Informed Consent for Treatment
Confidentiality and Consent to Use and Disclose Health Information

Client Name (legal): _____ Client DOB: _____

Parent/Legal Custodial Guardian: _____

Client Address: _____

☐ Amanda Keller, LPCC (Amanda Keller, LPCC, LLC)	☐ Maeve Rising, LISW (Maeve Rising, LISW, LLC)
☐ Claire Miller, MSW, LSW (Claire Miller Counseling LLC) ☐ Supervising Therapist: Kristen Santel, LISW-S	☐ Jonathan Sherman, LISW (Jon Sherman Counseling and Consultation Services LLC dba John Sherman Counseling)
☐ Danielle Weatherholtz, LPCC-S (Danielle Weatherholtz, LPCC, LLC)	☐ Jande Thomas, LPC (Jande Thomas Counseling, LLC) ☐ Supervising Therapist: Danielle Weatherholtz, LPCC-S
☐ Kelly Chambers, LPCC (Kelly Chamlis Counseling LLC)	☐ Molly Ottaviano, LPCC, (Molly Boggs Counseling, LLC)
☐ Kristen Santel, LISW-S (Kristen Santel, LISW-S, LLC)	☐ Kimberly Morales, LISW-S (Kimberly Morales, LISW-S, LLC)
☐ Katie Pontious, MSW, LISW (Katie P Counseling LLC)	☐ Autumn Dunn MSW, LISW (Autumn Eckstein Counseling, LLC)
☐ Cassie Campbell, MSW, LISW (Cassandra Campbell Counseling LLC)	☐ Deborah Cannon, MSW, LISW (Deb Cannon Counseling, LLC)
☐ Nicki Cristina, LPCC (Nicki Cristina Counseling, LLC)	☐ Emilee King, M.S.E., LPC (Royal King Counseling, LLC) ☐ Supervising Therapist: Danielle Weatherholtz, LPCC-S
☐ Kathleen Gibbs, LPCC (Keeping Wellness Counseling LLC, dba Kathleen Gibbs Counseling LLC)	☐ Emily Hunter, MSW, LSW (Emily Hunter Counseling LLC) ☐ Supervising Therapist: Kristen Santel, LISW-S
☐ Haley Gniadek, MSW, LSW (Resilience Reclaimed Counseling LLC) ☐ Supervising Therapist: Kristen Santel, LISW-S	☐ Justin Richards, LPC (Pillars Counseling LLC) ☐ Supervising Therapist: Danielle Weatherholtz, LPCC-S
☐ Brandi Allen, MA, LPC (Brandi Allen Counseling) ☐ Supervising Therapist: Danielle Weatherholtz, LPCC-S	☐ CT/SWT: Supervising Therapist: _____
☐ Dyaniese Brown, MSW, LSW (Dyaniese Brown Counseling LLC) ☐ Supervising Therapist: Kristen Santel, LISW-S	○

Santel & Kerr LLC is a group practice of independently contracted psychotherapists. Santel & Kerr LLC provides administrative services such as billing, scheduling, etc. Your psychotherapist, as listed above, is licensed by the State of Ohio Counselor, Social Worker, Marriage and Family Therapist Board (the Board) to engage in mental health assessment and psychotherapy, either independently or may require certain activities supervised by a licensed Supervisor. Your therapist is their own LLC and business owner. If your therapist requires supervision as mandated by the Board, the supervisor's name is also listed above and your therapist can explain in detail the supervision requirements. The listed Supervisor will have full access to your confidential and protected information to assist in the training/supervision of your therapist as well as administrative duties. Additionally, case consultation is considered a best practice in mental health counseling/therapy and therefore, all psychotherapists affiliated with Santel & Kerr LLC

will engage in regular case consultation. This consultation will be with other psychotherapists, including those with more experience and/or licensed as a Supervisor and will not include identifying information on any client. It is possible, however, within the case discussion that a client's identity could be discerned incidentally. All psychotherapists engaged in our case consultations have agreed to keep all client information strictly confidential. You agree, by signing below, to allow us to share information in accordance with these policies.

*** Note: the words "psychotherapist", "counselor", and "therapist" are used interchangeably throughout this document.**

Mental Health treatment has risks and benefits associated with it, some of which are described below. Your (client and/or parent/legal guardian) signature(s) below indicates that you wish to receive this treatment and that you have had these risks and benefits explained to you.

Informed Consent for Treatment

1. The approach to counseling and psychotherapy will reflect the various evidenced based therapeutic modalities and is a collaborative effort between the therapist and client. By entering into this therapeutic relationship, you are stating that you are prepared to attend scheduled appointments and partner in the counseling process. It is expected that you will make the commitment to attend scheduled appointments. You understand that the counseling time is valuable, and that my counselor is committed to working with you/your child. By signing this consent, you are stating understanding that repeated cancelations call into question your commitment and/or availability to the therapeutic process, impede progress, and can result in the loss of your regularly scheduled appointment times previously agreed upon.

2. You have the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.

3. Your counselor uses a variety of communication to stay in contact including phone, text messaging, and email, if preferred. IF you decide to use unencrypted electronic communications, you agree to accept the risks involved, including that the communications may be intercepted by third parties. Also, your therapist cannot be reached 24 hours a day and emergencies happen. If you are experiencing an emergency, you will contact Netcare in Franklin County at 614-276-CARE or dial 911 in or outside Franklin County, or Nationwide Children's Crisis Line if the client is under age 18 at 614-722-1800.

4. Your appointment time has been blocked off for you. You will make every effort to keep your scheduled appointment. If you are unable to keep your appointment, you know that it is expected to give 24 hour notice directly to your treating therapist or you will be charged a late or no-show fee as listed later. You understand that if you do not keep your scheduled appointment that your commitment to treatment could come into question and your therapist might decide that termination is appropriate.

5. By signing this informed consent, you are stating that you understand that there are no guarantees as to the success of treatment. Treatment goals may not be achieved should you decide to discontinue treatment against the advice of you or your child's therapist, and/or continued cancelations occur.

6. You have the right to be informed in advance of the reason(s) for discontinuance of services, and to be involved in planning for the consequences of that event, including being provided with a list of referrals if you request those, the right to receive an explanation of the reasons for denial of service, and the right to know the cost of services. You always have the right to terminate services at any time.

7. You understand that counselors and therapists can ethically only practice within their scope of practice, per the state governing board. If you are seeking out services outside of the scope of practice of your counselor, you will be given additional resources in the community to help support you with those needs.

8. You understand that you have the responsibility to provide accurate and complete information in order for treatment to be appropriate and effective, and for accurate assessment and evaluation to occur. This includes current active insurance information, and any changed insurance information, history, symptoms, functioning, among others.

9. Your therapist may use several therapeutic techniques in counseling including, but not limited to, EMDR (Eye Movement Desensitization and Reprocessing), Ego State therapies, body based and Somatic Therapies, IFS-Informed therapies, Mindfulness, Attachment focused therapies, Deep Brain Reorienting, expressive arts, the use of food, movement, and/or walking in therapy, polyvagal theory, play and recreation therapy, bilateral body-movement/somatic therapy, small-animal assisted therapy, sensory-based therapy, interpersonal neurobiology, psychoanalytic-informed therapy, body-based regulation techniques, Flash Technique, Brainspotting, Memory Reconsolidation Therapy, Clinical Hypnotherapy, Coherence Therapy, Internal Family Systems, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Gestalt, among others. These techniques can be helpful in some situations with some clients. If determined by your therapist that the use of these techniques may be useful, information will be offered about these services and you will be provided opportunities to ask questions and obtain additional information to inform you of their potential risks and benefits. These techniques, and others, are offered as a helpful adjunct to psychotherapy and the decision to utilize any technique is entirely yours.

10. The services offered can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, grief, and helplessness, among many other feelings and emotions, as well as possible changes in relationships. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to changes in relationships, functioning, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

11. You understand that walking (inside or outside of the office), food, movement, small animals, and other therapeutic interventions may be used in counseling sessions. These interventions are utilized as a best practice for certain clients and you can ask for more information and education on them at any time.

12. You understand that Santel & Kerr has an office cat that remains on premises daily. This animal is present for additional therapeutic intervention as deemed appropriate by your counselor. If there are allergies or other issues that require you or your child to be away from the cat, please make that information known to your counselor and accommodations will be made.

13. You understand that no outside dogs or animals are allowed inside Santel & Kerr offices or common areas, unless they are a legal, registered service dog/animal. Emotional support animals are not legal service animals.

14. You understand that any harassment, verbal and/or written aggression or abuse, emotional abuse, or aggressive or violent language or behavior towards any therapist at Santel & Kerr, any other client seeking services, or any person in the building will result in your services being terminated.

Confidentiality

The code of ethics of the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board and other counseling boards ensure that the conversations you will be having with your counselor will be held in strict confidence. There are,

however, certain exceptions to this important rule. The Notice of Privacy Practices explains this information in more detail. By signing below, you acknowledge that you have received or been offered this Notice form.

1. The child abuse reporting laws of Ohio require your counselor to report to Children's Services any suspected physical, sexual, or emotional abuse, neglect or abandonment of any child that is currently under the age of 18 years or a developmentally disabled person under 21 years of age.
2. Your counselor is mandated by law to warn and protect any intended victim if there is reason to suspect imminent and serious bodily harm or threat toward someone a person and may allow information to be shared in other situations involving harm to yourself and/or others. Your counselor reserves the right to inform possible affected parties and/or make appropriate referrals, if necessary, including contacting the police, as allowed or required by the law.
3. Ohio law requires professionals to report elder abuse, neglect, exploitation, or the suspicion of abuse to the Department of Human Services. These laws also apply to the developmentally delayed population.
4. If you are involved in a court proceeding and a request is made for information concerning your treatment, your counselor cannot provide such information without your (or your legal representative's) written authorization, and a court order or a subpoena signed by a judge (not a lawyer). If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
5. If a government agency or insurance company is requesting the information, your counselor may be required to provide it.
6. If you file a complaint or lawsuit against your counselor, he/she may disclose relevant information about you in order to defend him/herself.
7. If you file a worker's compensation claim, your therapist may, upon appropriate request, have to provide a copy of your records or a report of your treatment.
8. First and foremost, social workers' and counselors' primary ethical responsibilities are to promote the well-being of clients (Code of Ethics, Standard 1.01). Social workers and counselors must also "respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals"
9. You agree that the practice may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.
10. Your therapist's relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" your therapist or anyone else in the practice on Facebook or on any other social media site.

In the course of behavioral health services with your child, I may meet with parents/custodians/guardians, either separately or together. Please be aware, however, that at all times, my client is your child – not the parents/custodians/guardians, any siblings, or family of the child. If I meet with you or any other family members in the course of your child's treatment, I will make note of that meeting in the child's treatment records. Please be aware that these notes will be available to any person or entity that has legal access to your child's treatment record and your information may not be protected, since the child is the only client and generally this information is available to both parents or legal guardians, unless blocked by court order. In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have you or your child's permission. Examples of these situations may include, but are not limited to, the list below.

Confidentiality cannot be maintained when:

1. Clients tell me they have plans to harm themselves or others and I believe they have the intent and ability to carry out this threat. I must take steps to inform a parent/custodian/guardian of what the child has told me and how serious I believe the threat to be, possibly law enforcement and/or the potential victims.
2. Clients tell your therapist they are doing things that could cause serious harm to themselves or others, even if they are not intending to cause harm. In these situations, I will use professional judgment to decide whether or not a parent/custodian/guardian needs to be informed, all in accordance with what the law requires or allows your therapist to do.
3. Clients tell me, or I otherwise learn or suspect, that a child is being neglected or abused (physically, sexually, mentally, or emotionally). In this situation I am required by law to report the alleged abuse to the appropriate state child protective services agency or local law enforcement. This might include if a minor tells me they are "sexting" or viewing or circulating child porn.
4. I am ordered by a court to disclose information. Therapy is most effective when a trusting relationship exists between the behavioral health therapist and the client. Privacy is especially important in earning and keeping that trust, which is why it is important for minors to have a space of privacy, where they are able to discuss personal issues without fear that their thoughts and feelings will be immediately communicated to their parents/custodians/guardians or other third parties. However, minors need to understand that in most situations their parents have a right to at least access the records of sessions, unless blocked by court order, and there may be other instances when confidentiality cannot be protected.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information that your child has disclosed to me without your child's agreement, in most instances. This includes activities and behaviors that you may not approve of or may be upset by, but that do not put your child at risk of serious harm. If your child's behaviors or activities become riskier or more serious, then I will use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that they are in such danger, I will communicate this information to you and potential to the proper authorities. There may also be other situations in which subjects arise that I feel would be beneficial for you to know, but it is not my place to share that information. In situations like these, I will work with your child and encourage them to tell you, helping them find the best way to do so.

Although Ohio law gives parents/custodians/guardians the right to see any written records that I keep about your child's treatment, unless blocked by court order, by signing this agreement, you are agreeing that your child should have a zone of privacy in their meetings with me and you agree not to request access to your child's written treatment records, although your child needs to understand that you have the right to revoke this consent at a later time and obtain the records.

Consent Signatures for Minor Clients

I, _____, understand the information above and give consent for:
Parent/Custodian/Guardian Name

_____(_____/_____/_____) to receive behavioral health services at:
Child Name Child Date of Birth

_____
Legal
LLC Practice Name

I understand that behavioral health services may include, but are not limited to, discussions on family history, educational achievements and aspirations, criminal history, and any medical/drug/drug-treatment history. Services may

also include, but are not limited to: intake; diagnostic assessment; screening for other co-occurring diagnoses, physical, sexual, mental, and emotional traumas; group therapy options; outside resources, and family therapy options. I understand that my child's therapist will review my child's symptoms and behaviors in order to diagnose (or rule out diagnoses) for my child based solely on evidence, even if it is a diagnosis that I may disagree with. I give consent for my child's therapist to diagnose or treat my child as you deem it appropriate. Examples of diagnoses that I consent to, as long as they are applicable to my child, with resulting treatment include, but are not limited to: depression, anxiety, attention-deficit hyperactivity disorder, obsessive compulsive disorder, gender dysphoria, gender-related condition, post-traumatic stress disorders, autism spectrum disorder, eating disorders, oppositional defiant disorder, dissociative disorders, dysregulation disorder, bipolar disorder, and/or personality disorders.

_____ _____
(Parent/Custodian/Guardian initials)

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided periodic updates about general progress and/or may be asked to participate in therapy sessions as needed.

_____ _____
(Parent/Custodian/Guardian initials)

Although I may have the legal right to request written records or session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's treatment, although I understand that I may revoke this consent in the future.

_____ _____
(Parent/Custodian/Guardian initials)

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted.

_____ _____
(Parent/Custodian/Guardian initials)

Parent/Custodian/Guardian Signature: _____
(By typing my name into this field I am signing my legal signature for the above document)
Date _____

Parent/Custodian/Guardian Signature _____
(By typing my name into this field I am signing my legal signature for the above document)
Date_____

By signing below, you show that you have read and understand the policies described. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date _____

Supervision

If your therapist is working under Supervision, as defined by Ohio Counselor, Social Worker, and Marriage and Therapist Board, by signing below you agree that your therapist will discuss your case with his/her Supervisor and that the Supervisor, as listed at the top of this agreement will have full access to your Protected Health Information as well as the clinical information about your case.

Consulting with Other Therapists and Attorneys

By signing below, you agree that your therapist may consult with other therapists and possibly other health care therapists about your care. In addition, from time to time, your therapist may feel the need to discuss legal issues involving your case with their consulting attorney. By signing below, you consent to these consultations, which will be limited to the amount of information necessary for your therapist to properly address issues that may arise in your therapy.

Electronic Communication

Electronic messages (email, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards, which are outside our control. Therefore, we are unable to exchange clinical information with you by unencrypted electronic communication. We may communicate regarding scheduling or billing issues. By signing this consent, you agree to these conditions and understand, and agree to the fact, that if you initiate an unencrypted email or text message to us, your identification, information that you are communicating with a therapist, and/or other Protected Health Information could inadvertently be disclosed to an outside party. **If you do not wish to communicate using unencrytped email or text, even for scheduling and billing issues, or do not wish to have you contact via mail or another way, you must have a working voicemail set up on a valid phone and agree to allow your therapist to leave a voicemail.** If you wish for us to communicate with you in another way, please let yout therapist know that at the first session.

Initial where applicable:

_____ I agree to electronic communications knowing they may not be secure or encrypted and, therefore, can be breached or hacked at any time.

_____I do not agree to electronic communication and prefer only phone calls to the following phone number. I have voicemail activated on this number and give permission for my therapist to leave a message at _____ (number).

Health Information

The Notice of Privacy Practices* (NPP) explains in more detail your rights and how we can use and share your information.

You will be provided with a copy at your initial appointment. This document is also available in printed form in the office, and online at https://www.santelandkerr.com.

Business Associates

We may disclose your protected health information (PHI) to third parties, known as *Business Associates*, who perform services on our behalf, such as billing, claims processing, data storage, legal, accounting, or quality assurance services. Business Associates are permitted to use or disclose PHI only as necessary to perform the services for which they are engaged and are required by federal law to safeguard your information through written agreements that comply with HIPAA. We share only the minimum necessary information with these Business Associates, and they are legally required to protect your information and follow HIPAA privacy and security rules. By signing below you state understanding and informed consent of these policies.

Consent Form for the Use of Artificial Intelligence in Non-Identifying Clinical Documentation

At Santel & Kerr, LLC, a group of independently contracted therapists, we are committed to providing high-quality care and continually seeking innovative solutions to enhance the growth and development of our clinicians and practice. As part of this commitment, we utilize Artificial Intelligence (AI) technology to assist with creating treatment goals in general, describing best practices for a particular diagnosis, and for other related tasks to improve our services. However, unlike other practices that utilize AI by recording client sessions, with the AI then generating session notes, we do not ever enter any client identifying information into the AI system nor is any recording done. In other words, the use of AI is only for general, non-client specific purposes.

The integration of AI technology is designed to:

- Enhance the accuracy and efficiency of our clinical work.
- Support our clinicians in managing and analyzing best practices for different types of diagnoses.
- Facilitate the development of tailored treatment plans.

By signing this document, you, as a client of Santel & Kerr, LLC, consent to the use of AI technology for the purposes described above involving clinical support tasks related to your care. You understand that this technology is used as a tool to assist your clinician and is not a replacement for professional judgment and interaction. The resulting work will be just a draft and will be revised by your therapist to make sure everything is accurate. Only the final materials will be maintained as part of your record, if any of it is entered into your records, which you may request within the required period of time your therapist is required to maintain it.

We prioritize your privacy and confidentiality. In using AI technology, we ensure that:

- **No identifying information (such as names, addresses, or social security numbers) will be input into the AI system.**

While AI technology provides significant benefits, it is important to acknowledge potential risks, including:

- The possibility of inaccuracies or errors in AI-generated content, which will be reviewed and corrected by our clinicians as needed.
- The risk of data breaches or cybersecurity threats, against which we have implemented robust security measures to protect your information. This is unlikely to happen since the information AI is provided will not contain any Protected Health Information related to you.

Your participation in this AI-assisted documentation is voluntary. You have the right to:

- Ask questions and receive clear explanations about the use of AI in your care.
- Withdraw your consent at any time, including to reject the use of AI prior to beginning treatment, without affecting your right to care.

I, have read and understand the above information regarding the use of AI technology at Santel & Kerr, LLC. I have had the opportunity to ask questions and have them answered to my satisfaction. By signing below, I agree to the use of AI in my clinical documentation as described above.

Initial: _____

Or: _____ I do not want AI used in connection with my treatment

Prohibition of audio, video or photographic recording

While in counseling/psychotherapy sessions and/or in the common areas or bathrooms of the office of Santel & Kerr LLC, there is to be no audio, video, or photographic content recorded by any device or app. By signing below, you agree to not use any type of documenting device or recording device while attending counseling online, in the office, or while simply being in the building, and that doing so could lead to termination of your treatment. This includes social media, and taking picture and video. If, due to unusual circumstances, you would like to record or videotape your individual psychotherapy/counseling session, and if your therapist deems an exception to this prohibition is reasonable and necessary, the exception will be granted to you in writing.

Office Policies - Please initial where indicated:

_____You understand that adults attending counseling cannot leave children unattended. If a parent/guardian needs to discuss their child's therapy in private, arrangements will be made with the therapist to schedule a private conversation.

_____ You understand that coming into the office contains a risk of exposure to coronavirus or other viruses, and you agree to assume the risk of exposure to yourself and/or any child that you bring into the office.

_____ You agree to take the following below precautions to help keep everyone safer from exposure and understand that failure to follow these precautions may result in only Telehealth services available to you:

- You will only keep your in-person appointment if you are symptom free.
- **If you test positive for coronavirus you agree to follow all current CDC Guidelines regarding quarantine and must provide proof of a negative test prior to returning to the office.**
- You will wait in your car or outside away from the doorway and text your therapist when you arrive. Your therapist will return the text when you can enter and will advise you to either come directly to their office or your therapist will meet you at the door.
- You will wash your hands or use hand sanitizer when needed. Sanitizer is available in your therapist's office or in the entry areas.
- If you are bringing your child, you will make sure that your child follows all of these protocols. Children under the age of 10 must be met at the door and escorted back to the car by your therapist.
- You will immediately let your therapist know if you are exposed to anyone testing positive for coronavirus or other infectious disease.
- You understand that these policies may be changed at any time based on local, state, or federal guidelines. Notice of changes will be provided directly to you by your therapist and continuing to schedule therapy sessions will act as consent to these revised policies.

Telehealth Services/ Electronic Service Delivery

Electronic Service Delivery is defined as mental health therapy in any form offered or rendered primarily by electronic or technology assisted approaches when the mental health therapist and the client are not located in the same place during delivery of services. While working with your therapist you will always have the opportunity to ask any questions that you have about the therapy, electronic communications in general, and other issues involving your therapy. Your therapist will also assess your ability to handle computers and the internet, so that you and he or she may work in this way. By signing this form, you agree to the policies and procedures as outlined below for Telehealth/Electronic Service Delivery services and understand the risks associated with this form of mental health therapy.

As a client receiving mental health services through electronic service delivery methods, you should understand:

(1) This service is provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face, communication. There are benefits and limitations to these types of services. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information may not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. Your therapist will assess whether or not therapy through means of electronic service delivery is appropriate for addressing your issues and whether or not you have the knowledge and skills to use the technology involved.

(2) As a therapist licensed in Ohio, your therapist may only deliver services to residents or people located in Ohio. If you plan on leaving Ohio for any length of time in the future, please let your therapist know as soon as possible so that you and he or she can make proper arrangements for future work or referrals, as appropriate. If you are going to be out of state during therapy, then your therapist will have to comply with the licensing laws of the state where you will be located.

(3) If a need for direct, face to face in person services arises, it is your responsibility to contact therapists in your area, or to contact this office for a face-to-face appointment. You understand that your therapist may be unable to meet face-to-face based on many circumstances, and other therapists may not have openings.

(4) These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet or through other electronic services that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. Your therapist and you will regularly reassess the appropriateness of continuing to deliver services through the use of technology. When using these services, you agree to accept the risks involved with the unencrypted exchange of information.

(5) Your therapist will need to verify your identity in a face-to-face meeting, which may be via video electronically or in person. At the initial session you and your therapist will address imposter concerns. You should be aware that misunderstandings are possible with telephone, text-based modalities (e.g., email), and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, since bandwidth may be limited and images may lack detail, misunderstandings may occur. Your therapist is an observer of human behavior. He or she will gather information from body language, vocal inflection, eye contact, and other non-verbal cues. Cultural differences and how they affect non-verbal cues may also be involved and your therapist will assess whether or not this type of therapy is appropriate for your therapeutic treatment goals, cultural experiences, your environment, and your therapeutic needs. If work is being done with families or groups with different levels of technology competence, power dynamics will be acknowledged. Please let your therapist know if you have any type of audio/visual or cognitive impairment prior to beginning therapy. If you have never engaged in online counseling, you need to have patience with the process and request clarification if you believe that you are not being understood by your therapist or you do not understand something that your therapist says. He or she will regularly review whether or not electronic service delivery is meeting your goals of therapy. Your therapist will also discuss with you how to handle disruptions in services and all methods of delivering services that are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.

(6) In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a. In emergency situations: If it is an imminent situation that requires face-to-face contact call 911, call or text 988, or go to the nearest emergency room. If it can be managed over the phone you can call your therapist but if your therapist does not respond immediately or within a short period of time, you should contact local emergency services (for example, call 911, go to local emergency room, call National Suicide Prevention Hotline at 1-800-273-8255.) Also, other local hotline crisis phone numbers may be available to call.

b. Should services be disrupted: Try to regain contact using the same medium. If that does not work, attempt to make contact using text or email. Your therapist will also make every effort to regain contact. If service is disrupted during a therapy session before the pre-agreed time has ended, you will have the opportunity to use the remaining time as soon as contact is made. If contact is not re-established within the session hour, you will be charged a pro-rated amount or allowed to schedule an additional session to use the remaining time.

c. For other communications: Your therapist and you may agree to communicate via phone call, video conferencing, email, text, fax, or mailed letters in accordance with policies set forth in this document.

(7) The potential benefits of online counseling include flexibility in scheduling and allowing you to engage in counseling outside of the office, which increases access to care and services, eliminates issues like transportation, and other psycho-social barriers that might make it difficult for you to handle in a traditional office setting. The provision of online counseling may include risks related to the technology used, the distance between you and your therapist, and issues related to timeliness. For example, the potential risk of confidentiality may pertain to your accessing the internet from

public locations. You should consider the visibility of your screen and being overheard when in public settings. It is recommended that you be in a private setting, and not a public setting, when engaging in online counseling as to not violate your confidentiality. You should also always use strong passwords to protect any information shared with your therapist. Never use a work computer for therapy as your employer may have access to the information shared in electronic communications. Be cautious when using a shared network with others.

(8) Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than it is in person. You are responsible for confidentiality in your own environment, including securing your hardware, internet access points, chat software, email, and passwords. You also are responsible for ensuring you or your child have a private space with a closed door to engage in therapy as to not violate your confidentiality. Please develop passwords that are appropriate and strong and not use auto-fill for usernames or passwords. Although your therapist will take steps to protect your information, he or she will have policies in effect to notify you of a breach of any of your confidential information which is required to be reported to you.

(9) Your therapist may utilize alternative means of communication in the following circumstances: if you do not respond to text, your therapist may call. If you do not respond to a call, your therapist may follow up with text or e-mail. If you do not respond to a call, text, or e-mail, your therapist may send you a letter. In case of emergency (or concerns over your welfare), your therapist may contact your emergency contact if you have provided one.

(10) Most insurance companies in Ohio reimburse for telehealth therapy, so there may be insurance coverage for therapy sessions delivered through technology in Ohio. . **The fee for Telehealth/Electronic Service Delivery sessions are the same as in-person sessions**. You agree to check with your insurance company to determine if they will pay for electronic service delivery sessions at the same rate as in person sessions. If insurance does not pay for Telehealth/ESD or does not pay their regular contracted rate, then you agree to pay the full fee for our services and seek reimbursement directly from your insurance company.

(11) You need to take the following precautions to ensure that your communications are directed only to your therapist or other individuals: Ensure that you use the correct e-mail address, telephone number, or online name, fax number, and physical address to contact the appropriate individuals. Only leave voice messages after ensuring that the correct phone number was dialed and the voicemail introduction identifies the correct individual. Your therapist will attempt to respond to communications and routine messages within 48 hours if he or she is available.

(12) Your communications exchanged with your therapist, if capable of being put into written form, will be stored in the following manner: e-mails, texts, and other electronic communication relevant to treatment will be printed and kept in your file. Mailed letters and documents will also be kept in your file. Notes outlining electronic service delivery treatment sessions will be written and kept in your file. Your file will be kept in a locked file cabinet or stored electronically and will be accessible only by those who require or are allowed access and will be available to you or someone named by you for the length of time required under Ohio law. Your therapist will not record sessions without first discussing it with you and obtaining your permission to do that. Under most circumstances, you have a right to receive a copy of your record and your therapist may be able to charge you fees for providing those to you.

(13) The laws, ethics and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on your therapist, all of our therapists are licensed by the Counselor, Social Worker & Marriage and Family Therapist Board. The Counselor, Social Worker & Marriage and Family Therapist Board's website is found at www.cswmft.ohio.gov.

Insurance and Fees

Please review this agreement before signing. By signing this informed consent, you agree to abide by the fee agreement. You also understand that you are financially responsible for the amount of charges not covered by your insurance.

You understand that you are responsible for obtaining necessary insurance authorization/referrals and for confirming coverage and agree to notify your therapist of any changes in insurance coverage.
By signing this form, you acknowledge that although insurance will be billed directly as a convenience to you, that you are responsible for the balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company or other third party. Prompt payment is expected from you of any insurance payments made directly to you for counseling services, or of any co-payments, deductible payment, etc. due from you. You agree to inform your therapist if your insurance changes at any point, and understand that any changes in insurance can affect your coverage and that you could be left paying for services if your insurance has changed and your therapist is not made aware due to "timely filing" statutes deemed by insurance companies. If the timely filing period has ended, it is your responsibility to pay your outstanding bill out of pocket and speak with your insurance about coverage of claims. Therapists cannot guarantee they will be in-network if insurance changes. Therapists also cannot guarantee that an insurance company will agree to back-bill for any unpaid sessions. By signing below you state understanding that you will be responsible for any unpaid sessions, or session fees recouped from an insurance company if they have deemed those sessions no longer reimbursable.

Payment is expected on the day of service. You understand that if you do not wish to have us submit an insurance claim, you will be expected to pay full cash fee prior to each session. The full cash fee, as well as the rate billed to insurance, for a counseling session is $150.00 per 1 hour (53 minutes) session. The full cash fee, as well as the rate billed to insurance for the first 2 sessions including assessment, diagnosis, and treatment planning is $175.00 per 1 hour (53 minutes) session. For telephone calls and report writing, your therapist has the right to charge for these services and will typically bill on a prorated basis of their normal hourly rate.

By signing below, you understand that if you or your insurance company do not pay for services rendered, Santel & Kerr LLC and your individual therapist LLC may send your information to a credit reporting agency or a collection agency to collect any balances due, plus an upcharge of 25% of your fees for administrative costs. If this occurs, your therapist will only release enough information about you to collect the debt. It is asked that every client authorize payments of medical benefits directly to Santel & Kerr LLC and/or your therapist. If you are using a credit card to pay your fees and you challenge a charge, you agree to allow the practice to send sufficient information in order to justify the charge.

By signing this form you are stating understanding that outstanding payments for rendered services are due upon receipt. You also state understanding that if outstanding balances remain unpaid, the therapist may cease treatment until the balance is paid.

By signing this form, you understand that if your therapist is required to bill the Bureau of Workers Compensation and/or any of the associated managed care organizations, the rate of reimbursement increases to $200.00 per therapy hour due to the increased amount of paperwork, documentation, collaboration, phone calls, etc. required by these organizations.

By signing below, you consent to the disclosure of necessary information to your insurance company, which is required for billing (diagnosis, treatment plans, dates of service, and, if required, treatment progress). You also give consent to bill your insurance company for services rendered and allow a photocopy of your signature to be used.

Individuals have the right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the healthcare item or service. You understand that you have this choice in your treatment.

I choose to self-pay out of pocket: Y_____ N_____

Primary Insurance Company: _____
Co-Pay Amount: _____
Name of Insured on Insurance Card: _____
Date of Birth of Insured on Insurance Card: _____
Member ID: _____
Group Number: _____
Insurance Contact Phone number for Therapists: _____
* Please call your insurance company to verify coverage and copay amount, and **if there is a deductible to be met first.**

If you carry Secondary Insurance that may provide additional coverage beyond your Primary Insurance coverage, you are responsible for filing and managing your claims with your Secondary Insurance carrier. Your therapist will not bill any other insurance beyond your Primary Insurance listed above. You agree to notify your therapist as soon as possible if your Primary Insurance Company changes in any way.

If at any point in the future your insurance company does a "clawback" with your therapist and recoups money from past sessions, your signature below states understanding that you are required to pay your therapist for the lost sessions in-full within 90 days, as well as take primary responsibility in managing the claims with your insurance company.

CANCELATION POLICY:

By signing this document and initialing below, you understand that **you will be charged a full session fee ($175.00 for the first or second scheduled appointment, or $150.00 per session thereafter) for appointments canceled without 24-hour notice or for no-show appointments if we are allowed to do that under your insurance program**. Clients who repeatedly do not give a 24-hour notice for cancellations or who do not keep their scheduled appointments may be terminated. You understand that insurance does not cover "missed appointment" fees or late cancel fees and you are responsible for payment of these fees at your next appointment. By initialing below, you are stating understanding regarding the collections process noted in above section. Insurance companies will not reimburse for late payment fees. **By initialing below you state understanding that if you are 15 minutes late for your scheduled session that your session can be canceled and you will be subject to a late cancelation fee that is not billable to insurance.**
You understand that you are responsible for inquiring about, and/or filing complaints or suits against your insurance company if they deny or delay payment on an eligible visit or decline payment for any reason. You understand you are financially responsible for payment of the balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company. Initial: _____

Legal Proceedings
Therapist involvement in legal proceedings is discouraged. Therapeutic relationships are based on trust and involving your therapist as a witness may jeopardize this relationship and progress in therapy. Even though you are responsible for all testimony and legal fees, it does not mean that your therapist's testimony will be solely in your favor. Therapists can only testify to the facts of the case. Therapists are not custody evaluators or forensic psychologists and cannot make any recommendations (for custody, visitation, or otherwise). If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for any professional time spent on your legal matter, even if the request comes from another party. Therapist involvement in court proceedings is at a contractual rate of $300 per hour for all professional services the therapist is asked or required to perform in relation to your legal

matter, to attend court, and for travel. This includes preparation time of reports, submission of reports/records, phone calls, court appearance, testimony, and travel.
In the event that your therapist becomes involved in legal proceedings as a result of therapy, such as but not limited to responding to a court order or attending a deposition or a hearing, you agree to pay for fees in connection with such a proceeding. You also agree that your therapist may consult with his/her attorney on how best to proceed and you agree to pay those legal costs. Time for depositions and court may involve preparation, travel time, and waiting to testify. In such situations your therapist may request a retainer which will be charged at the normal rate charge at that time for therapy. If any money in the retainer is not used your therapist will refund the balance. In the event that your therapist does not schedule clients in anticipation of a court proceeding and notice of a cancellation of the court proceeding within one week of its scheduled date is not received, you agree to pay for time your therapist lost with clients that would have otherwise been scheduled.

If requested to testify in a court proceeding or to provide clinical information during a court proceeding, your therapist will require a court order signed by a judge, not a subpoena from your attorney. You agree to notify your attorney of this requirement, which is based on Ohio law and advice of our attorney.

By signing below, you state understanding that your therapist is not a forensic psychologist, a forensic interviewer, or a child custody evaluator or evaluator of any kind. Your therapist cannot provide child custody recommendations for you to any party. Your therapist is limited by the Board's guidelines regarding conflict of interest and scope of practice as to what testimony, if any, may be given.

*By signing below, you are stating that you will provide any and all current and up-to-date child custody paperwork, legal visitation paperwork, and/or legal guardianship paperwork to your child's therapist before a minor will be seen for therapy if there are court orders on these matters. You are also stating that you acknowledge responsibility in keeping all of the child's custodial parents and legal guardians up-to-date on all counseling appointments, and keep your child's therapist up-to-date on all legal changes to custody and/or legal proceedings.

Initial: _____

Professional Records

The laws and standards of our profession require that your therapist keep Protected Health Information about you in your Clinical Record. If records are requested copied for another therapist, legal proceedings, etc., in most circumstances, your therapist is allowed to charge you or your personal representative a copying fee which is set by Ohio law and is updateed yearly, plus the cost of any related postage, unless otherwise required by federal law. If you want the records in an electronic format, you may request that they be delivered that way.

Therapist Incapacity or Death

By signing this informed consent, you acknowledge that in the event of your therapist's incapacitation or death, it will become necessary for another therapist to take possession of your file and records. You give consent to allow another mental health professional at Santel & Kerr LLC to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice. You agree to select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional of your selection.

Disclosing Information to Family Members, Relatives, or Close Friends

By signing below, you agree to allow your therapist, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, to disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if your therapist determines that it is your best interest based on his or her professional judgment. If you object to me doing this, please let me know during our first session together.

Signature of Agreement:

If you have any questions or concerns about the information presented to you in this form, you can speak with your counselor at any time. Signing below indicates that you have read and understand that there are limits on confidentiality, there is a fee and payment procedure and that you hereby give your consent for, and understanding of, all items listed in the above ten pages.

Your signature certifies that you have either received a copy of the "Notice of Privacy Practices" or waived that right. You understand that you can obtain a copy at any time from your counselor or online via the website santelandkerr.com.

If you are signing this form electronically, you confirm that typing your information into the below areas confirms your legal signature. By signing below, you are agreeing to and stating understanding of all information outlined above for yourself and/or your child. You consent to receive the services outlined above or you consent for your child, who is under the age of eighteen (18) to receive these services.
You have had the opportunity to discuss this consent with your therapist and do hereby give full voluntary consent/ authorization for the treatment for yourself and or your child/family under the conditions set forth.

Client Legal Name (Please print): _____

_____ _____

Client's Signature Date

(*By typing my name into this field I am signing my legal signature for the above document)*

_____ _____

Parent/Legal Custodial Guardian Signature for a minor under 18 years of age Date

(By typing my name into this field I am signing my legal signature for the above document)

Parent/Legal Custodial Guardian Printed Name: _____

Therapist Signature: _____Date: _____
Therapist Legal LLC: _____

Minor Seeking Treatment:

As a minor 14 years of age or older, I understand I am entitled to receive counseling services for not more than six sessions or thirty- (30) days, whichever comes first, without the consent of my parent/guardian and without that parent/guardian being informed, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of your therapist's intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option This law for minors *could be affected by HB 68 and services could be terminated. If services extend beyond the point of six sessions or 30 days, or treatment is affected by HB 68, I will work with my therapist to involve my parent / guardian in my treatment*

Minor Signature _____ *DOB:* _____*Date:* _____
(By typing my name into this field I am signing my legal signature for the above document)

Minor printed name: _____

Therapist Signature: _____Date: _____
Therapist Legal LLC: _____