Become YOUR Happy LLC

***Wendy Wahlquist, LMFT**: Individual, Couple, and Trauma Therapist*
11565 Perry Hwy Ste 8 Wexford, PA 15090 p) 412-368-2072
wendy@becomeyourhappy.com **www.becomeYourhappy.com**

WELCOME TO BECOME YOUR HAPPY LLC

I am thrilled you have chosen Become Your Happy LLC to begin or continue your personal and/or relational growth. We appreciate and acknowledge the courage it takes to want to make a change, and we are delighted, honored and privileged to be working with you through this journey. It can be a daunting process (not to mention what it already took you to get to this spot now). Seeing all these forms and policies can also be overwhelming, which I totally get. You can always have a copy (whether you do this electronically or hard copy) to refer to if needed. I also keep the intake packet up on my website for people to download, so in case you lose yours, you can still see what you signed.

The following pages review informed consent, policies and financial agreements, along with your HIPAA/privacy. Please complete them to the best of your ability, and feel free to ask questions. If you are coming in as a couple, please put both of your information down in the client information form, even though there is only space for one of you. Also, please both of you sign in every signature spot designated.

Signatures on all the policy pages ARE necessary (these are found on pages 8, 9, 10, 11-12-insurance only, 16, (18 a phone number is needed), 19, and 20). Page 21 is for informational purposes only if you choose to call your insurance company to figure out benefits, as it can be helpful to you, but not necessary. I can also send you my biopsychosocial assessment if you request, which you can work on or just review prior to our appointment, or be prepared as they are the questions I will be reviewing our first few sessions together.

Thanks, and take a big breath before going to the first page of documents!

My Background

I, Wendy Wahlquist, am a Licensed Marriage and Family Therapist (LMFT) in the state of Pennsylvania. I am also a clinical member of the American Association for Marriage and Family Therapists (AAMFT). I have taken advanced training in Somatic Experiencing (SE), and Emotionally Focused Therapy (EFT). I believe that people tend to know what is best for them deep down, and it is my job to assist them in discovering what they feel is the best solution. I am systemically oriented in my therapeutic work, seeing a problem as imbedded in relationships either within the family, or even the larger societal system. I also work from an attachment theory foundation. Attachment theory focuses on the innate biological drive that compels us to connect with others. Somatic Experiencing is also based on innate biological drives that help us heal… allowing the wisdom of the body to help heal us from traumatic experiences.

Thank-you,

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THERAPY CONSENT, POLICIES, & AGREEMENT
PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborative identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.

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- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 55 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment at least 24 hours prior to the scheduled appointment time (Email is preferred method of notification). If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. Each insurance panel has a different policy on whether clinicians can charge for missed appointments. Check your provider's policies regarding cancellations and/or no shows.***

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES: The fee is $100 for a 45 minute session, and $125 for a 53-60 minute session. This includes making the payment and rescheduling. The Initial Diagnostic Interview or intake process for the first session is charged at $150. The fee structure may be reassessed periodically, and if you are a "self pay" client, feel free to talk to me about fees. **Individual therapy is generally covered to some degree by insurance, but couples therapy is not.**

Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $50 for any returned check), or credit/debit card. A credit card can be kept on file for all charges.

A late cancellation fee (less than 24 hours notice) is $50, and a no show fee (no notice given at all and you do not show up for your appointment) is full fee at $125.

I reserve the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification.

I charge an hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed. **All costs for services outside of session will be billed. These are NOT covered by insurance**, so will be billed to you personally (and can be paid with methods noted above).

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TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, **you will be charged a fee of $250 an hour to include travel time, court time, preparing documents, working with legal and ethics board, etc.**

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $1.50 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from Mon-Thurs 9am - 4pm, Fri 9am-12pm. If you need to contact me for any reason please call 412-36-2072, leave a voicemail, and a return call will be made within 2 business days. Email for scheduling/non clinical issues may get a quicker response, though you risk confidentiality. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911. You can also contact Resolve Crisis Services hotline for 24-hour crisis help at **1-888-7-YOU-CAN (796-8226)**. Resolve Crisis also has a number for non-urgent matters **412-864-5004.**

INCLEMENT WEATHER POLICY
I will honor the Seneca Valley School District closing and delay schedule. I may or may not be able to get to the office myself during these times, so please look for an email by 8am that day whether I will be in the office or not. If it is unsafe for you to make your appointment, please do not come in. Please call and leave me a voice mail, or send me an email. There will be no missed appointment or late cancellation fee for inclement weather issues dealt with in this way. We also have the option of doing a phone consultation or a telehealth session.

FINE PRINT LEGAL STUFF
Become YOUR Happy LLC is not responsible or liable for any property loss, property damage, physical injury, or psychological stress that clients may sustain which is not a result of gross negligence by Become YOUR Happy LLC. Clients are completely responsible for their actions and well-being.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect your safety, which may include disclosure of confidential information.

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- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that I believe in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about an you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is

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detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, authorization from each participant (or their representatives and/or guardians) in the sessions must be provided before the records can be released.

- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk, but this is left to your discretion.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of your medical record.
- **Electronic Communication:** If you need to contact me outside of our sessions, please do so via phone or email. I prefer email as I can get back to you quicker, but you need to know the risks:
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of your phone.
    - **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call or email to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. **E-mail is a part of your medical record.**
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

PART III: HEALTH INSURANCE

YOUR INSURANCE COMPANY: By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

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IMPORTANT: Some psychiatric diagnoses are not eligible for reimbursement (ie: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. Wendy Wahlquist, LMFT of Become Your Happy LLC reserves the right to seek payment of unpaid balances by charging your credit card, collection agency, or other legal recourse after reasonable notice to you.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY: When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. If insurance is requesting information for continued services, confidentiality cannot be guaranteed. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS: Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is important that you're an informed consumer. This allows you to take charge regarding your health and medical record. At times, having a diagnosis can be helpful (ie: child needing extra services in the school system or a person being able to receive disability).

PART III: REASONS I DO NOT ACCEPT INSURANCE for COUPLES CONSULTING

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services,

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your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.

- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the ways previously noted.

Why Clinicians Do Not Take Insurance: These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don't accept health insurance for couples therapy, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

EMERGENCY CONTACT:

It is necessary that Wendy Wahlquist, LMFT of Become Your Happy LLC has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank-you.

☐ I agree to allow Become Your Happy LLC to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

.

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PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Wendy Wahlquist, LMFT. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Wendy Wahlquist, LMFT to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to Wendy Wahlquist, LMFT of Become Your Happy LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Wendy Wahlquist, of Become Your Happy LLC may utilize payment recovery procedures after reasonable notice to me, including charging your credit card, a collection company or collection attorney, or other legal recourse.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Wendy Wahlquist, LMFT to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Wendy Wahlquist, LMFT prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Witness –Wendy Wahlquist, LMFT **Date**

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APPOINTMENT CANCELLATION AND NO SHOW POLICY

There is a waiting list of clients for open time-slots, and when you schedule an appointment, that time-slot is reserved for you. If you need to cancel an appointment, please provide at least 24 hours notice to allow for sufficient time to offer your time-slot to another client.

Company policy requires that you have a current credit card on file. If you do not show up for your scheduled appointment, your credit card will be charged a $125 fee. If your appointment is cancelled less than 24 hours before the appointment (notice is given), your credit card will be charged a $50.00 fee. This fee may be waived for emergencies, or if you reschedule for the same week, provided there is an opening. Your signature bellows indicates your consent to this cancellation fee policy and authorization to charge your credit card the $125 or $50.00 fee when applicable.

_____ _____
Credit Card Number expiration date

_____ _____
Name on Card CCV (3 digits on back)

_____
Signature

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ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM
(If Using Insurance)

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases, the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Client Name _____ Date of Birth _____

Insurance Policy Holder Name _____

Relation to client: ☐ self ☐ spouse ☐ parent

Primary Insurance _____

Secondary Insurance _____

Address _____

City_____ State _____ Zip Code _____ Telephone

_____

Primary Insurance Policy # _____ Group # _____

Secondary Insurance Policy # _____ Group # _____

Assignment of Benefits
I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other mental health/medical plan, to issue payment check(s) directly to Become Your Happy LLC for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Wendy Wahlquist, LMFT of Become Your Happy LLC to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and or process claims for payment. This information may include, but is not limited to types of service, dates of service, times of service, diagnosis, treatment plans, progress of therapy and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of Become Your Happy LLC's Notice of Privacy Practices.

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2. Request payment of insurance benefits be made directly to Become Your Happy LLC for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from Become Your Happy LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: _Wendy Wahlquist, LMFT_____ Date: _____

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.
HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.
The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with ChildLine at 1-800-932-0313. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Pennsylvania Abuse Hotline 1-800-490-8505. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.50 per page. Please make your request well in advance and allow

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2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Pennsylvania Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Signatures on next page….

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: Wendy Wahlquist, LMFT_____ Date: _____

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TECHNOLOGY ASSISTED COUNSELING (TAC)
CONSENT, POLICIES, & AGREEMENT (For Teletherapy/Video/Phone Therapy)

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engage in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

Benefits:
The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

Limitations:
It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. During a phone session, I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. During a video session, the video reception may be poor and I have only a limited view that may limit my ability to assess your body language and non-verbal reactions to what we are discussing.
3. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
4. Technology might fail before or during the TAC counseling session.
5. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
6. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics:
When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort

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MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) where I am licensed. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me at 412-368-2072 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 3 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked, but please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

Number(s)

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

Payment for Services:
Payments for services must be made **prior** to each session. I will charge your card on file or send you an invoice. Payment is to be completed prior to our session.

Cancellation Policy:
If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the ***full fee*** for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the

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therapist and client will address the need for ongoing therapy. Should a client express and wish and/or desire to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, the payment will not be reimbursed for the missed or canceled session. Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality:
I request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____
Street Address

_____
City State Zip Code

_____
City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in TAC Sessions:
By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Clinician's Signature/Credentials: _____ Date: _____

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CLIENT INFORMATION FORM
Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexuality: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s): _____
Is it ok to leave a voicemail? *YES* *NO*

Email: _____
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How were you introduced to us? _____

** Please complete below for additional client*

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexuality: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s):_____
Is it ok to leave a voicemail? *YES* *NO*

Email: _____

Date Completed: _____

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Insurance information

*Information needed to obtain **outpatient mental health benefits**:*

This section is helpful if you plan to use insurance and want to call ahead to get benefits, as I do not do this for you. I will submit claims for you if I am in-network, and can give you invoices for out of network claims to submit on your own.

Policy Holder Name: _____ Policy holder Date of Birth: _____

Insurance Carrier: _____ Insurance ID: _____

Group #: _____ Provider Service # from back of card: _____

(Look for a different number for mental health benefits and/or possibly a different insurance company listed on the card specifically for mental health benefits)

- *Please complete the following information when you place the call to verify outpatient mental health benefits.*

Effective Date: _____

Benefit Year (calendar, fiscal, monthly) : _____ to _____

Co-Pay: _____ Co-Ins: _____ Deductible: _____

Out of Pocket Max per Year: Individual: _____ Family: _____

Number of Office Visits Allowed Per Benefit Year: _____

Number of Visits Remaining: _____

Authorization Required: (Y/N)_____ Authorization#:_____

Effective/Expiration Date: _____

Number of sessions: _____

Verify Where Mental Health Claims get sent - Electronic Payer ID: _____

Address: _____

_____

Date Verified: _____ Person Verified With: _____