_\_\_  
\_\_\_\_\_

## **INFORMED CONSENT AND AGREEMENT FOR CLINICAL SERVICES.**

Please read the following information carefully. After you have read the Agreement, please sign your name below to accept the terms of this Agreement.

This document (the Agreement) contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice). The Notice explains HIPAA and its application to your personal health information in greater detail.

This document also contains important information about psychotherapy, professional services and business policies related to the psychotherapy your clinician delivers. Please read it carefully and ask any questions you might have. By signing this form, you indicate that you agree to and understand the psychotherapy process and business policies between you and your therapist. This document represents an agreement between you and your clinician.

### **A. INFORMED CONSENT**

As a legally consenting individual, you agree to permit the clinician to provide evaluation, treatment, and therapy to yourself, or any individual under your guardianship. You understand that the clinician has the right to terminate evaluation, treatment, or therapy at any time without incurring additional costs.

Psychotherapy can have benefits and risks. As with most other forms of treatments, results cannot be guaranteed.

Participation in therapy can result in a number of benefits to you, including increased insight into your patterns of feeling, thinking, behaving and relating to others; improvement in your relationships; solutions to specific problems you bring forward in therapy; and improvement in symptoms of distress.

Benefits to therapy require openness on the part of the therapy client. When information about your feelings, thoughts, behaviors, relationships, or other difficulties are withheld, it is not possible for the therapist to help you with them or to help you understand how they may be related (or not) to the issue for which you are seeking treatment. Benefits also require consistent attendance in therapy and work both in and outside of therapy sessions.

Since evaluation and/or therapy often involves discussing unpleasant aspects of your life, you may experience difficult emotions. For some symptoms and emotions get better when shared, and for others they may get worse before getting better.

When these feelings come up, it is important to talk to your therapist about them. They may be a natural, tolerable, and expected reactions to your work in psychotherapy. Other times it may be necessary or preferable to change the pace

of your therapeutic work if the feelings are too uncomfortable. Or, if the treatment is not helping, it is important to talk about other treatment options.

## B. EMERGENCY SITUATIONS

I operate by appointment only and do not provide 24-hour crisis services. If you have a life-threatening crisis, please call 911, a crisis line, or go to a hospital emergency room. You can also contact 211, or 988 for psychological crisis support. If you anticipate needing additional support, please let your clinician know and we can sure we come up with a support plan that meets your needs.

## C. CONFIDENTIALITY

Confidentiality is incredibly important to psychotherapy. Information shared with your clinician will remain confidential and I will not share it with anyone without your written authorization. However, there are circumstances in which I am required to disclose information without either your consent or authorization, including:

- If you are involved in a court proceeding, information pertaining to your evaluation, diagnosis, or treatment is protected by the clinician-patient privilege law. The clinician cannot provide any information without either:
  - o Your or your personal representative's written authorization
  - o Receipt of a subpoena with documentation of satisfactory assurances of notice to the client and a certification that no objection was made by the client, or that the time for filing objection has elapsed, and no objection was filed, or all objections filed were resolved by the court, and the disclosures are consistent with the resolution OR
  - o A court order signed by a judge
- Your clinician may be required to provide information if a government agency is making a request for the information to be used in health oversight activities.
- Your clinician may disclose relevant information regarding a patient in order to defend himself/herself if a patient file a complaint or lawsuit against him/her.
- If you participate in court ordered therapy and the court requests records or documentation of your participation in services, your clinician will discuss the information being sent to the court with you prior to submitting it.
- In the case of a credit card dispute, your clinician reserves the right to provide the needed and adequate documentation (i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy) to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you make other arrangements. There are some situations in which your clinician may be legally obligated to take actions in order to

protect you or others from harm. At this time, I may have to reveal some information about your treatment, including:

- If your clinician has reasonable cause to suspect that a child under 18 is abused, abandoned or neglected, or I have reasonable cause to believe that a vulnerable adult is abused, neglected or exploited, the law requires that I file a report with the appropriate government agency.
- If your clinician believes that you present a clear and immediate probability of physical harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization of the patient.
- your clinician may be required to seek hospitalization for you or to contact family members or others who help provide protection if I believe that you present a clear and immediate danger to yourself,

Additionally, your confidentiality may be waived in the event your clinician chooses to enlist a collection agency and/or claims court to recover any unpaid balance for which you are responsible. In this case, only information relevant to payment would be released such as dates and types of service, no clinical information would be conveyed.

I sometimes find it helpful to consult with other professionals regarding clients. When doing so, a client's name and other identifying information is not disclosed. Confidentiality is maintained during these consultations and the client's identity remains anonymous.

At times I use an administrative assistant for scheduling, filing and. All administrative staff have been given training about protecting your privacy and have agreed not to release any information without being legally required or with the permission of the client or clinician.

If you sign an authorization to release information form and specify the information you want released, I will release that information to the agency or person you approve unless releasing the information could be harmful to you.

#### D. CONFIDENTIALITY OF EMAIL, CHAT, CELL PHONE, VIDEO, AND FAX COMMUNICATION.

Communication with your clinician via any online or electronic means (e.g. email, text, video chat) is limited in security and thus your confidentiality may not be guaranteed. In the event of an injury, illness, or other unexpected emergency situation that results in your clinician being unavailable, your basic contact information (name and contact numbers or email) may be provided to a fellow clinician or associated professional. This will allow for your timely notification of appointment cancellations, as well as provide you with an opportunity to obtain further information regarding your continued care.

Considering all of the above exclusions, if it is still appropriate, upon your request, your clinician will release information to any agency/person you specify unless he/she concludes that releasing such information might be harmful in any way.

Ecounsel email, chat, and video exchanges are secure. By signing this document, you agree to work with online email, chat, video services determined to be suitable by Ecounsel. If you choose to use your personal email account, please limit the contents to administrative issues (e.g., cancellation, change in contact information, etc.). Remember that unless we are both on landline phones, the conversation is not confidential. Similarly, text messages are not confidential. If you are working online, your clinician asks that you determine who has access to your computer and electronic information from your location, including family members, coworkers, supervisors, and friends. We advise you to communicate through a computer that you know is safe (i.e. wherein confidentiality can be ensured). Finally, be sure to fully exit all online counseling sessions and emails before leaving your computer.

E. APPOINTMENTS The clinician should be notified at least 24 hours in advance if an appointment cannot be kept or you will be responsible for the fee for the missed appointment.

#### F. RIGHT TO DISCONTINUE TREATMENT

The clinician has the right to discontinue evaluation, treatment, or therapy for any appropriate reason, including but not limited to, repeated lateness and excessive cancellations. In such cases, the patient or the patient's personal representative agrees to accept full responsibility for pursuing alternate professional services. A letter will be sent informing you or your personal representative that treatment is being discontinued.

#### G. PROFESSIONAL RECORDS

You have access to your clinical record, unless such access is determined by the clinician to be harmful to you. If that access is restricted, the patient or his/her legal representative, will receive written notice of that fact and the reasons for the restriction will be recorded in the clinician's clinical record. If you are a parent, you understand that you have the right to general information about your child's treatment but may not necessarily have access to the complete record. You agree to provide information to the clinician that will enable him to deliver appropriate care and assistance. I also agree to actively participate in my treatment. It is important for you to know that the clinician is independently providing you with clinical services and is fully responsible for those services.

#### H. PATIENT RIGHTS

HIPAA provides you with a number of rights, which briefly include the right to amend the information in your record and to request restrictions as to how you are contacted. Please review the Notice of Privacy Practices carefully.

#### I. MEDICAL EXAMINER'S OFFICE

In the event of my death, you hereby release and hold harmless the clinician as the custodian of your Clinical Record from any and all liability resulting from or arising out of the release of your record to the Medical Examiner's Office pursuant to state law.

## J. ELECTRONIC COMMUNICATION AND SOCIAL MEDIA POLICY

Multiple types of electronic communications are common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put client privacy at risk and can be inconsistent with the law and with the standards of this profession. Consequently, the clinician has prepared this policy to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with the clinician.

### **Email Communications**

The clinician uses email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. Any email communication or text messages with the clinician, should be limited to things like setting and changing appointments, billing matters, and other related issues. If you need to discuss a clinical matter with the clinician, please do not email but rather feel free to call him/her to discuss it on the phone or wait so to discuss it during your therapy session. Emails will be responding to during business hours only, unless otherwise specified.

### **Text Messaging**

Because text messaging is a very unsecure and impersonal mode of communication, I do not use text messaging to contact clients or respond regarding treatment. Please discuss with me if you need to use a messaging platform for any reason.

### **Social Media**

The clinician does not communicate his/her clients through social media platforms (e.g., Twitter, Facebook, Instagram, etc). If the clinician discovers that an accidentally established online relationship with the patient exists, he/she will cancel that relationship. This is because these types of casual social contacts can create significant security risks for the patient. The clinician participates on various social networks, but not always in professional capacity. If you engage in online forums, there is a possibility that you may encounter the clinician by accident. If that occurs, please discuss it with him/her during scheduled time together. Please do not try to contact him/her via social media. The clinician will not respond but rather terminate any online contact no matter how accidental.

### **Websites**

The clinician has a professional website that is used for professional reasons to provide information to others about the clinician and his/her practice. You are welcome to access and review the information that on that website and, if you have questions about it, it should be discussed during your therapy sessions.

### **Web Searches**

The clinician will not use web searches to gather information about you without your permission. The clinician believes that this violates your privacy rights; however, he/she understands that you might choose to gather information about the clinician that way. There is an incredible amount of information available about individuals on the internet, much of which may be inaccurate. If you encounter any information about the clinician through web searches, or in any other fashion for that matter, please discuss this with him/her during scheduled time together so that it can be processed. Patients may sometimes want to review their health care provider various websites. Unfortunately, mental health professionals cannot respond to potentially inaccurate comments or related errors because of confidentiality restrictions. If you encounter a review of the clinician, please share it in treatment so that it can be discussed. Please do not rate his/her work on any of these websites while in treatment together as it could potentially damage the therapeutic relationship.

### **Limitations of Online Psychotherapy**

Telephone, chat, and video sessions have strengths and limitations compared to sessions provided in a shared physical space. It is important to consider if those limitations may impact your therapeutic progress and if so, select an in-person provider. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice. Online psychotherapy providers, like many in-person providers, do not provide 24-hour crisis services. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room. Should your clinician determine that you are at risk, she may call local police to assess your safety in person. Your clinician follows the laws and professional regulations of the state in which the provider is licensed, and the sessions will be considered to take place in the state and country in which the provider is licensed.

### **K. MINORS & PARENTS**

Emancipated Minors do not need parental consent for mental health care. Their private health information is confidential and cannot be released to anyone without the client's consent. Unemancipated Minors must have the consent of their personal representative (e.g., natural or adoptive parents, legal custodians or guardians, or a person acting as the minor's parent) for nonemergency mental health care. Unless the personal representative agreed in advance to a confidential status between the child and the clinician, they have access to the minor's record. Confidential status means that a clinician asks a personal representative to step out so that the provider may talk confidentially to the minor client (i.e., the representative agrees to confidential relationship between the child and the



provider, and may only know what the conversation was about if the child authorizes it). It is our center's policy to require authorization for treatment from all legal guardians of the minor child except under specific situations which may require an affidavit. Furthermore, if consent is revoked by any of the legal guardians or parents, it is our center's policy to terminate treatment except in emergencies.

#### L. TERMINATION OF SERVICES

You are free to end service at any time for any reason, whether or not the clinician considers it advisable. The clinician prefers that you tell him/her when you plan to terminate treatment instead of just not returning and that you schedule one final appointment in order to review your progress and discuss any referrals that might be beneficial to you. There are a few situations in which the clinician may end service regardless of your wishes:

- If the clinician is convinced that you no longer need service and cannot benefit from continuing.
- If the clinician is convinced that your needs surpass his/her ability to help you, he/she will refer you to a suitable source of help.
- If you do not comply with our mutually developed treatment plan, and there is no benefit in continuing service.
- If you do not abide by the policies and procedures of this setting as set forth in our working agreement, including missing appointments or failing to be current in payments.
- If our service relationship becomes compromised, troubled, or deteriorates. In such instances, we will discuss potential issues as part of therapy. If the problems cannot be resolved, it will be necessary to end our service relationship. The clinician will then refer you to another source of service. If you are in crisis, the clinician will make every effort not to end the relationship until the crisis is resolved.

#### M. TIME OF APPOINTMENTS

Each of our appointments is scheduled to last 50 minutes. The clinician usually begins at the scheduled time. If the clinician is ever late, he/she will try to let you know in advance. If the late start is due to the clinician, the session's duration will still be for a full 50 minutes. If you arrive late for an appointment, we will end the meeting 50 minutes after it was originally scheduled to begin. The charge to you for these shortened meetings will be for the full amount; however, you will not be charged for a session if you cannot keep it and let me know at least 24 hours in advance. You will be charged if you fail to keep a scheduled appointment or do not notify me 24 hours ahead of time. Serious immediate emergency conditions will be considered. In the event that you are called away for an emergency or have a sudden illness or accident, please make every effort to contact, or have someone else contact, the clinician as soon as possible. He/she will be concerned about you

and will want to know your circumstances. The clinician will want to reschedule the appointment if possible. In the event that the clinician is called away for an emergency or has a sudden illness or an accident, the clinician will make every effort to contact you as soon as possible, to apprise you of the circumstances, and to reschedule the appointment.

#### N. RESPONSIBILITY OF PAYMENT.

You understand that the fee for service is \$125 per 50-minute therapy hour or whatever was agreed upon at the time the appointment was made. You understand that there is a full fee charge for appointments that are not cancelled with at least 24 hours of notice. You understand this cancellation policy and agree to the terms. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the clinician has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require disclosure of otherwise confidential information.

#### O. AUTHORIZATION FOR INSURANCE BENEFITS BILLING.

You hereby authorize the release of any medical or other information necessary to process claims. You also authorize payment of medical benefits to the clinician for the services described in the submitted claims.

#### P. THE THERAPEUTIC PROCESS.

1. Participating in therapy may have several beneficial consequences, including improving personal relationships and resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). Major benefits that may be gained from participating in therapy include: a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress; greater understanding of personal and relational goals and values; greater maturity and happiness as an individual and increased relational harmony; and resolving specific concerns brought to therapy. The clinician cannot guarantee ultimate outcome of therapy.
2. Homework assigned in therapy is an essential aspect of change and the clinician may assign tasks between sessions related to your goals. It is imperative that you commit to work as efficiently as possible. At times, you may feel as if therapy progress slower than you anticipated. The clinician and you will work together to identify your therapeutic goals and then periodically, review your progress toward the identified goals.
3. In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort in several ways, including through intense, unexpected feelings or relational changes that may not be originally intended. It is important to understand that albeit the collaborative effort of the clinician and patient, there is a possibility that the goals

of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

#### R. LENGTH OF THERAPY.

Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but the clinician will continuously assess, together with you, how much longer therapy is recommended.

#### S. TRIAL, COURT ORDERED APPEARANCES, LITIGATION.

Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if the clinician gets called into court by you or your attorney, you will be charged \$575.00/hour (e.g., travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc.). A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to your practice location or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks.

#### **Discharged from care**

Psychotherapy is best ended with a process of termination and a scheduled final appointment. This will allow you to review therapeutic gains achieved during treatment; develop a plan of action to maintain those gains; identify what other services or activities may still be needed; and to process any emotions that may exist regarding the ending of the therapeutic relationship. If you decide to end therapy without engaging in the process of termination by not scheduling appointments or by not returning at least two telephone calls, it will be assumed that you are no longer a client of your clinician and you are, therefore, discharged from care.

Both the therapist and the client have the right to end counseling at any time.

#### **Litigation Limitation**

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

#### **Mediation and Arbitration**

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initial of arbitration. The mediator shall be a neutral third party chosen by agreement of iTherapy, your clinician and you (the client). The cost of such

mediation, if any, shall be split equally, unless otherwise agreed. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

**Agreement**

Your signature indicates that you have read this contract in its entirety; that you understand all that it contains; that you agree to abide by its terms; and that you voluntarily consent to treatment. Additionally, your signature below indicates that you understand that I, **Howard Lane, MS, LMHC**, am an independent practitioner; therefore, ecounsel, and associated providers are not responsible for or involved in your care or treatment unless you directly contracted with that provider.

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Signature of Client or Personal Representative

Date