ALMA MILLER COUNSELING
Alma Miller, MA, LMFT, LPC

18834 Stone Oak Parkway, Suite 104, San Antonio, TX 78258 (210) 429-7557

Informed Consent for Counseling Services

_____________________________ _____________________________
Client Last Name Client First Name

Welcome to ALMA MILLER COUNSELING. This informed consent document is being provided so that you are fully informed, can review the policies and services, and learn what you can expect in the counseling process. Please read each section carefully and initial each section where indicated. This informed consent is subject to amendment; however, you will receive written notification of any changes. You may make a copy of this document for your records.

A more detailed background can be found on "ALMA MILLER COUNSELING" website.
Counselor: Alma C. Miller, MA, LPC, LMFT
Licensed Professional Counselor, License # 75187, State of Texas
Licensed Marriage and Family Therapist, License # 202662, State of Texas

SERVICES
Services include individual, family, couple, and marriage counseling. All services begin with an initial intake session 55 minutes and subsequent sessions are 50-55 minutes each. During the initial assessment we will work together to determine how to best meet your needs. The initial intake session does not establish a therapeutic counseling relationship. Referrals will be made if your needs would be best met elsewhere, or after ongoing counseling you are not making progress and would be better served with a referral.

I have read and agree to the above section: ______________________________

THE COUNSELING RELATIONSHIP
After this informed consent is signed, you will meet with your counselor for the first session. This session is unique because an initial evaluation is being performed during the intake process. This is usually completed in one 55 minute session, but may require more time or sessions. During this time, together you and your counselor will identify problems, assess your needs, create a treatment plan unique to you and your situation. This evaluation usually consists of interviews, forms, and possibly screening/testing that is indicated. After the evaluation is complete, you and your counselor will discuss suggestions and a course for treatment. Along with the plan, you will discuss expected duration and cost.

During the intake session, the counselor will decide if she has the skills and experience to help

you or if you would be better served with a referral. This is also the time for you to decide if she is the right therapist for you. This is an important decision that requires a commitment of your time and finances, so you should be comfortable with your choice. The completion of this assessment/evaluation and the decision to continue therapy is a joint decision and marks the beginning of the therapeutic relationship.

The counseling relationship is strictly a professional one. Contact will be limited to the paid sessions or the phone calls to schedule a session. Your counselor will not correspond via email or text except to confirm appointments, since electronic communication is not secure. You will be best served if the relationship remains strictly professional, and the sessions concentrate on your concerns.

I have read and agree to the above section: ______________________________

THE COUNSELING EXPERIENCE

The initial intake session and subsequent sessions are 55 minutes long and begin on the hour. Unlike a medical clinic where several clients may have the same scheduled appointment time, only one client is scheduled per hour; therefore it is not necessary to arrive more than five minutes early. Please do not arrive late. Clients who are later than 20 minutes beyond the scheduled session time will need to reschedule. Sessions are usually weekly although occasionally they will be more or less frequent. It is the counselor's goal that each client will end or suspend therapy upon completion of treatment goals without unnecessary costs or time.

Each client and situation is unique. Techniques that work well with one client may be unsuccessful with another. It is important that you work together with the counselor, giving honest feedback if you feel uncomfortable with a suggested technique or approach to counseling. Counseling is an interactive process. It requires much work, both in session and at home during the week. To experience the best possible benefits from the counseling experience, you must be willing to do the work that you and your counselor agree upon.

There are both benefits and risks associated with participating in counseling. While you and your counselor will work toward yielding the greatest level of benefits from counseling, it is important that you are aware that counseling may also remind you of unexpected feelings that might lead to unintended change that could impact you and your relationships.

I have read and agree to the above section: ______________________________

CONFIDENTIALITY AND PROFESSIONAL RECORDS

The counselor must maintain confidentiality according to the ethical guidelines of their licensure as well as legal requirements. While you are entitled to a copy of your record, we do not recommend this due to the possibility of misinterpreting the meaning of notes. They are written for the health care professional and are often abbreviated with medical shorthand. A verbal summary can be provided upon your requests or a written narrative for $145. If

medical/mental health professionals request records, you will be charged $95 for copying and mailing.

Effective counseling sometimes requires sharing confidential information with licensed professionals for collaboration and additional perspective. In some cases personally identifiable information, although not counseling related information, may be shared with a tax accountant.
The counselor will only share information with these individuals for clinical or administrative purposes, such as scheduling, filing, and billing. In every situation your privacy is of the utmost importance and will be protected. Records are kept for five years after your last session in accordance with the ethical and legal requirements of the Texas State Board of Examiners of Professional Counselors.

Everything you discuss with your counselor remains confidential. You must give signed permission before your counselor can share information with anyone, except for the aforementioned, about any aspect of counseling. If you do give permission, you will have an opportunity to specify who should receive information from your file, what information they are allowed to receive, the purpose for which they may use the information and the period of time during which you are granting the permission.

Sometimes certain situations override confidentiality. No records or information about you will be released without your written consent except under the following circumstances:

- If your counselor feels you are a serious danger to yourself or others
- If you are under 18 years of age and you disclose that you are being abused or neglected
- If you are abusing or neglecting an elderly person or dependent adult
- If you have sexually or physically abused a minor child and that child or other children are at risk of continued abuse
- If you are involved in a criminal case, the judge can order your file to be turned over to a court
- If a valid subpoena is issued for my records or there is some other legal process requiring disclosure
- If you become abusive or threatening to anyone in counseling sessions and your counselor feels he/she needs to notify the police for safety purposes
- In the treatment of a minor client, a mental health professional may advise a parent, managing conservator or guardian of a minor, with or without the minor’s consent, of the treatment needed by or given to the minor.

Confidentiality with couples and/or families is a special consideration. During treatment, the counselor may need to share information learned in an individual session (a session with only a portion of the treatment unit being present) with the entire unit- that is, the couple or family, if the counselor is to effectively serve the unit being treated. The counselor will use her best judgment whether, when, and to what extent they will make disclosures to the entire treatment

unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely do not want shared, you may want to consult with an individual therapist who can treat you individually.

Apart from these circumstances, you can be assured that the only people who will have access to your records or statements are those for whom you have given written consent.

I have read and agree to the above section: ______________________________

COUNSELING OF MINORS

I am committed to providing confidentiality for minor clients to provide the most therapeutic experience. However, I will provide general information about the therapy sessions to the parents/guardians of the client, as I feel necessary and helpful. Consent for treatment of minors must be signed by the parent or guardian with the legal authority to do so and all fees must be paid by the consenting parent regardless of your legal agreement.

In the case of divorced parents, please provide a copy of the custody agreement section of divorce paperwork within one week of the first counseling session. Receipts will be provided for you if you intend to seek reimbursement from the other parent. However, I will not intervene
in any dispute of financial responsibility dispute between the consenting parent and another party.

I have read and agree to the above section: ______________________________

SOCIAL NETWORKING AND EMAILS

Neither you nor your counselor should solicit or accept connections or interactions via Facebook, LinkedIn, Pinterest, Instagram or other similar social media platforms with each other. Email exchanges are to contain information regarding scheduling, ONLY. If there is any other confidential information sent by email, the counselor will not respond to it by email but will address it during your next scheduled appointment in order to maintain confidentiality. Please keep in mind that confidentiality cannot be guaranteed with electronic communication.

LEGAL PROCEEDINGS

The therapeutic process often involves making a full disclosure with regard to many matters which may be of a confidential nature. If you choose to begin legal proceedings of any kind (including but not limited to divorce and custody disputes, work-related injuries, lawsuits, etc.), you agree that neither you, your attorneys or anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court or in any legal proceeding. By your signature below, you specifically agree to abide by this condition of treatment.
If I am subpoenaed to provide records or testimony in violation of this agreement, you acknowledge and agree you will pay for all my professional time, including preparation and

transportation costs, even if I am called to testify by another party. For providing services in any legal matter, my hourly fee is $350 per hour and for court appearances a $2500 retainer fee will be collected. I will charge this rate for preparation time related to any legal proceeding, travel time from my office to the location of the proceeding, and all time spent in attendance at any legal proceedings. If I am subpoenaed to provide records or testimony in violation of this agreement, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT provide custody evaluations or recommendations. I will NOT provide medication or prescription recommendations. I will NOT provide legal advice. None of these activities are within scope of my practice.

I have read and agree to the above section: ______________________________

REQUEST FOR TREATMENT RECORDS

In the event that a client requests a copy of their treatment records, a written release of information will be filled out by the client in order to complete the request. If there is a request for the treatment records of a couple or family, we will seek the authorization of all members of the treatment unit before we release confidential treatment records to just one person of the couple and/or family or a third party. All requests for mental health care records will be granted within 15 days of the written request according to the Texas H&SC 611.008.

I have read and agree to the above section ______________________________

FEES, Methods of Payment, Appointments, Discharge and Cancellation Policy

Fees for treatment will be expected at the time of the appointment.
Counseling Fees:
$185 Initial Visit/Intake
$170 - Individual/Couples (In-person or Virtual)
$170 - Phone /Teletherapy Session 15-50 minutes
$250- Extended Session Time (90min)
$145 - Printed Reports or Letters (Excludes legal items. See Legal Proceedings section above)

Fees may be paid with cash, check, or credit card and are due at the time of service. Checks should be made out to “*Alma Miller*". There will be a $35 fee charged for checks written with insufficient funds.

Credit card authorization and information must be given while making the first appointment. A credit/debit card will be kept on file to cover insufficient funds, fees associated with failure to cancel an appointment, failure to return books, or failure of insurance payment. Please complete the Pre-authorization for Credit Card form. These forms are kept securely at all times. Please let the counselor know if you plan to pay using an alternate method, before your appointment.
________ Initial

While insurance is not accepted, a receipt can be provided for you to turn in to your insurance carrier for reimbursement as an out-of-network provider. Health insurance plans and benefits vary, so please consult your insurance provider about reimbursement for your counseling services prior to your visit.

48 Hour Cancelation Policy
Therapy sessions are by appointment only. You may cancel or reschedule your session, however, it is highly recommended you provide notice via email, text, or phone call within 48 hours of your session time to avoid the cancellation or change fees. For your convenience, a voicemail box is available to receive messages 24/7 to request a change in appointment day or time, or to inform of a cancellation: 210-429-7557.
If cancellations or changes are made with less than 48 hours notice, or if you fail to show up for your session, you will be charged the full regular visit fee. Unfortunately, your reserved session time likely cannot be filled with less than 48 hours notice.
Failure to confirm an appointment does not equal cancellation. Further services are rarely provided until this fee is paid.

No fees are assessed for cancellations or changes made with more than 48 hours' notice. Waiving of Cancelation Fees in emergency situations will be considered on a case by case basis.

I agree to pay the rate of $170 per session for therapy services and I understand I will be charged the above stated fees for missed appointments not canceled or changed 48 hours in advance. FULL session charges include: absences due to same day illnesses, doctor appointments, vacations and other unavoidable obligations.

Discharge
Frequent cancellations may result in termination of the therapeutic relationship. Clients who are not on specific maintenance schedule as per their treatment plan, and are not in ongoing treatment with regularly scheduled sessions and a lapse of 8 weeks or more without a session will be discharged from the practice and referred to another provider upon request. This does not apply to clients who have communicated vacation or time away with the therapist.

Appointments
All appointments begin and end promptly. All sessions begin on the hour and last approx. 50-55 minutes. On rare occasions the counselor may be in an emergency situation. Please be patient. The counselor will come out and inform you of the approximate wait time and/or reschedule your appointment. Please be sure all forms are completed and submitted electronically 24 hours PRIOR to your session. Please do not be late. If you are less than 15 minutes late for your appointment your session will still take place but will end at the originally scheduled time.

Arrivals exceeding 20 minutes past scheduled start time will need to be rescheduled and will be assessed a full session fee rate.

Please do not bring children or babies to counseling unless you have a family session scheduled. Newborns may be an exception. Children are disruptive to counseling sessions, and they cannot remain in the waiting room. So that you and other clients can receive the maximum benefits during counseling, please make arrangements for childcare outside of the office when you have an appointment.

I have read and agree to the above sections: ______________________________

TIME OUT OF OFFICE FOR EMERGENCIES

The counselor is not available for client emergencies or crises. In case of an emergency, you should call 911. In addition, the counselor may not work weekends, will take vacations or be absent due to training, family emergencies, etc. The counselor is not available to answer phone calls or emails during work hours. You may leave a message on the office voicemail and the counselor will do their best to return messages and emails within 24 business hours, during normal business hours.

Please fill in the line items to consent which methods the counselor has permission to return your call, leave a message, or send appointment reminders:
Cell Phone: _________________________________ Texting OK?: Yes___ No ___

Home Phone: ________________________________

Work Phone: _________________________________

Email Address: _______________________________
The counselor will only use email for scheduling or canceling appointments, or for sending handouts or forms as per the state code of ethics. All other emails will be deleted without being read. Similarly, the text messaging system can only be used for schedule and canceling appointments or providing brief instructions or notices. The counselor connect guarantee confidentiality with electronic communications.

I have read and agree to the above section: ______________________________

CLIENT EMERGENCIES

In cases of a client emergency, please provide the name and number of an Emergency Contact that can be saved in your file, and that you consent to being contacted in cases of emergency.

Name: _______________________________________

Relation to Client:______________________________

Phone Number (s): __________________________________

I have read and agree to the above section: ______________________________

TERMINATION/CLIENT RIGHTS
You may choose to discontinue the counseling relationship at any point. If you decide to discontinue therapy, please discuss your decision with the counselor. Your counselor will be supportive of that decision and if needed, assistance in locating another therapist can be provided. If you wish to file a complaint, you may call the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540 or you may write to: Texas State Board of Examiners of Professional Counselors, PO Box 141369, Austin, TX 78714-1369.

I have read and agree to the above section: ______________________________

HOLD HARMLESS CLAUSE
Clients and their family members agree to waive all legal claims against Alma Miller. Your signature below means that you have read and agree to participate in counseling voluntarily without force. Furthermore, your signature indicates that you understand all of the information in this document and hold your counselor harmless for any legal, financial, and/or other results which do not meet you or your family members' stated expectations for therapy.

I have read and agree to the above section: ______________________________

RECORDINGS
Due to the sensitive nature of the topics discussed in counseling sessions, client's confidentiality rights and HIPPA regulations, no recordings of any sessions and/or conversation with your therapist may be made at any time whether it be in individual, couples, or family sessions.

I have read and agree to the above section: ______________________________

HIPPA - Health Insurance Portability and Accountability Act
The HIPAA Privacy Rule provides federal protections for personal health information (PHI) held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of PHI needed for patient care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Your Health Information Is Protected By Federal Law
Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule, a Federal law that protects health information in electronic form, requires entities covered by HIPAA to ensure that electronic protected health information is secure.

Who Is Not Required to Follow These Laws
Many organizations that have health information about you do not have to follow these laws. Examples of organizations that do not have to follow the Privacy and Security Rules include:

- Life insurers
- Employers
- Workers compensation carriers
- Many schools and school districts
- Many state agencies like child protective service agencies
- Many law enforcement agencies
- Many municipal offices

What Information Is Protected

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow these laws How Is This Information Protected
- Covered entities must put in place safeguards to protect your health information.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary for their purpose.
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

What Rights Does the Privacy Rule Give Me over My Health Information
Health Insurers and Providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
- File a complaint with your provider or health insurer
- File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights.

Who Can Look at and Receive Your Health Information

The Privacy Rule sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your health care

HIPAA ACKNOWLEDGEMENT

I have read the HIPAA document and I agree to its terms.

____ ______________________

Client's Signature Date

THE COUNSELOR'S WORLDVIEW

I believe that the Holy Spirit is the Great Counselor and only with His power and wisdom can I adequately guide and counsel individuals, marriages, and families in a manner that will bring godly, lastly transformation. While I do not attempt to push these beliefs on the client, I feel it is important for you to understand what your Christian counselor believes.

- The Bible is God's Word. It contains the absolute, inerrant truth and was composed by God Himself.
- God's truth is the foundation for all healing; therefore counseling is based on truths from God's word.
- Since the Holy Spirit provides the wisdom for effective and lasting change this Spirit is invited to participate in the counseling experience.
- The counselor's desires is to encourage each of you to understand who God created you to be and to fully experience the abundant life God desires for each of His children.
- The counselor sees this practice as both a ministry and business to offer Biblical counseling to individuals of all faith and denominations. We do not discriminate against anyone on the basis of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV/AIDS), sexual orientation, mental disability, medical condition, age, or marital status.
- We proclaim the Trinity of the Godhead and each individual's need for a personal relationship with Jesus Christ, as the One and only means of eternal life.
- This relationship with Jesus Christ is a covenant relationship based on grace alone and

has nothing to do with religious affiliation. This saving grace (salvation) cannot be earned or achieved. It is absolutely a free gift.

- Individuals are not predetermined by genetics, family of origin, or other failings in life. Allowing the Holy Spirit to guide you and provide insight to change thoughts, attitudes, and behaviors can overcome these flaws and allow your character to be transformed.
- God's word clearly describes a marriage as one man and one woman in a covenant relationship together with God. Marriage is not cohabitating. Each person is to honor the other and remain sexually pure in thought and behavior.

I have read this Statement of Faith. I understand that my counselor will practice from a Christian Worldview with Christian morals and principles. I agree to this type of counseling.

I have read and agree to the above section: ___________________________

Proof of identification with a government ID is required. Please submit with your completed Forms.
Therapist's Initials _________________ *Date*___________________

GOOD FAITH ESTIMATE

Under Section 2799B-6 of the Public Health Service Act, the new "No Surprises Act," you have a right to receive a "good faith estimate" explaining how much your therapy services will cost. Healthcare providers are required to provide clients who do not have insurance or who choose not to use their insurance for therapy services with an estimate of the cost of those services. The total cost for each client will vary depending upon the length of time and frequency of sessions that occur throughout the therapeutic relationship as determined by the initial assessment and continued evaluation of treatment needs and progress.

The estimate below is for regular sessions at the rate of $170 if a client came weekly for one full year (12 months).
Should any fee changes occur, or upon your request, I will provide you with a new Good Faith estimate. Please note that this is only an estimate. Any services scheduled separately or in addition to the standard therapy services are not reflected in this good faith estimate.

This estimate is not a contract and does not obligate you to obtain said services
If you are billed for more than this Good Faith estimate, you have the right to dispute the bill. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS@1-800-958-3059.

For questions or more information about your right to a Good Faith Estimate or the

dispute process,visitwww.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1- 800- 985-3059.
Keep a copy or image of this Good Faith Estimate in a safe place. You may need it if you are billed a higher amount.

Details of Services/Items and Fees:
Initial Evaluation Fee: $185 Individual/Family/Marital Therapy Session Fee: $170
*Please note this does not include optional extended session time fees.
Total Estimated Cost of Services for One Year of Weekly Therapy:
Initial Session, PLUS 52 weeks of weekly sessions: $9,025.00

I have reviewed my Good Faith Estimate outlined above:

Client Signature: ____

Date: _______________________

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this carefully and let me know if you have any questions. This consent shall only apply to clients physically within the State of Texas seeking therapeutic treatment within the State of Texas. This Informed Consent shall be signed in conjunction with Alma Miller Counseling Disclosure Statement and Informed Consent for Services.

Benefits and Risks of Teletherapy

Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It can also increase the convenience and time efficiency of both parties.

Although there are benefits of teletherapy, there are some fundamental differences between in-person psychotherapy and teletherapy, as well as some inherent risks. For Example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. I will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room

or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.

- Crisis management and intervention. As a general rule I will not engage in teletherapy with patients who are in a crisis situation. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

- Efficacy. While most research has failed to demonstrate that teletherapy is less effective than in person psychotherapy, some experienced mental health professionals believe that something is lost by not being in the same room. For example, there is debate about one's ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between us related to our use of technology, please bring up such concerns immediately and we will address the potential misunderstanding together.

Electronic Communications

We will discuss which is the most appropriate platform to use for teletherapy services. I will make my best efforts to comply with the American Counseling Association's Ethics Code guidance on Distance Counseling as well as the Texas Department of Regulatory Agency's Teletherapy Policy, and I will provide you with a copy of these guidelines upon request.

You may be required to have certain system requirements to access electronic psychotherapy via the method we choose. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

For communication between sessions, I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however if an urgent issue arises, you should feel free to attempt to reach me by phone. I will make every effort to return your call on the same day you make it, with the

exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Confidentiality:

I have a legal and ethical responsibility to make my best efforts to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential and/or that a third party may not gain access to our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third party.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Disclosure Statement and Informed Consent for Services still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Teletherapy

If at any time while we are engaging in teletherapy, I determine, in my sole discretion, that teletherapy is no longer the most appropriate form of treatment for you, we will discuss options of engaging in face-to-face in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, I will ask you where you are located at the beginning of each session and I will ask that you identify an emergency contact person who is near your location and who I have permission to contact in the event of a crisis or emergency to assist in addressing the situation.

If the session cuts out, meaning the technological connection fails, and you are having an emergency do not call me back, but call 911, or go to your nearest emergency room. Call me after you have called or obtained emergency services.

If the session cuts out and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes then call me on the phone number 210-429-7557.
If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees:
The same fee rates shall apply for teletherapy as apply for in-person psychotherapy. However, if your HSA, or FSA, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session.

Informed Consent:
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Your signature below indicates agreement with its terms and conditions. This agreement is supplemental to my general informed consent and does not amend any of the terms of that agreement.

I, ______________________________________, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy; the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

Signature of Client __________________________________ Date________________

Signature of Therapist _______________________________ Date ________________

CREDIT/DEBIT CARD AUTHORIZATION FORM

All fees are due at time of service. Each client is required to have a credit card on file to secure services with the therapist.
Please complete the information below:

Client Name: ____________________________ Date: ____________

I authorize Alma Miller Counseling to charge my credit card for the balance due, based on charges established in Informed Consent. Fees are due for all scheduled appointments.

Failure to cancel appointments, or no shows within 48 hours will result in the full session fee on your credit card. Messages regarding changes or cancellations can be left 24/7 on the confidential office voice mail box at 210-429-7557.

Circle One : MasterCard Visa Discover American Express
Other: ____________________

Charge Account Number:____

Zip Code _________________

Expiration Date: ________________ 3 Digit Security Code: _____________

Cardholder Name: ____

Cardholder Signature: ____________________________________ Date: _____________