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 – Families

We hereby request that

_____ (Patient Name & DOB)	_____ (Patient Name & DOB)
_____ (Patient Name & DOB)	_____ (Patient Name & DOB)
_____ (Patient Name & DOB)	_____ (Patient Name & DOB)

we be accepted for mental health treatment family counseling services as described to us.

1. We give our authorization and consent to receive outpatient diagnostic and treatment services from The Family Connection, LLC.
2. We have received and understand My Rights and Responsibilities as a Family Connection, LLC patient regarding treatment and agree to these statements.
3. We have been given the Notice of Privacy Practices of The Family Connection, LLC which describes how medical information about our information may be used and disclosed and how we can get access to this information.
4. We 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.
5. We have signed and understand the specific constraints of participating in couples/family counseling and are in agreement with its limitations.
6. We understand that confidentiality is extended to the entire unit, as the couple unit is the Identified Patient. We understand that records will not be released unless the entire unit consents as privilege for confidentiality is held by the unit, not individuals within the unit.
7. We understand that we have a right to have our information kept confidential. This information will remain confidential unless certain criteria are met; everyone in the family unit provides written consent to disclose specific information, if anyone in the family unit is in imminent danger to self or others or if anyone in the family unit discloses abuse (physical, sexual, etc. or neglect) that The Family Connection, LLC is required by law to report or if the court requires specific information.
8. We have read and understand the limitations of confidentiality in couples counseling as outlined in the Couple/Family Counseling Policy and are in agreement with the "no secrets" policy.

9. We acknowledge that The Family Connection LLC conducts on-going in-house training and that details of our case, without identification of the patient, may be discussed to improve treatment during clinical supervision.
10. We have been given information regarding the cost of services from The Family Connection, LLC. We understand that we may be responsible to pay a co-pay and that it is payable each time I receive treatment and that it is our responsibility to work with our insurance company regarding disputes. We also acknowledge that we are responsible for any fees not covered by the insurance company.
11. We have signed and understand the specific constraints of participating in family counseling and are in agreement with its limitations.
12. We understand that we may address any concerns or grievances with my therapist or any other representative of The Family Connection, LLC at any time. We understand that we may also contact the licensing board which regulates my therapist's professional practice.
13. We are freely choosing to enter into treatment, and we understand that we may discontinue treatment at any time.
14. We 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.
15. We authorize the release of any medical or other information necessary to process claims. We also request payment of governmental benefits to The Family Connection, LLC. We recognize that we will bill under the insurance (as applicable) of the person the unit identifies in the referral as the person whom they chose to access their insurance benefits. We understand that all documentation will be under the identified insured person's name but confidentiality will remain as the entire unit. We authorize payment of medical benefits to The Family Connection, LLC for treatment services.
16. We understand that we may be assessed the full session fee for all/any appointment cancelled without 24 hour notice. We understand that, unless previously outlined by our therapist, all participants in the family counseling must be present to or the session may be cancelled and the full session fee assessed.
17. We 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. We agree not to involve The Family Connection LLC in any legal disputes, especially a dispute concerning custody or custody arrangements (visitation, etc.). We acknowledge that if The Family Connection, LLC or any of its staff is subpoenaed regarding our care that we 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 signatures below reflect that the parties agree to the terms set forth above.

_____	_____
Signature of Patient & Date	Signature of Patient & Date
_____	_____
Signature of Patient & Date	Signature of Patient & Date
_____	_____
Signature of Patient & Date	Signature of Patient & 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 couples 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 **righ**t 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**

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					
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.

TFC.Health
(505)717-1155

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 the following 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.

You may cancel this authorization at any time by contacting us in writing. This authorization will remain effective until cancelled.

Couple/Family Policy

This statement of policy is intended to inform you, the participants in therapy, that when The Family Connection, LLC agrees to treat a couple or a family, we consider that couple or family (the treatment unit) to be the client. For instance, if there is a request for the treatment records of the couple or the family, we will seek the authorization of all members of the treatment unit before we release confidential information to third parties. Also, if our records are subpoenaed, we will assert the psychotherapist-patient privilege on behalf of the client (treatment unit).

During the course of our work with a couple or a family, we may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with us, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so, or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, we may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit---that is, the family or the couple, in order to effectively serve the unit being treated. We will use our best judgment as to whether, when, and to what extent we will make disclosures to the treatment unit, and we will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow The Family Connection, LLC couple/family therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family. If we are not free to exercise our clinical judgment regarding the need to bring this information to the family or the couple during their therapy, we might be placed in a situation where we will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such termination.

By signing below, you, as members of the couple/family or other unit receiving treatment, acknowledge that each of you has read this policy, that you understand it, that you have an opportunity to discuss its contents with your therapist, and that you undertake couple/family therapy in agreement with this policy.

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

COVID-19 In-Office Appointment Client Informed Consent and Waiver

This document contains important information about the decision to resume in-person services considering the public health crisis caused by COVID-19. Please read this agreement carefully and let your provider know if you have any questions.

DECISION TO MEET FACE TO FACE

Thank you for your trust in our practice. **By signing this consent form you are agreeing to meet in person for all or some future sessions**. Given the benefits, and inherent risks, of conducting in-person services while COVID-19 remains an active contagion in our society, we wish to address the ways in which we are working to mitigate risk of infection at our offices. We strive to protect you and our staff via hygiene and infection control practices informed by the CDC, EPA, OSHA, WHO, and other guiding organizations. We also ask that you engage in infection control practices to contribute to the health and safety of in-person services, and that **you recognize that you are voluntarily choosing to seek in-person services with knowledge of the inherent risks of infection.** If there is a resurgence of the COVID-19 virus or if other health concerns arise, we may require a return to Teletherapy appointments for everyone's well-being. In addition, at any time, you may speak to your provider if you wish to return to Teletherapy appointments.

OUR PLAN FOR OFFICE SAFETY

The Family Connection LLC takes the health and safety of our clients and staff members very seriously, and we strive to provide excellent clinical services in the safest possible environment by taking the following measures:

- Clients who are ill will be asked not to come into our offices. Staff members who show any symptoms of a contagious illness, or who have been in contact with those showing symptoms of COVID-19, or testing positive for COVID-19, will be required to stay home.
- Pre-Screening: On arrival, clients will complete a brief screening to ensure they are symptom-free and have not had close contact with anyone with COVID-19 symptoms.
- Hygiene Practices: Our staff will be practicing infection control hygiene practices, including covering coughs and sneezes, frequent hand washing, and refraining from handshakes.
- Masks: Our building management requires that all people entering the building wear a mask. Our staff will wear masks in common areas.
- Waiting Room: We will be asking parents or those coming with clients not to wait in our waiting rooms.
- Shared Items: We have removed commonly touched items to help minimize transmission of the virus, such as magazines in the waiting room.
- During Sessions: To minimize virus transmission in session, seating will be arranged to facilitate social distancing of at least six feet where possible; utilization of air purifiers; windows can be opened for air ventilation; and each office and waiting room will be equipped with hand-sanitizer, sanitizing wipes, facial tissue, and trash cans for disposal.

- Frequent Sanitizing: Common areas and equipment, such as door knobs, will be sanitized throughout the day, offices will be sanitized between sessions, and therapy and testing materials (e.g,. chairs, tables, waiting room, toys, desks) will be sanitized between use, per CDC guidelines.
- Scheduling: We will be staggering staff schedules where needed to minimize crowding in the office. We ask for your understanding and flexibility if your usual appointment time is impacted by these schedule changes.

YOUR RESPONSIBILITY FOR PROTECTING YOURSELF AND OTHERS

If you, a family member, or anyone that you have been in contact with in the past 14 days have had symptoms of COVID-19, including fever/chills, coughing, shortness of breath, muscle pain, and/or sore throat, OR tests positive for COVID-19, please do not plan to come into the office . We ask that you take your/your child's temperature at home prior to coming into the office. Anyone with a temperature above normal are asked to reschedule your appointment or change to a Teletherapy session.

- Minimizing Crowding in Waiting Rooms: In order to minimize the number of people and prevent crowding in our waiting rooms we ask that you enter the office at the time of your appointment and not before. Should you arrive early please wait in your car until the time of your appointment. Please come to appointments alone. In the case of young children, please have only one parent or family member accompany them to the office then, when possible, wait in the car until the session is complete. Please do not linger after appointments in our waiting rooms or the hallways.
- Masks: Our building requires anyone entering the building at this time to wear a mask. This applies to all clients and family members who might accompany them to appointments. **Please keep masks on in the waiting rooms and all common areas.**
- Hygiene: You are encouraged to use bathrooms to wash hands upon arriving for your appointment, hand sanitizer will be available in all rooms, and we ask that clients refrain from touching faces, and maintain social distancing, where possible.

IDENTIFICATION AND NOTIFICATION OF EXPOSURE TO COVID-19

Although we are making every reasonable effort to manage infection risk, and believe that most clients are doing the same, we recognize that some individuals with the virus remain asymptomatic and that there is no way to guarantee that those entering our offices will not be exposed to COVID-19. For public health protection, *we ask that any client who has been in our offices and subsequently experiences symptoms of COVID-19, or has been exposed to another person with symptoms of COVID-19, please* ***notify our office immediately*** *so that we can take any additional infection control measures and notify others who have been exposed.*

Should we learn that any staff member, client, or household member of anyone who has been in our office has symptoms of COVID-19 or tests positive for the COVID-19 virus, **we will notify all individuals who have been in our office in the same time frame of the potential that they may have been exposed.** Notifications will be provided to those who had been in our offices and may have come into close contact on the day that the infected individual was also in that office.

We will not disclose names or the role of the person infected (e.g., client, janitorial staff, therapist) in an effort to protect confidentiality and privacy.

COVID-19 PROTOCOL COORDINATOR

Kelly St Germain, Executive Assistant, is our COVID-19 Office Protocol Coordinator. She is the contact person to address any questions or concerns and can be reached at (505) 717-1155 ext.125 or kelly@nmfamilyconnection.com. Please contact Ms. St Germain immediately to report any exposure to or positive test of the COVID-19 virus.

DISCLAIMER

We realize these changes might feel strange or uncomfortable, and that the COVID-19 virus situation may change in the coming months. We encourage you to speak with your clinician if you have difficulty adjusting to the new health practices. **Teletherapy continues to be an option for you at any time if you are not comfortable coming to the office for in-person sessions.**

As you elect to return to the office for in-person appointments, we have procedures in place to mitigate risk per recommended guidelines. However, as with the transmission of any communicable illness, you can still be exposed to COVID-19 at any time. By signing below, you agree to hold The Family Connection LLC and all staff members harmless in the event that you, or anyone exposed by you, becomes ill with the COVID-19 virus.

_____ _____

Name of Client Date

_____

Signature of Client or Parent/Guardian

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact Amanda Davison, CEO.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the therapist's practice.

Following are examples of the types of uses and disclosures of your PHI that the therapist's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

***Treatment*:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a health insurance or Medicaid Program that provides care to you.

We will also disclose PHI to other health care providers who may be treating you or providing other health care type services to you. For example, an Occupational Therapist or psychiatrist may request consultation.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for therapy sessions or hours may require that relevant PHI be disclosed to the health plan to obtain approval for treatment.

***Healthcare Operations*:** We may use or disclose, as-needed, your PHI in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to student interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your demographic information and the dates that you received treatment from your therapist, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or

the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If a therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide

emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. You may request a restriction by contacting our Privacy Contact.

You have the right to be Treated fairly We do not discriminate on the basis of race, color, religion, national origin, sex, age, disability, or any other status protected by law or regulation

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your therapist amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Amanda Davison, CEO (505) 717-1155 or at nmfamilyconnection@comcast.net for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

Social Media Policy

This document outlines the social media policy for The Family Connection. Please read it to understand how we conduct ourselves on the Internet as a mental health professional and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have questions about anything within this document, I encourage you to bring them up with your therapist or with the Agency Director. As a new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes, offer a printed copy of the updated policy or you can view it on our website at TFC.Health.

Friending

We do not accept friend or contact requests from current or former clients on any social networking site (i.e. Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please bring them up with your therapist or you can discuss it with one of our Clinical Directors.

Fanning

We do not have a professional Facebook page, as we believe that the potential risks of maintaining such a Page outweigh any potential gains.

Emails, Cell Phones, Computers and Faxes are NOT private

No form of client communication is 100 percent guaranteed to be private. Conversations can be overheard, e-mails can be sent to the wrong recipients and phone conversations can be listened to by others. But in today's age of e-mail, Facebook, Twitter and other social media, therapists have to be more aware than ever of the ethical pitfalls they can fall into by using these types of communication.

Although they add convenience and expedite communication, it is very important to be aware that computers and e-mail and cell phone communication can be accessed relatively easily by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Although we are exploring various encryption software programs to protect your privacy, our emails and data on our computers may not be encrypted, it is always a possibility that e-mails and faxes can be sent to the wrong address, and computers, including laptops, may be stolen. Our agency computers are equipped with a firewall, virus protection and passwords, and we also password-protect and back up all confidential information from our computers on a regular basis.

If you need to cancel or change an appointment time please call our front desk and leave a message, if no one is able to pick up, as that is the most efficient and frequently checked mode of communication regarding appointments. Our automated system does generate reminder calls, emails and/or text messages to remind you of your appointment(s) as a courtesy, if you desire such support. However, please keep in mind that these automated reminders are vulnerable to someone having unauthorized access by having access to your cell phone, email account, etc. Please remember to update The Family Connection LLC

immediately if you have a change in phone number, email, etc. to limit the risk of information being sent to an old contact.

If you communicate confidential or private information via SMS (text) or e-mail, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and we will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies. Due to computer or network problems, e-mails may not be deliverable, and we may not check our e-mails or faxes daily.
The Family Connection LLC prefers that appointment scheduling and modifications be done with either your clinician, in person during the course of treatment, or with our administrative team, to decrease potential errors and limit potential miscommunication. If you e-mail your clinician related to your therapy sessions, please note that e-mail is not completely secure or confidential. **If e-mail communication outside of therapy requires more than 5 minutes to read and respond to, you may be charged for professional services rendered in 15 minute increments. Please indicate if you intend to pay these charges, or we will wait to respond until your appointment time, to clarify your expectations and needs.** Please do not send forwarded messages, regardless of how inspirational they may seem to our professional e-mail addresses. We use e-mail for work related issues and do not want to risk viruses spread by forwarded e-mails.
If you choose to communicate with The Family Connection LLC or anyone on our team, via e-mail, be aware that all e-mails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be
read by the system administrator(s) of the Internet service provider(s). You should also know that any e-mails we receive from you and any responses that are sent to you become part of your patient chart and may be revealed in cases where your records are summoned by a legal entity.

SOCIAL MEDIA SHOULD BE CONSIDERED PUBLIC COMMUNICATION

Messaging on Social Networking sites such as Twitter, Facebook, LinkedIn, etc. is not secure. It could compromise your confidentiality to use Wall postings, @ replies, or other means of engaging with The Family Connection LLC and/or its staff online if an already established client/therapist relationship has been established. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. The Family Connection LLC and/or its staff may not read these messages in a timely fashion. If you need to contact The Family Connection and/or its clinical staff between sessions, the best way to do so is by phone at (505) 717-1155 and leave a message for admin, if the call is not immediately answered, as this is monitored frequently during business hours.

FRIENDING MAY EXPOSE OUR PROFESSIONAL RELATIONSHIP AND UNDERMINE YOUR PRIVACY:

This social network policy services as your notification that being linked as friends or contacts on these sites can compromise your confidentiality and our respective privacy. As in any other public context, you have control over your own description of the nature of our acquaintance, if you chose to disclose a professional relationship. For example, if you were seen at church by an employee of The Family Connection, they would ignore you but if you initiated contact, they would follow your lead. If you introduced the employee to your friends, they would agree with your description of how you met. Employees of The Family

Connection will not confirm nor deny any professional relationship between the staff and clients on any social network sites. We reserve the right to discontinue any social network connections without prior notification and we encourage you to do these same. We discourage the use of social networking sites for any communication about the therapeutic relationship, due to the lack of privacy protections.
In addition, viewing your online activities without your consent and without explicit arrangement towards a specific purpose could potentially have negative influence on your treatment relationship. If there are things from your online life that you wish to share with your treating clinician, please bring them into session where you can view and explore them together, during the therapy hour. The current treatment agreement states that your patient information is kept private and will not be shared with others unless there is reason to believe that the patient or another individual is at risk, or compelled by a court of law. It is easy to forget that when we type names into a search engine or a field on a social network, we are also sharing information with others. If you have questions about this, please bring them up during treatment and you can discuss them with your provider during the treatment session.

LOCATION-BASED SERVICES REVEAL YOUR LOCATION:

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a consistent basis. Please be aware of this risk if you are intentionally "checking in" from our office or if you have a passive LBS app enabled on your phone.

WE DO NOT USESEARCH ENGINES TO LEARN ABOUT YOU:

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If we have reason to suspect that you are in danger and you have not been in touch with your clinician via the usual means (coming to appointments, phone or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, your clinician will fully document it and discuss it with you when you meet next.

BUSINESS REVIEW SITES ARE INEFFECTIVE PLACES TO VOICE YOUR COMPLAINTS:

You may find our counseling agency on sites such as Yelp, Healthgrades, Yahoo, Psychotherapy Networker, TherapySite, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regarding of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as our client. Of course, you have the right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment to confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility it will not be seen by your provider.

During your work at The Family Connection LLC it is our hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide that your connection with your provider is not a good fit. If you decide that it is not a good fit, please know that you can always follow up with our Agency Director a Clinical Director, to have another clinician assigned to your case and/or discuss any feedback you may have. In addition, we provide the opportunity for feedback anonymously through patient surveys available at the reception area and quarterly surveys conducted agency wide. None of this is meant to keep you from sharing that you are in therapy or with our agency but to share with you that confidentiality means that we cannot tell others that you are a client. The regulations and Ethics Codes that govern our professional licenses guide our interactions and prohibit various activities, including prohibiting your clinician from requesting testimonials. But you are more than welcome to tell anyone you wish that you are receiving counseling services and who your provider is and how you feel about the treatment you are being provided, in any forum of your choosing.

If you do choose to write something on a business review sites, we hope that you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular e-mail address or friend networks for your own privacy and protection.

If you do feel like something has been done that is harmful or unethical, and you do not feel comfortable discussing it with us, you can always contact the New Mexico Counseling and Therapy Practice Board, which oversees licensing and they will review the services we provide.

New Mexico Counseling and Therapy Practice Board
2550 Cerrillos Road
Santa Fe, NM 87505
(505) 476-4610

CONCLUSION

Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to our attention so that we can discuss them.