True Hope Christian Counseling

1706 Tennison Parkway, Suite 140
Colleyville, TX 76034

truehopechristiancounseling.com
832-262-2351

CHILD/ADOLESCENT INTAKE

Date: _____

Adolescent Information:

Name: _____ Age:_____ DOB:_____

Address:_____

Street City State Zip

School: _____ Grade:_____

Employment (if any) _____

Parent/Guardian #1 Information:

Name: _____

Address:_____

Street City State Zip

Phone: _____ Is it okay to leave a message? NO YES

Email: _____Employment: _____

Parent/Guardian #2 Information:

Name: _____

Address:_____

Street City State Zip

Phone: _____ Is it okay to leave a message? NO YES

Email: _____Employment: _____

Parents' Marital and Custody Status:

Marital Relationship: married separated divorced never married

If divorced please describe custody arrangements (also provide a copy of divorce decree):_____

Emergency Contact:

Name: _____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Medical History:

When was client's most recent physical exam? _____

Please list all current medications:

Medication Dosage Purpose

_____

_____

_____

Significant medical concerns or conditions:_____

Spirituality:

Does your child/adolescent currently attend a church? YES NO

If yes, what is the name of the church? _____

Would you like spiritual matters to be a part of their counseling? YES NO

Reason for Visit:

What are the main reasons you are seeking counseling? Please check all that apply

Sadness/Depression	Low Self-Esteem	Loneliness/Isolation
Hopelessness	Body Dissatisfaction	Social Difficulties
Perfectionism	Physical Symptoms	Impulsiveness
Anxiety/Worry	Sleep Difficulties	Thoughts of Harming Others
Irritability	Obsessions/Compulsions	Family Conflict
Eating/Weight Concerns	Grief/Loss	Adoption
Fear	Suicidal Thoughts	Abuse
Anger	Panic Attacks	Trauma
Over Exercise	School Difficulties	Pornography
Stress	Self-Harm	Self-Acceptance

Other: _____

By signing below, I give permission for the minor named above to participate in evaluation and/ or treatment with Jonathan Fisher, M.S., LPC. I certify that as the minor's custodial parent or legal guardian, I have the legal right to give such permission.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Minor

PARENT AGREEMENT FOR THERAPY WITH CHILDREN AND ADOLESCENTS

Prior to beginning treatment, it is important for you to understand my approach to child/adolescent therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Informed Consent. Under HIPAA and the ACA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

DISAGREEMENTS

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision; however, I ask that you allow me the option of having a closing session with your child to appropriately end the treatment relationship.

PRIVACY

Therapy is most effective when a trusting relationship exists between the counselor and the client. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide parents with general information about treatment progress, and I wholeheartedly welcome your feedback and insight regarding your child. Generally speaking, I will not share with you what your child has disclosed to me without your child's consent. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will tell you if your child does not attend sessions.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol, drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation. Other times, they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

RECORDS

Upon turning 18, the child gains control over treatment, information and records.

DIVORCE AND CUSTODY

By signing below, you represent that you have legal authority to obtain counseling for any child/minor for whom you are the parent of or have guardianship over. You must provide court documentation in the form of a divorce decree to the counselor before services can begin.

In the event that the decree shows joint custody of the child/minor, it is your responsibility to contact the other parent to receive consent and/or to resolve potential disagreements before treatment is started. If possible, it is best to have the other parent co-sign the consent or provide written consent in a statement. Please understand that regardless of whether you have taken this step or not, in joint-custody situations, your counselor will contact the other parent to let them know the child is in counseling. Your counselor will also provide the other parent with updates after each session and copy them on all email responses. Understand that if the other parent has joint custody, they also have authority to access and release the child's otherwise confidential treatment records at any time.

COURT HEARINGS BETWEEN PARENTS

Although my responsibility to your child may require my involvement in conflicts between parents, my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. I strongly encourage you to not involve me in any legal proceedings about custody as the proceedings can interfere with the therapy relationship between me and your child.

If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.

As noted in the Psychological Services Agreement, if legal actions occur in which I am requested or subpoenaed to provide testimony (either by you or another party), you will be responsible to pay me directly for the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent in court. Because of the difficulty of legal involvement, I charge $300.00 per hour for preparation and attendance at any legal proceedings and $50 for each copy of the file. Payment for the estimated number of hours is due 10 days prior to the court date and must be paid in the form of a cashier's check.

Statement of Agreement

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____
Printed Name: _____

Parent/Guardian Signature: _____ Date: _____
Printed Name: _____

Therapist Signature: _____ Date: _____

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Please read the following carefully and initial each statement. *If the adolescent comes from a divorced home, both parents of the child receiving counseling need to sign and initial.*

Nature and Purpose of Counseling

Counseling is a unique and professional relationship between a client and a counselor in which both parties collaborate to help the client grow, mature, and overcome difficulties in his/her life. Counselors at True Hope Christian Counseling utilize Cognitive Behavioral, Interpersonal, Gestalt, Emotion Focused, and a variety of other established counseling theories and techniques to promote positive change in their clients. Counselors at True Hope Christian Counseling operate from a Christian worldview which influences their understanding of the healing process. True Hope Christian Counseling does not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation, and our counselors are prepared to meet with clients from any religious background. Still, ethically they cannot help clients accomplish goals or behaviors that are contrary to their beliefs. Should such a conflict arise, please speak with your counselor. If the situation cannot be resolved, they will provide referrals for other treatment options to better meet your needs.

_____Initials _____Initials

Limits on Confidentiality

Information discussed in the counseling office is considered private and confidential much in the same way as a doctor/patient relationship. There are, however, circumstances when disclosure can occur without your prior consent. The following are typical, but not exhaustive, examples of circumstances under which information may be disclosed without prior consent:

- Your counselor assesses that you are a danger to yourself or someone else
- In situations of suspected child abuse, elder abuse, or abuse of a disabled person
- Upon disclosure of sexual contact with another mental health professional
- Your counselor is ordered by the court or otherwise legally required to disclose information
- Your counselor is discussing aspects of your records with other professionals to determine the best course of treatment
- The handling of scheduling and filing of your records by clerical staff

Please see attached HIPAA forms for a more thorough discussion of confidentiality.

_____Initials _____Initials

Confidentiality in Couples or Family Counseling

If you enter therapy as a couple or family, the couple or family, not the individuals within the system, is considered the client. As such, it is standard practice for all concerned parties to be present during counseling as much as possible. In the course of treatment, there may be circumstances in which one party or another meets with the therapist individually. In such situations, the following conditions will be in place:

- Other members involved in counseling will be made aware of the individual session and have the opportunity to respond
- Individual sessions will be added as needed to benefit the system as a whole
- Individual sessions do not become a hindrance to your overall ability to take hold of, organize, and manage your own personal growth while in the presence of others in therapy

If therapy is started for a couple or family and one person chooses to disclose secret, personal information (ie affair, mismanagement of financial resources, etc) in an individual session, that information will be held in confidence between that person and the counselor with the following provisions:

- Ramifications of the disclosed information will be examined
- Options for what to do with the disclosed information in relation to the marriage or family system will be examined
- You will be encouraged to take personal responsibility and proceed with integrity as this information is processed and applied to the growth of the marriage or family

Because family systems cannot thrive when secrets are present, your therapist will ask that information pertinent to the health of the marriage or family be disclosed in a timely and appropriate manner. If you are not willing to do this and the withholding of this information creates a block in the process of marriage or family counseling, your therapist may suggest termination of counseling and provide referrals for other therapeutic options.

_____Initials _____Initials

Benefits and Risks of Counseling

Therapy can have many benefits and risks. Change is difficult. Since therapy often involves discussing unpleasant aspects of life, at times you may experience uncomfortable feelings such as sadness, anger, guilt, loneliness, etc. On the other hand, counseling often brings greater freedom, increased happiness, restored relationships, deeper friendships, increased confidence, and spiritual transformation. Even so, it is impossible to guarantee specific results regarding your therapeutic goals.

_____Initials _____Initials

Course of Treatment

During the initial visit, your counselor will seek to understand your situation, clarify goals and develop a plan of care to outline a working understanding of the problem, a treatment plan, and therapeutic objectives. If you have any unanswered questions about any of the procedures used in the course of therapy or about the treatment plan, your counselor will explain them to you. You have the right to decline any services provided by True Hope Christian Counseling or request alternative treatment options. It is important that you are engaged in the treatment process because the degree of your participation will affect the degree of success you experience. It is also very important that you complete the entire course of treatment, not circumventing the full therapeutic process. Sometimes people experience a high degree of relief early on in therapy. Other times, change is slower and the process may not always be pleasant. People in both situations may be tempted to end counseling prematurely. If you find yourself wanting to stop counseling before completing your plan of care, it is extremely important that you discuss this with your counselor. Failure to do so increases the risk that your situation may worsen.

_____Initials _____Initials

Concerns or Complaints

If you have a complaint or concern, we strongly encourage you to inform your counselor. Your counselor will work hard to understand and resolve any differences you may encounter. Furthermore, working through a conflict can be of tremendous therapeutic benefit. If, however, you cannot resolve the issue and wish to discontinue therapy, as per your right, your counselor will be happy to provide referrals for other treatment options. If you feel you must make a formal complaint, you may do so by contacting the Texas State Board of Examiners of Professional Counselors by mail at 1801 Congress Ave, Ste 7.300, Austin, TX 78701 or by contacting (512) 305-7700 or their 24 hour, toll-free complaint system at 1-800-821-3205.

_____Initials _____Initials

Scheduling, Fees and Payment

Counseling sessions can be scheduled by calling/texting the primary office number at (832) 262-2351 or online. **The fee for each 45 minute session is $150.00.** A $50 deposit is required to schedule new client appointments online which will be applied towards the balance due for your first session.

In order to facilitate payment, True Hope Christian Counseling requires that a credit card number be kept on file to process all charges. The credit card information is stored in a secure, PCI compliant, virtual safe and all paper records of the card are shredded. Your card will be run for charges on the morning of your session or as soon as reasonably possible thereafter. Should you wish to avoid charging your card, please notify your therapist 24 hours in advance of your session. You are then welcome to pay with cash, check (made payable to "True Hope Christian Counseling"), or an alternate card at the beginning of your session. **Please note that returned checks will incur an additional $35.00 fee.**

In some cases, a third party may be paying for counseling sessions. If this is the case, please discuss this arrangement with your counselor at the beginning of the counseling process. Regardless of third party payee involvement, it is important to note that you, the client, are ultimately financially responsible for the counseling fees.

_____Initials _____Initials

Cancellation Policy

If you must reschedule or cancel a session, please inform True Hope Christian Counseling at least 24 hours in advance of your appointment. **If you fail to cancel your session 24 hours in advance or you fail to attend your session entirely, you will be charged the full fee of your session. You may switch your session to telehealth to avoid missing your session.** If you are more than 20 minutes late and do not notify your counselor of your delay, your session may be cancelled, and you will be charged the full fee for the appointment. If your counselor is unable to attend your session, they will attempt to notify you as soon as possible concerning the cancellation. If your counselor will be unavailable for longer than one week, they will discuss this absence with you in advance and provide you with the name of an alternate counselor with whom you may meet should you feel the need to see someone during their absence.

_____Initials _____Initials

Inclement Weather Policy

True Hope Christian Counseling does not cancel individual or couples sessions due to inclement weather. If you do not feel comfortable traveling to the office, your counselor may be able to host your session via HIPAA compliant video conference call or telephone call. If you cancel due to inclement weather, your cancellation will fall under the regular cancellation procedures discussed above.

_____Initials _____Initials

Telephone and Emergency Procedures

Phone consultations with your counselor should be limited to scheduling or brief clarifications and should last no longer than 5-10 minutes. If the call lasts longer than 10 minutes you may be charged as follows:

Phone call lasting 11-15 minutes	Charge of 1/3 your session fee
Phone call lasting 16-30 minutes	Charge of 2/3 your session fee
Phone call lasting 31-45 minutes	Charge of your full session fee

This office is not a 24 hour emergency service. **If you experience a medical or mental health emergency please call 9-1-1 or a suicide hotline immediately.** The phone number for the **National Suicide Crisis Center is 9-8-8**. Should you require an urgent appointment, please call our main line at 832-262-2351.

_____Initials _____Initials

Confidential Communication With Your Counselor

Your security and privacy are of utmost importance to True Hope Christian Counseling. Understanding how to communicate confidentially with your therapist can help ensure your privacy. The most confidential way to communicate is by speaking over the phone.

Please thoroughly read the communications policy for an extensive look at True Hope Christian Counseling's policies.

_____Initials _____Initials

Dual Relationships and Media

In order to protect your confidentiality and ensure the quality of the counseling relationship, it is important that counselors not interact with their clients in a manner that is non-counseling in nature (social acquaintance, business partner, etc). In order to ensure this does not happen, your counselor will not initiate a greeting or spend time with you socially outside the counseling office. In addition, they will not be able to connect with you on personal accounts via social networking sites like Facebook. If you are currently connected via these sites your counselor will have to "un-friend" you.

_____Initials _____Initials

Court Testimony

In regards to legal matters, counselors at True Hope Christian Counseling will not testify or discuss the content of any session with any legal representative unless compelled to do so by a court order. Even then, they will only share very specific content pertinent to the case. Because of the time and preparation involved for court appearances, **an hourly fee of $300.00** may be charged from the time of departure from the office to the time of release by the court with **a minimum of 6 hours for each day** of the court proceedings. **A non-refundable retainer fee for a minimum of six (6) hours must be paid in advance o**f the actual court appearance. If you are considering having your counselor testify on your behalf, please discuss this with them further. Please note, in regards to couples counseling, your therapist will not be in a position to testify or serve as a witness for either one of you against the other in the unfortunate event of a divorce because the couple itself is the client.

_____Initials _____Initials

Your Records and Right to Review Them

Your counseling records are kept by True Hope Christian Counseling for 6 years (or 6 years after the client's 18th birthday) after your counseling has ended. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your counselor feels that releasing such information might be harmful in any way. Cost for a copy of your records is **$50**. Upon receipt of written request and payment, your counselor will release information to any agency/person you specify unless they feel that releasing such information might be harmful in any way. When more than one client is involved in treatment such as in cases of couple or family therapy, your therapist will release records only with signed authorization from all the adults involved in treatment. In the event of your counselor's death, incapacitation, or termination of his/her license, the custody of your records will pass to Haleigh Fisher, MS, LPC.

Consent to Enter Treatment

I have read the above statements and understand the nature of services provided, the potential benefits and risks of treatment, the availability of alternative treatments, and the limits of confidentiality outlined above. Understanding these statements, I fully consent to treatment.

_____
Parent/Guardian #1 Name (Please Print)

_____
Client's Guardian's signature Date

_____
Parent/Guardian #2 Name (Please Print)

_____
Client's Guardian's signature Date

Therapist Statement

I have inquired to ensure that the patient understood the nature of services provided, the potential benefits and risks of treatment, the availability of alternative treatments, and the limits of confidentiality outlined above.

_____
Therapist's Name

_____ _____
Therapist's Signature Date

CREDIT CARD CHARGE AUTHORIZATION FORM

I hereby authorize True Hope Christian Counseling to charge my credit card for individual, group, marital, or family counseling sessions, as well as any additional fees (including late cancellation, no show or deposit fees) or balance on the account. Charges will be made on the same business day as your session or as soon as reasonably possible, thereafter. If you wish to use a different form of payment you should contact your therapist at least 24 hours prior to the counseling appointment.

Client Name: _____

Card Holder Name as it appears on card (Please Print) :_____

Card Holder Signature: _____

Date: _____

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND KEEP PAGES 11 and 12.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Counselor's Duties

Client's Rights:

- *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. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor'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.

V. 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 the Texas State Board of Examiners of Professional Counselors by mail at 1801 Congress Ave, Ste 7.300, Austin, TX 78701, or by contacting (512) 305-7700 or their 24 hour, toll-free complaint system at 1-800-821-3205

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by verbal or written communication

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT FORM

Your signature below indicates that you have received a copy of the Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please ask Jonathan Fisher, MS, LPC at True Hope Christian Counseling.

Client (Adolescent) Name: _____

Parent/Guardian #1 Name: _____

_____ _____
Client Guardian #1 Signature Date

Parent/Guardian #2 Name: _____

_____ _____
Client Guardian #2 Signature Date

COMMUNICATIONS POLICY

This document outlines my office policies related to communication. Please read it to understand how I conduct my practice and how you can expect me to respond to various interactions that may occur between us via electronic means. If you have any questions about anything within this document, I encourage you to bring them up when we meet.

Communication in the Therapy Relationship

The main form of communication in our work together is face-to-face communication during our therapy sessions. However, it may become useful during the course of treatment to communicate by phone, email, text message (e.g., "SMS"), facsimile, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on these messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages. (In addition, such devices might also store records of your phone calls and voicemail messages.)
- Your employer, if you use your work email to communicate with me.
- Third parties on the internet such as server administrators and others who monitor internet traffic.

Communication Policies

- I respond to emails, text messages, and phone calls as soon as possible. My response time is typically faster for emails and text messages. I typically respond to all communication within 24-hours of receipt during normal business hours.
- All electronic communication will become a part of your medical record.
- Electronic communication is best used for administrative purposes (i.e., appointment scheduling, billing). It is typically more helpful to communicate about clinical issues during our scheduled session times. If something arises between sessions, please feel free to contact me to set up a time to discuss in person or over the phone.
- Sometimes when working with adolescents, parents will send me periodic emails with clinically relevant information that they want to share with me. This can be helpful as a time effective and convenient way to relay information to me. However, please be aware that if you choose to send such clinical information via nonsecure electronic means, there is always the risk of your privacy being breached. In addition, I tend to respond to such messages solely with an acknowledgement that I received the information. If you instead desire to have a more in-depth conversation about such clinical issues, please contact me to schedule an appointment.
- **If you have a crisis or emergency,** you may call me or send me an email or text message. However, **you should first call 911 or go to the nearest emergency room.**
- Your email/text communication will not be forwarded to a third party without your expressed permission, unless you have already signed a release for me to communicate with a professional or unless required by law.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NONSECURE MEANS

I consent to allow Jonathan Fisher, M.S., LPC, to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

(Please initial each that you are consenting to)

_____ Information related to the scheduling of sessions or other appointments.

_____ Information related to billing and payment.

_____ Referral information when relevant.

_____ Responses to email or text messages that I have sent to Jonathan Fisher, MS, LPC of my own accord.

_____ Brief clinical information or updates that Jonathan Fisher, M.S., LPC, feels is better communicated in writing (for reasons of either clarity or convenience).

In addition, I offer automated appointment reminders that can be sent via email/text 24-hours prior to your scheduled appointment time. These messages are sent via nonsecure methods so have the same potential risks as outlined above. If you would like to receive these reminder notifications, please initial below:

_____ I would like to receive appointment reminders via text.

OR

_____ None of the above. I will remember my appointments on my own.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ Signature of Parent/Guardian #1

_____ Printed Name of Parent/Guardian #1

Date: _____

_____ Signature of Parent/Guardian #2

_____ Printed Name of Parent/Guardian #2

Date: _____