PAMELA GATES MA, LPCS, LCDC
TELEMENTAL HEALTH CONSENT FORM

I, _____, hereby consent to participate in telemental health with, Pamela Gates, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:
1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect please call me at 512 328 2563 to discuss since we may have to re-schedule.

.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOLS

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

IN CASE OF AN EMERGENCY, MY LOCATION IS:

_____

AND MY EMERGENCY CONTACT PERSON'S:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

I have read the information provided above and discussed it with my therapist. The information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____ _____

Signature of Therapist Date

PAMELA GATES MA, LPCS, LCDC

NEW CLIENT INFORMATION FORM

CLIENT'S NAME:_____DOB_____AGE_____

DL#/state_____Sex_____Marital Status_____

ADDRESS_____ZIP CODE_____

BEST NUMBER(S) TO REACH YOU?_____

EMAIL: _____

NAME OF SPOUSE(OR PARENT) _____PHONE_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?

NAME_____

ADDRESS_____ZIP CODE_____

PHONE(S)_____

EMAIL:_____

EMERGENCY CONTACT NUMBER:_____

NAME_____ RELATIONSHIP_____

****

REASON FOR VISIT:_____

HOW DID YOU GET MY NAME? _____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

****

INSURANCE CO._____PHONE:_____

ID#_____GROUP/POLICY#_____

INSURED NAME_____DOB _____

CLIENT'S RELATIONSHIP TO INSURED? (Put X): _____SELF / _____SPOUSE / _____CHILD / ____OTHER

INS COVERAGE: DEDUCTIBLE _____ COPAY _____

****

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER THE PAYMENT OF POSSIBLE INSURANCE BENEFITS.

SIGNED _____DATE_____

(CLIENT OR PARENT IF MINOR)

INSURANCE POLICY HOLDER CONTRACT

Please read and understand the following:

1. You are responsible for all Member Expenses, such as co payments and deductibles. These payments are due at the time of your visit.
2. Your insurance company may not cover the cost for all services rendered, If for any reason your insurance company fails to pay for services provided to you under the Member's Benefit Contract or if the claim was rejected because they deem the services to be "medically unnecessary" you will be fully responsible for the costs.
3. If you change your insurance policy or are no longer a member of your current insurance plan, you are liable for your outstanding balance, including the costs or penalties that may have incurred.
4. All services may require authorization from your health insurance carrier. If your insurance company delays or does not authorize services, you will be responsible for the payment for any denied service..
5. Your medical records may be requested by your carrier at any time to perform utilization management and quality improvement activities You agree to give consent to release your medical records in the event that it is required by your insurance provider.
6. You, not your insurance company, will be charged for all NON-mental health charges that are outlined in the INFORMATION FORM or PROFESSIONAL DISCLOSURE AND ADMISSIONS FORM (i.e. bounced checks, no show fees, legal fees and medical records request).

I have read and understand my responsibilities for payment even though I have Health Insurance. I promise to pay any charges that incur during my treatment that is not covered by Health Insurance.

SIGNED _____

(Client OR parent/guardian: if client a minor):

DATE: _____

Informed Consent and HIPPA Signature Page

THIS IS TO VERIFY THAT:

CLIENT:_____

and PARENT/ LEGAL GUARDIAN: _____

ADDRESS_____

_____

has (have) been provided an opportunity to review the following forms provided by Pamela Gates:

Professional Disclosure and Admissions Form and Telemental Health Consent

I have read, understand and agree to the information provided by Pamela Gates in the Professional Disclosure and Admissions Form and the Telemental Health Consent Form. By signing below I give full informed consent for professional counseling services.

_____ _____

client/parent/ legal guardian signature date

_____ _____

counselor's signature date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

I have been provided an opportunity to review or receive a copy of the Notices of Privacy Practices from Pamela Gates. I am aware that this notice is available, at any time, on Pam's website.

_____ _____

client/ parent/legal guardian date

Instructions For Filling Out PAYMENT CONSENT FORM

If we have discussed payment, how I will collect fees for services and what fees and charges you can expect, please complete and sign the Payment Consent Form. If we have not discussed these details or if you have questions, we can go over this form in our first session together and you can complete, sign and return this form following our discussion and your agreement. I will collect payment for this first visit before we end our session.

Pamela Gates, MA, LPCS, LCDC
Payment Consent Form

NAME on CARD_____

TYPE of CARD: _____VISA / _____MASTERCARD / _____HSA / _____DEBIT / _____DISCOVER
(please no American Express)

CARD #:_____

EXP DATE: _____ SECURITY CODE:_____ ZIP CODE_____

EMAIL: _____

I authorize Pamela Gates to charge my credit card for professional services and fees as follows:

INITIAL VISIT IN THE AMOUNT OF: _____

SESSION CHARGES IN THE AMOUNT OF: _____

NO SHOW RATE FOR FIRST EVENT: _____

FOR SUBSEQUENT EVENTS: _____

Late cancellation (defined as **less than 24 hours notice** or following teletherapy session link or other reminder from Pam). My billing software company will be sending 48 hour notice reminders of appointments. No fee for **verified** illness or unforeseen circumstance.

YOUR FEE FOR LATE CANCELLATION: _____

Full fee of _____ if there is a pattern of late cancellations which is defined as three or more.

I do not charge for brief communications via phone, text or email when communicating with either you or an individual or entity in which you have given signed consent. If these communications take more than 20 minutes then they may be charged to you or to your insurance company, if they can be legitimately defined as a session or crisis. I will discuss with you the fee at the time of the event or as soon as possible.

Please be aware that unless an agreement is negotiated with me all outstanding balances not paid within 30 days after a bill is sent or an insurance company or I have notified you of your balance will be charged to your credit card.

_____ _____

SIGNATURE DATE

Please note that all information will be kept confidential and your information will only be used to obtain payment for services.