Participant Information

Name _____ Preferred Name_____

Gender at Birth _____ Gender Identity_____

Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Birth date _____Age_____ SSN _____ Marital Status _____

Do you want to ☐ Private Pay ☐ Use Insurance Benefits listed below

Insurance Type ☐ Commercial ☐ Centennial ☐ EAP

Primary Insurance Provider _____ Insurance ID # _____

Primary Insured Name _____ Primary Insured DOB: _____

Primary Insured SSN _____ Secondary Insurance Provider _____

Secondary Insurance ID # _____ Secondary Insured Name _____

Secondary Insured DOB _____ Secondary Insured SSN _____

Are you presently under a physician's care? YES NO

If yes, for what? _____

Physician's name _____Psychiatrist's name_____

Were you referred to this agency? YES NO

If yes, by whom_____

Do you have a Psychiatric Advance Directive (PAD)? YES NO

If yes would you be willing to provide us a copy for your record? YES NO

If No, would you like us to provide you information on a PAD? YES NO

Medication (s) and dosage (current) _____

_____

_____

Have you received prior counseling? YES NO

If yes, was it: OUTPATIENT INPATIENT

When _____ Where _____

By whom _____ Length of treatment _____

Problem(s) treated

_____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the same ☐ Somewhat Worse ☐ Much Worse

Form Completed By: _____

Emergency Contact:
Name _____ Relationship _____
Address_____
Home/Cell Phone _____ Work Phone _____

Please check any of reasons listed below which resulted in you seeking services

- ❍ Depression
- ❍ Anxiety
- ❍ Issues w/partner
- ❍ Communication Difficulties
- ❍ Relationship enhancement
- ❍ Parent/Child conflict
- ❍ Identity issues
- ❍ Court-ordered for: _____
- ❍ Gambling
- ❍ Personal Growth
- ❍ Medical: _____
- ❍ Alcohol or substance use
- ❍ Difficulty with loss or death
- ❍ Problems at school/work
- ❍ Issues w/Family
- ❍ Trauma/Abuse
- ❍ Child Behavior/Acting Out
- ❍ Divorce
- ❍ Legal problems
- ❍ Parenting
- ❍ Skills Acquisition
- ❍ Other: _____

Please provide a summary of why you are seeking therapy in the space below.

As you think about the primary reason that brings you here, how would you rate its frequency and your over-all level of concern at this point in time (note: a problem may occur rarely but be of serious concern, or occur frequently, but be of little concern)?

Concern	Frequency
❍ No concern	❍ No occurrence
❍ Little concern	❍ Occurs rarely
❍ Moderate concern	❍ Occurs sometimes
❍ Serious concern	❍ Occurs frequently
❍ Very serious concern	❍ Occurs nearly always

On a scale of 0 to 10, how **IMPORTANT** is it for you right now to change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 *Extremely Confident*

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 *Extremely Confident*

On a scale of 0 to 10, how **READY** are you to make this change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 *Extremely Confident*

This form has been completed to the best of my abilities and I attest that the information contained herein in accurate.

_____ X _____ Client/Parent/Guardian Signature

_____ Date

Informed Consent for Treatment – Adolescent (age 14-18)

I,_____born on_____hereby request that I
(Patient Name)
be accepted for mental health treatment as described to me.

I give my authorization and consent to receive outpatient diagnostic and treatment services from The Family Connection, LLC.

I have received and understand my Rights and Responsibilities as a Family Connection, LLC patient regarding treatment and agree to these statements.

I understand that I have a right to have my information kept confidential. This information will remain confidential unless certain criteria are met; written consent to disclose certain information, if you are an imminent danger to self or others, if you disclose abuse (physical, sexual, etc. or neglect) that The Family Connection, LLC is required by law to report, or if a court requires specific information. As a general rule the information you share during treatment will not be shared with your parent/guardians but you will be encouraged to have open, healthy communication with your parents/guardians. Also, when meeting with your parents, we may address general problems, without specifics, in order to help them know how to be more helpful to you. If there are things you would not like addressed even in general terms, please communicate those with the therapist, to ensure that you are able to have your goals and desires met. The goal of treatment will always be to protect your confidentiality and the effectiveness of the therapeutic relationship by helping you communicate and share your needs and desires, to foster healthy communication patterns.

I have been given the Notice of Privacy Practices of The Family Connection, LLC which describes how my medical information may be used and disclosed.

I have been given The Family Connection's Social Media policy which describes how The Family Connection LLC and its employees conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.

I acknowledge that The Family Connection LLC conducts on-going in-house training and that details of my case, without identification of the patient, may be discussed to improve treatment during clinical supervision.

I acknowledge that I, or whomever is responsible for payment on my behalf, will be responsible for payment of any fees associated with my account. I acknowledge that I am responsible for communicating with the person responsible for payment on my behalf regarding charges associated with my account. I also acknowledge that I have the right to sign a Release of Information to allow the person responsible for payment on my behalf to have information regarding the financial aspects of my treatment and that I am responsible for designating my desires in writing.

I have been given information about the advantages and disadvantages of the treatment recommended, as well as other alternatives. As with any effort to create lasting change, counseling requires time, energy and commitment. Counseling can feel frustrating because we cannot control the pace of change. On the path toward healing, clients may experience an increase in painful feelings; this is a normal part of the process.

I understand that I may discontinue treatment at any time.

I understand that I may address any concerns or grievances with my therapist or any other representative of The Family Connection, LLC at any time. I understand that the best practice is to work with the therapist and supervisor to resolve any complaints but understand that I may also contact the licensing board which regulates my therapists' professional practice.

I authorize the release of any medical, mental health, or other information to my health insurance carrier or the other person or company paying for my treatment. The release of such information should be limited to that necessary to process claims for payment. I have a right to examine and copy any information disclosed to insurers or other payers under this paragraph.

I authorize payment of medical benefits to The Family Connection, LLC for treatment services.

I acknowledge that the therapeutic process is most effective when family members and the therapist make a commitment to the therapeutic process. I understand that I, or whomever is responsible for payment on my behalf, may be assessed the full session fee for all/any appointment cancelled without 24-hour notice.

I understand that the role of the therapy is treatment, and *it is policy of The Family Connection, LLC not to testify or otherwise participate in any legal proceeding unless legally compelled to do so.*

The signatures below reflect that I agree to the terms set forth above.

_____ _____

Signature of Patient Date

Parent/Guardians:

I,_____, as the legal guardian of _____born on_____, I request that my adolescent child be accepted for mental health treatment.

1. I have read and understand the above agreements that my adolescent patient has agreed to.
2. I have been given information regarding the cost of services from The Family Connection, LLC. I understand that as the parent/legal guardian of the patient, I may be responsible to pay a co-pay and that it is payable each time the adolescent patient receives treatment. I also acknowledge that I am responsible for any fees not covered by the insurance company for treatment associated with the adolescent patient.
3. I acknowledge that the therapeutic process is most effective when family members and the therapist make a commitment to the therapeutic process. I understand that as the parent/legal guardian of the adolescent patient I may be assessed the full session fee for all/any appointment cancelled without 24-hour notice.
4. I agree that my adolescent will hold the privilege of confidentiality of records and treatment for counseling services, acknowledging the importance of trust and confidentiality in the therapeutic relationship for successful treatment.
5. I will refrain from requesting detailed information about individual therapy sessions with my adolescent. I understand that because my adolescent child holds the privilege of confidentiality I will only be given information that has been released by the patient.
6. I acknowledge that I may be asked to participate in therapy sessions as needed, only upon the authorization of the adolescent patient.
7. I acknowledge that The Family Connection, LLC and its representatives are required by law to report suspected abuse or neglect.
8. I acknowledge that the goal for seeking counseling services for my adolescent is for the sole purpose of the improvement of psychological distress and that the process of treatment.
9. I understand that the role of the therapy is treatment and it is policy of The Family Connection, LLC not to testify or otherwise participate in any legal proceeding unless legally compelled to do so. I agree not to involve The Family Connection LLC in any legal disputes, especially a dispute concerning custody or custody arrangements (visitation, etc.). I acknowledge as the parent/legal guardian of the adolescent child that if The Family Connection, LLC or any of its staff is subpoenaed regarding my adolescent child's care that I, as the legal guardian, will be financially responsible for all costs associated as outlined on the Client Financial Agreement per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

The signature below reflect that I agree to the terms set forth above.

_____ _____

Signature of Parent/Legal Guardian Date

Client Financial Responsibility Agreement

The Family Connection, LLC is committed to providing high quality mental health outpatient counseling. In order to do so, we expect payment at the time of service. The Family Connection, LLC will file insurance claims as a courtesy to those clients who are eligible for reimbursement through their insurance. However, the patient and/or financial/legal guardian are responsible for all fees associated with the services provided. We participate in many healthcare plans and work to provide each patient with a clear understanding of the patient's financial responsibility for services provided. The patient should understand they are responsible for payments – these payments can be made by the patient directly, by the insurance company or by a combination of both. Below is a listing of the approximate fees that may be associated with your care:

USUAL & CUSTOMARY FEE SCHEDULE:

Initial Consultation $200.00	Family Psychotherapy with patient $175.00
Individual Therapy Session (16-37 minutes) $90.00	Family Psychotherapy without patient $170.00
Individual Therapy Session (38-52 minutes) $120.00	Group Psychotherapy (per visit) $55.00
Individual Therapy Session (53-60 minutes) $190.00	Psychotherapy for crisis, first 60 minutes $215.00
Evaluation of records (per/15 minutes) $60.00	Crisis code, each additional 30 minutes $115.00
Preparation for court (minimum of 2 hrs.) ..... $250.00/hr.	Report preparation (per/15 minutes) $50.00
Records request ..... $6.50 avg min, estimated upon receipt of written request, based on copying time, supplies & postage	Court testimony (first 2 hours) .....$500.00/hr.
	Court testimony (each additional hour).....$250.00/hr.

I acknowledge that I have read and understand my obligations regarding the various options for reimbursement of services received at The Family Connection, LLC by initialing below:

( ) Cash Patient/Sliding Scale – I agree to pay the entire session fee (s) prior to services rendered. I agree to submit a complete, thorough and accurate reflection of my entire household income by submitting monthly paystubs etc., to determine financial eligibility for a discount on services. I understand that I am responsible for paying the entire session fee prior to services being rendered, in order to qualify for a sliding scale discount.

( ) Insurance Policy Coverage/Centennial Care - I understand that I am financially responsible for any applicable deductible, co-insurance or co-pays associated with my policy. I understand that my insurance plan may have negotiated specific rates for services rendered and I would be responsible for the cost my specific insurance has identified, provided my insurance covers the service. Should services be denied, I understand that I am responsible for all fees associated with my account and my care. I understand that my plan may have certain restrictions with regard to yearly visit limits, services covered, etc. and understand that I am fully responsible for ensuring my insurance has the information they need to provide coverage for the claim.

Records Requests/Court Fees – I understand that I am responsible for all fees associated with records requests and/or court fees. I acknowledge that these fees will not be covered by my insurance policy.

FINANCIAL POLICY STATEMENT

1. I understand that I am responsible for paying the full amount of each therapy session. TFC accepts cash, Visa, MasterCard, Discover and Health Savings Account cards as well as payments by check and debit cards. Payments may also be made in person and over the phone.

2. I understand that I may make a payment myself, use insurance, or use a combination of these two methods to pay.

3. TFC reserves a time slot especially for the patient. I understand that The Family Connection, LLC requires 24 hours' notice of cancellation of a scheduled session. Failure to cancel within this period will result in a charge for the session up to the billable amount of $100/hour.

4. In understand that The Family Connection, LLC will file insurance claims as a **courtesy** to those clients who are eligible for reimbursement through their insurance. If my insurance plan includes a co-pay, I understand that I am responsible for paying the co-pay on the day of the session. If the co-pay amount changes, I understand that I am responsible for paying the new amount for all sessions covered by the change. If, at any time, my insurance company denies coverage, I understand that I am responsible for the full amount of the session(s) not covered by the insurance. I understand that if I have an insurance policy with an annual deductible, I may be responsible for the full amount of the session(s) until that deductible is met and that payment will be due at the end of each session. I understand that if the insurance company sends payment for services directly to myself, that balance must be sent or dropped off at one of The Family Connection office locations within 72 business hours of receipt.

5. I understand that I am responsible for notifying The Family Connection, LLC immediately of any changes in my insurance, including canceling a policy and/or plan changes. I also understand that I am responsible for paying all sessions according to those changes.

6. I understand that I can request a Good Faith Estimate regarding the estimated cost of services, in compliance with the No Secrets Act.

7. I understand that it is my responsibility to set up a payment plan as soon as possible, in the case there are financial difficulties interfering with my ability to pay. We will work with each client to create a suitable payment plan. The Family Connection, LLC expects that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. We do

utilize the services of a collection agency. I understand that The Family Connection, LLC will refer any balances over 60 days, not in a payment contract, to our collection agency and any fees associated with the collection agency, will be my responsibility. No one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available based on family size and income.

8. I understand that The Family Connection believes that the issues you have brought to counseling are important. We ask that you participate in this counseling contract by keeping the appointments you schedule.

9. The parent/guardian is responsible for payment of services rendered to your dependents account. In cases where a written court order allows payment for medical costs associated with a dependent, it is the responsibly of the parent/guardian to obtain reimbursement from the other party involved. For parents sharing legal custody, it is up to the parents to determine whom is responsible for payment/reimbursement for services. The Family Connection, LLC will determine each parent with legal custody to be responsible for the charges and will seek to be paid, while the legal parents determine how that fees will be reimbursed independent of TFC.

Attestation Statement:
I have read, understand, and agree to comply with The Family Connection, LLC Client Financial Responsibility Policy outlined above. I understand that I am responsible for all charges associated with my care, including but not limited to charges not covered by my insurance, company as well as applicable co-payments and deductibles. I acknowledge that these policies do not obligate The Family Connection, LLC to extend credit.
I authorize my insurance benefits to be paid directly to The Family Connections, LLC.
I authorize The Family Connection, LLC to release pertinent information to my insurance company when requested or to facilitate the payment of a claim.

_____

Patient / Responsible Party Print Date

_____

Patient / Responsible Party Signature Date

Patient Name_____ **DOB** _____

Clients' Rights and Responsibilities

- You have a **right** to receive information about The Family Connection, LLC services, therapists, treatment guidelines and your rights and responsibilities.
- You have a **right** to be treated with dignity and respect.
- You have a **right** to privacy and confidentiality. I understand that during couple's session's confidentiality goes to the couple unit.
- You have a **right** to participate with your therapist in making decisions about your treatment planning.
- You have a **right** to access supports outside of your counseling appointments, such as the use of 911 in emergencies or the 24/7 NM Crisis & Access Line at 1-855-662-7474, a free and confidential support service
- You have a **right** to voice complaints about The Family Connection and/or the care provided to you.
- You have a **right** to make recommendations regarding these "Clients' Rights and Responsibilities".
- You have a **responsibility** to provide, to the extent possible, information that The Family Connection, LLC and its therapists need in order to care for you.
- You have a **responsibility** to follow the plans and instructions that you have agreed upon with your therapist.
- You have a **responsibility** to participate, as much as possible, in understanding your behavioral health problems and developing mutually agreed-upon treatment goals.
- You have a **responsibility** to cancel your appointments with a minimum of 24-hour notice.
- You have a **responsibility** to notify and work with your therapist regarding any concerns of safety to yourself or others, including following through on agreed upon safety contracts.

Signature_____ Date_____

Signature_____ Date_____

Behavioral Health Release of Medical Information for Care Coordination with PCP

Patient Name:_____DOB:_____

Parent/Legal Guardian Name (if applicable): _____Relationship to patient: _____

The current health care system is complicated. When patients get care, they may interact with any number of providers across multiple settings and if health care providers don't coordinate with each other, the consequences can be harmful to the patient. As a community provider we aspire to ensure that you get the best quality care, which includes providing you the opportunity to allow your care to be coordinated with your primary care provider. Please complete the form below to advise us what information, if any, you would like shared with your primary care provider.

☐ **I DO NOT authorize** information about my physical/behavioral health treatment to be released

☐ **I authorize** The Family Connection, LLC to use and disclose the protected health information as indicated below:

- o All health records related to drug/alcohol/substance abuse
- o All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- o Other:_____

Release of medical information from/to The Family Connection LLC to/from my:

Primary Care Physician:_____
Address:_____
Phone:_____Fax: _____

I understand that this medical information may be used to coordinate my care.
I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: _____

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative **Date**

THE FAMILY CONNECTION
CHANGING MENTAL HEALTH

Symptom Distress Scale

During the last seven (7) days, about how much were you distressed or bothered by:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
a. Nervousness or shakiness inside……	1	2	3	4	5
b. Being suddenly scared for no reason……	1	2	3	4	5
c. Feeling fearful……	1	2	3	4	5
d. Feeling tense or keyed up……	1	2	3	4	5
e. Spells of terror of panic……	1	2	3	4	5
f. Feeling so restless you couldn't sit still……	1	2	3	4	5
g. Heavy feeling in arms or legs……	1	2	3	4	5
h. Feeling afraid to go out of your home alone……	1	2	3	4	5
i. Feeling worthless……	1	2	3	4	5
j. Feeling lonely even when you are with people……	1	2	3	4	5
k. Feeling weak in parts of your body……	1	2	3	4	5
l. Feeling blue……	1	2	3	4	5
m. Feeling lonely……	1	2	3	4	5
n. Feeling no interest in things……	1	2	3	4	5
o. Feeling afraid in open spaces or on the street……	1	2	3	4	5
ADD ALL COLUMNS					

TOTAL (min: 15, max:)

Client Name DOB SS# Date

Scored By Title Date Scored

For Office Use Only:

Scoring: Items rated 3 or higher are considered to indicate serious distress. A total summed score of 25 or above indicated moderate distress; Scores of 33 or above indicate severe distress that requires immediate intervention

THE FAMILY CONNECTION®
CHANGING MENTAL HEALTH

Name: DOB:

Adult Depression Screening Form

Zung Depression Self-Rating Scale ©

INSTRUCTIONS: Please fill in one response for each of the 20 statements below based upon how you have been feeling over the past two weeks or longer. Then, please respond to the free-standing statement after item 20.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time	Item Rating
1. I feel downhearted, blue, and sad.	❍ 1	❍ 2	❍ 3	❍ 4	
2. Morning is when I feel best.	❍ 4	❍ 3	❍ 2	❍ 1	
3. I have crying spells or feel like it.	❍ 1	❍ 2	❍ 3	❍ 4	
4. I have trouble sleeping through the night.	❍ 1	❍ 2	❍ 3	❍ 4	
5. I eat as much as I used to.	❍ 4	❍ 3	❍ 2	❍ 1	
6. I enjoy looking at, talking to, and being with attractive women/men.	❍ 4	❍ 3	❍ 2	❍ 1	
7. I notice that I am losing weight.	❍ 1	❍ 2	❍ 3	❍ 4	
8. I have trouble with constipation.	❍ 1	❍ 2	❍ 3	❍ 4	
9. My heart beats faster than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
10. I get tired for no reason.	❍ 1	❍ 2	❍ 3	❍ 4	
11. My mind is as clear as it used to be.	❍ 4	❍ 3	❍ 2	❍ 1	
12. I find it easy to do the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
13. I am restless and can't keep still.	❍ 1	❍ 2	❍ 3	❍ 4	
14. I feel hopeful about the future.	❍ 4	❍ 3	❍ 2	❍ 1	
15. I am more irritable than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
16. I find it easy to make decisions.	❍ 4	❍ 3	❍ 2	❍ 1	
17. I feel that I am useful and needed.	❍ 4	❍ 3	❍ 2	❍ 1	
18. My life is pretty full.	❍ 4	❍ 3	❍ 2	❍ 1	
19. I feel that others would be better off if I were dead.	❍ 1	❍ 2	❍ 3	❍ 4	
20. I still enjoy the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
				RAW SCORE	
				SDS INDEX	

Patient Signature

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
I have recently thought of, or am currently thinking of, suicide.	❍	❍	❍	❍

Electronic Communication Consent by Non-secure Transmission

Patient Name_____ **DOB** _____

CELL #:_____ **EMAIL:** _____

This consent form is for the communication of Protected Health Information ("PHI") that The Family Connection LLC may transmit, without the written authorization of the client, as described in the Uses and Disclosures section of The Family Connections Notice of Privacy Practices.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Family Connection LLC there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communication with The Family Connection LLC.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I,_____, hereby consent and authorize The Family Connection LLC to communicate my PHI through the following non-secure transmissions (please initial all of your choices):

_____ Cellular/Mobile Phone, including text messages

_____Unsecured Email

I,_____, consent and authorize The Family Connection LLC to transmit thefollowing PHI by the above selected electronic communications (please initial all of your choices):

_____Information related to scheduling/appointments
_____Information related to billing & payments
_____Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____My health record, in part or in whole, or summaries of material from my health record.
_____Other information; Please describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

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, in writing, at any time.

_____ _____
Signature of client, parent or guardian Date

* Please complete ***only*** if you ***DO NOT*** consent to the above non-secure communication means: I,_____, ***DO NOT*** consent to the transmission of PHI via unsecure means but would rather receive information about communication through a secure portal.
_____(Please initial)

Informed Consent for Telehealth Services

Definition of Telehealth
Telehealth involves the use of electronic communications to enable The Family Connection LLC to connect with individuals using interactive audio, video, telephone and/or other audio/video communications.

Telehealth includes the practice of psychological health care delivery services such as assessments, diagnosis, consultation, transfer of medical and clinical data, psychoeducation, referral to resources, and treatment.

Considerations regarding Telehealth Services:

1) Technology

Comfort with technology varies among people and therefore, use of telemental health or "telehealth" requires a comfort and proficiency with technology. Your therapist will work to assess with you whether you might be a fit for telemental health prior to engaging in services.

As a standard of practice, we will request that you have an external wide-angle camera that allows for us to see your entire body to help us increase the efficacy of your treatment. We will also request that your internet access meet the minimum standards of 15 Mbps download and 5 Mbps upload.

I understand that there are various technology platforms available for Telehealth. The Family Connection uses Doxy and WeCounsel. The goal of these platforms is to provide access to care in a convenient and accessible way that allows you to focus on your mental healthcare needs. However, it is not without risk, as any Platforms used is not 100% secure and may have issues with wi-fi connectivity. Your provider will work with you to develop a back-up plan, which will include identifying alternate treatment methods if the original platform is not performing adequately or if internet services are down, which may include switching platforms used or scheduling an in-person meeting instead. I acknowledge and agree to follow the back-up plan outlined with your therapist to mitigate technology issues, understanding that there is no guarantee of services at the specific date and time when issues with the technology cannot be resolved.

2) Benefits and Risks

Because of recent advances in communication technology, the field of telehealth has evolved. What is important here is that you are aware that telehealth therapy may or may not be as effective as in-person therapy and therefore, we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy. As a standard of practice and to ensure that you are receiving the highest quality of care, The Family Connection LLC requires that a minimum of one session take place in person to complete a full assessment and ensure that telehealth is a viable option for health care delivery services for you as the patient. I understand that during the course of my services, if my therapist, at any time, believes that I

would be better served by another form of intervention (e.g. face-to-face services), I will be referred to in-person counseling and/or referred to a mental health professional who can provide those services in my area. I acknowledge that there is no guarantee that telehealth sessions will eliminate the need for me to see a therapist or other mental health provider in person.

I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of various technology platforms such as Doxy, WeCounsel, Zoom, etc. are not 100% secure and may have issues with WIFI connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with these communication platforms.

I understand that the alternatives to counseling through telehealth as they have been explained to me, and I am choosing to participate using telehealth technology.

3) Scheduling

I understand that scheduling is based on my therapist's normal clinic hours. I understand that the telehealth appointment is time set aside specifically for my care and therefore, late cancellations and/or no call no shows may be assessed the entire session fee. I acknowledge that parameters for interaction with my therapist, including anticipated response times are covered in The Family Connection's Electronic Communication Consent and Social Media Policy.

4) Financial Obligations

The Family Connection LLC will bill your available insurance for telehealth services.

If insurance is not available, fees associated with telehealth appointments are payable by credit or debit card only. If fees may be associated with my telehealth services, I agree to have my credit/debit card information on file with The Family Connection LLC. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, The Family Connection LLC will cancel my appointment and I will be charged in accordance with the cancellation policy.

5) Confidentiality

The laws that protect confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my treatment is generally confidential with exceptions for safety and legal implications, as expressed in the Informed Consent document. The Family Connection agrees to use a HIPAA compliant electronic platform with a Business Associates Agreement to protect your privacy and confidentiality.

I understand that there are risks and consequences associated with telehealth including but not limited to the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my medical information could be disrupted or distorted by technical failures.

6) Receipt of Services

With telehealth, there is the question of where is therapy occurring – at the therapist's office or the location of the client? It is The Family Connection's policy to inform clients that they are receiving services as if they are in our physical office and therefore are bound by the laws of the State of New Mexico. In addition, due to our therapists' licensure, clients must reside within the State of New Mexico for all treatment services. In participating in telehealth services by The Family Connection, I agree to remain within the State of New Mexico (or for Active Duty military to remain on United States soil) during the course of the treatment session.

7) Handling Emergencies

I understand that by signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based therapy services. If I am in crisis or in an emergency, such as having thoughts about hurting myself or others, having uncontrolled psychotic symptoms, or am in a life threatening or emergency situation, and/or if I abuse drugs or alcohol or am not safe, I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. My therapist and I have discussed my options in regards to handling potential emergency situations that might arise just prior to or during telehealth services, where I have agreed to follow our emergency plan, including the use of a code word when confidentiality is no longer upheld, such as someone entering the space where you are communicating in.

CONSENT TO THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

If Client is a minor:

By:_____

_____
(relationship to minor)

Date:_____

Client:

_____

_____
(printed name)

Date:_____

Authorization to Charge Credit Card

The following represents the conditions under which services will be rendered by **The Family Connection LLC**:

___(Initials) I authorize my credit card to be charged for services in accordance with the signed Client Financial Responsibility Agreement.

___(Initials) I authorize my credit card to be charged within 48 business hours of my scheduled appointment date.

___(Initials) I understand this form will be kept on file.

___(Initials) I understand that it is my responsibility to ensure that I have an updated credit card on file to ensure timely payments and to avoid late fees, collection activities, etc.

___(Initials) I understand and authorize that my credit card will be charged $100.00 cancellation charge for appointments cancelled with less than 24-hour's notice and/or no-show, in compliance with the Client Financial Responsibility Agreement. I understand and authorize that this fee will be charged to my credit card within 48 business hours of my scheduled appointment date.

Patient Information

Name:_____Date of Birth: _____

Credit Card Information

Name on Card: _____

Billing Address: _____

City:_____State:_____Zip Code: _____

Phone #:_____Email:_____

Credit Card Type: ☐ Visa ☐Mastercard ☐Discover ☐Amex ☐Other

Credit Card Number: _____

Expiration Date (MM/YY):_____CVV (# on back of card): _____

I certify that I am an authorized user of this Credit Card and will not dispute these transactions; so long the transactions correspond to the terms indicated in this authorization form.

Cardholder Signature:_____Date: _____

_____I **do not** wish to have a credit card saved on file. I will call the admin office at 505-717-1155 to coordinate payments, recognizing that I may be subject to late fees and/or have my appointments impacted if I do not have my payments made at least 2 hours **PRIOR** to my scheduled appointment.