PEDIATRIC PSYCHOLOGY ASSOCIATES

Aventura • Weston • South Miami
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1022

Dear Parent/Caregiver:

Welcome to our practice. In preparation to your first appointment, we have attached several forms to be filled out and signed by each parent. This will help us gather information regarding your child and family prior to beginning treatment. It is important that all of these forms are reviewed and completed before your first appointment.

Forms to complete:

- Forensic Family History Form
- Legal & Ethical Limitations in Individual Treatment **or** Legal & Ethical Limitations in Reunification Treatment
- Forensic/Legal Services Policies & Fees
    - Credit Card Payment Consent Form*
- HIPAA Notice of Privacy & Health Information Practices
- Telehealth Policies & Procedures

**If parents are sharing payment of services, please fill out one form for each parent.*

Who is Responsible for Payment?

If you have a court document outlining financial responsibility for mental health treatment, please share with our office when forwarding completed forms. Otherwise, in signing the *Forensic/Legal Services Policies & Fees* form, you are agreeing to pay for the treatment your therapist is recommending, and that may include your child(ren)'s other parent in some sessions. If you have any questions about who is responsible for payment, please consult with your legal counsel. Please note that our office will not provide services if payment information is not submitted and agreed upon by both parties.

We encourage you to complete these forms prior to your first appointment and forward to info@mailppa.com or fax to (305) 936-1022, along with additional paperwork that may outline legal parameters of custody, payment responsibility, visitations, and/or previously documented incidents.

If you should have any questions, do not hesitate to contact us.

Warmest Regards,

Pediatric Psychology Associates

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FORENSIC FAMILY HISTORY FORM

Name of Parent/Caregiver Completing Form:_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

(If more than 4 children, please write on back of page-child's name, age, birthdate)

Do your child(ren) have a cellular phone(s)? If so, please list child's name and number(s)?

_____

_____

What are the concerns or difficulties that cause you to seek professional help at this time?

_____

_____

_____

PARENT INFORMATION

Parent 1 Name_____Age_____Birthdate_____

Email:_____Occupation:_____Education_____

Cellular_____Alternative Phone:_____

Home Address_____

City_____State_____Zip Code_____

Attorney's name (if applicable) _____

Parent 2 Name_____Age_____Birthdate_____

Email:_____Occupation:_____Education_____

Cellular_____Alternative Phone:_____

Home Address (if different than Parent 1 Address)_____

City_____State_____Zip Code_____

Attorney's name (if applicable) _____

Date of: Marriage_____Separation_____Divorce_____Mark if never married ☐

Are there other persons living at home(s)? Yes ☐ No ☐ If yes, who?_____

_____

If applicable, what is the child(ren)'s relationship with parent's significant other or step-parent?

_____

Is there a parenting plan in place at this time? Yes ☐ No ☐ (If yes, please provide a copy)

Has a Guardian ad Litem been appointed: Yes ☐ No ☐ If so, Name _____

Contact information _____

Child(ren) live with: ☐ Biological ☐ Adoptive parents ☐ Other _____

If parents are living apart (separated/divorced) is the other parent aware that you are seeking psychological services?* Yes ☐ No ☐ **A consent form must be signed by the other parent if parents are divorced or living apart AND if the children will be part of our psychological sessions.*

Describe living/time-sharing arrangements:_____

_____

_____

How often do you have contact with the children when they are not with you? _____

_____

Describe the contact (visits, supervised/unsupervised, phone, etc.): _____

_____

_____

Describe your relationship with the other parent. Excellent ☐ Good ☐ Fair ☐ Poor ☐ The worst ☐

What effect do you think this relationship has on the child(ren)?

A great deal ☐ Some ☐ A little ☐ None at all ☐ Not sure ☐

How often do you have contact with the other parent? _____

How do you communicate (text, Talking Parents, Our Family Wizard, email)?_____

_____

Describe the problem(s) that have occurred between you and the other parent:

_____

_____

_____

Are you fearful of the other party for any reason? Yes ☐ No ☐ If yes, explain:_____

_____

Has the other party ever threatened to hurt you in any way? Yes ☐ No ☐ If yes, explain: _____

_____

Has the other party ever hit you or used any other type of physical force towards you? Yes ☐ No ☐

If yes, explain: _____

Has the other party emotionally, sexually or emotionally abused you? Yes ☐ No ☐ If yes, explain:

_____

Have you ever called the police, requested a protection for abuse order, or sought help for yourself as a result of abuse by the other party? Yes ☐ No ☐ If yes, explain:_____

_____

Has the other party ever threatened to deny you access to your child(ren)? Yes ☐ No ☐

If yes, explain:_____

Are there concerns about the children's emotional or physical safety? Yes ☐ No ☐ If yes, explain:

_____

_____

Have you or the other party abused alcohol or drugs? Yes ☐ No ☐ If yes, explain: _____

_____

Check the description of present alcohol use (including beer, wine, liquor)

Daily ☐ Once or twice a week ☐ Once or twice a month ☐ None ☐

Check all that apply current or prior drug use or abuse: Current ☐ Past ☐ Neither ☐

If yes, please list type used: _____

Please list use of prescription and/or non-prescription drugs: _____

_____

Have you ever been arrested for an alcohol/drug related crime? Yes ☐ No ☐ If yes, please explain:

_____

_____

Have you ever undergone treatment for substance or alcohol use/abuse? Yes ☐ No ☐

If yes, please explain: _____

_____

Please rate the effectiveness of this treatment: Very effective ☐ Helpful ☐ Waste of time ☐

Do you have concerns regarding the other parent's use of alcohol or other substances? If yes, please explain: _____

_____

Are you now or have you ever been on probation or parole? Yes ☐ No ☐ If yes, please explain:

_____

_____

Have you ever had a restraining order filed against you? Yes ☐ No ☐ If yes, please explain:

_____

_____

Is there a restraining order in effect right now that you are involved in? Yes ☐ No ☐

Have you or the other parent participated in domestic violence classes, batterer's intervention or anger management? Yes ☐ No ☐ If so, when? _____

If yes, please rate the effectiveness of these classes in eliminating abusive behavior:

☐ Very effective ☐ Helpful ☐ Waste of time

Have there ever been charges filed against you for physical assault, battery, domestic violence, or stalking?_____If yes, please explain: _____

_____

Do you have any concerns about your physical safety during joint meetings held with the other parent?_____If yes, please describe:_____

_____

_____

Is there anything else that would be helpful for me to know about the other parent, your child, or your situation? _____

_____

_____

BRIEF FAMILY HISTORY

Are there any health/learning/emotional issues about your child(ren) I should be made aware of?

If so, please list child's name and describe in detail:_____

_____

_____

_____

_____

What language(s) does your child(ren) speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Religious Affiliation:_____

Where does your child(ren) sleep in their home(s)? _____

By whom is your child(ren) usually disciplined?_____

What type of discipline is used?_____

Usually for what reason?_____

How does your child(ren) respond to discipline?_____

Do parents differ on discipline? Yes ☐ No ☐ If so, how?_____

_____

Please mark any areas which constitute a problem for your child(ren)-check and list name of child:

☐ Eating	☐ Nail biting	☐ Soiling clothing
☐ Sleeping	☐ Bedwetting	☐ Getting along with friends
☐ Nightmares	☐ Wetting clothing	☐ Self-help skills (dressing,
☐ Thumb sucking	☐ Soiling bed	bathing, eating, etc.)

List school and grade level of your child(ren):

_____

_____

_____

Has your child(ren) ever had counseling/psychotherapy, psychoeducational or psychological testing, speech, occupational or physical therapy, or seen a psychiatrist or received medication for behavior, attention or emotional problems? Yes ☐ No☐ If yes, list child(ren) name, date(s), name of practice/therapist(s) for each area:_____

_____

_____

Is there any family member (sibling, parent, grandparent, cousin, etc.) who presently have or in the past have had learning, attentional, or psychological/emotional issues or were in special classes? If so, who and what kind/type?_____

In addition to the current family situation/conflict, has your child(ren) ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? Yes ☐ No ☐

If yes, list child's name and describe. _____

_____

_____

Please put any other comments that will help us understand your child(ren) and current family situation better. _____

_____

_____

What are your goals/expectations from treatment?_____

_____

_____

What do you think it would take to achieve your treatment goals? _____

_____

_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email and text message. Even in the event that you do not receive a courtesy reminder, you are still responsible for your appointment. Please list your email and best cellular contact number below if you would like a courtesy reminder.

Email address (*Please write clearly*):_____

Cellular number:_____

Would it be okay to contact and thank the party responsible for the referral? Yes ☐ No ☐

If so, list name and phone # or e-mail: _____

In addition to being referred by a specific agency/individual, did you received or view any promotions or social media content listed below about our practice? If so, check all that apply: ☐ Google ☐ Email ☐ Flyer ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other, please specify: _____

Signature _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____**Relation to Patient** _____

Printed Name_____**Date**_____

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LEGAL AND ETHICAL LIMITATIONS IN INDIVIDUAL TREATMENT

1. Information provided by the minor in treatment is confidential. Therefore, the clinician cannot testify about information provided by the minor in treatment unless court ordered to do so.

2. If the clinician has reason to be concerned about the potential or possibility of previous, present, or future minor abuse or neglect, confidentiality is waived. The clinician is a mandated reporter and may need to make a report to the Department of Children and Families to investigate possible safety concerns.

3. Other than concerns about safety issues, clinician will not provide parents or guardians with detailed updates regarding specific content discussed in sessions with minor. This is meant to provide a safe space for them to feel comfortable being open and honest in sessions.

4. Information shared by either parent to the clinician is **NOT** confidential. Therefore, any information provided to the clinician by either parent or other parties involved in treatment, other than the minor, is subject to be shared with other parties with appropriate consent or court order. Communications with parents and/or guardians are not considered confidential.

5. Once the clinician has begun individual treatment, she is unable to perform any other mental health related services or interventions aside from that role.

6. The clinician must contact the minor's other parent to gather relevant background information regardless of whether they are actively participating in treatment or not. This is part of the treatment process and will incur a session fee charge.

7. The clinician needs written consent from the other parent for their minor to participate in treatment, **unless** there is documentation that notes that one parent has ultimate decision-making authority.

8. Release of treatment records **may not** be released even with both parents' consent, **if** the clinician has reason to believe this release of information could be harmful to the minor in any way, and/or without a court order to do so.

9. The clinician providing individual therapy is not able to make recommendations or changes to timesharing or speak to the other's parents' state of mental health. Moreover, the clinician does not have the authority or power to make the other parent follow agreed upon parenting plans in place at the time of treatment.

10. The clinician cannot speak to or include in treatment any outside parties such as the minor's school, other family members (i.e., stepparents, grandparents, etc.), attorneys, medical providers, etc., without the written consent of both parents.

11. The clinician cannot provide therapeutic interventions or recommendations via email. Quick updates on the minor's functioning and scheduling are the only purposes of email communications outside of scheduled sessions.

Name of Patient(s):_____ **Date:**_____

I,_____**, certify that the clinician reviewed these limitations with me and understand the above information and how it applies to my child's treatment.**

Signature:_____ **Relation to Minor**_____

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LEGAL AND ETHICAL LIMITATIONS IN REUNIFICATION TREATMENT

1. Information provided by all treatment participants is not considered confidential, as it may most likely need to be reported back to the court.

2. The clinician is a mandated reporter and may need to make a report to the Department of Children and Families to investigate possible safety concerns.

3. Other than concerns about safety issues, clinician will not provide parents or guardians with detailed updates regarding specific content discussed in sessions with minor(s). This is meant to provide a safe space for them to feel comfortable being open and honest in sessions.

4. The clinician most likely will need to meet with the child(ren), the reunifying parent, and the non-reunifying parent in separate meetings in order to address ongoing issues, conflict, or barriers to reunification success throughout the reunification process. As a result, there most likely will be weeks in which the children do not meet with the reunifying parent or only meet for part of the session in an effort to address these barriers to treatment success as they arise. This is part of the treatment process and will incur session fee charges.

5. The reunification process is one that takes time and moves at a pace appropriate for the child(ren), not according to either parents' desire for rate of treatment progress.

6. Once the clinician has begun reunification treatment, they are unable to perform any other mental health related services or interventions aside from that role.

7. The clinician providing reunification therapy is <u>not able</u> to make recommendations or changes to timesharing.

8. Both parents will sign releases of information for the clinician to speak to both parties' attorneys and any other relevant providers in the case, including but not limited to, the Guardian ad Litem, previous or current mental health professionals, and social investigators. Please note, the clinician cannot speak to or include in treatment any outside parties such as the minor's school, other family members (i.e., stepparents, grandparents, etc.), medical providers, etc., without the written consent of **both** parents.

9. The clinician cannot provide therapeutic interventions or recommendations via email. Quick updates on the minor's functioning and scheduling are the only purposes of email communications outside of scheduled sessions. Any time spent outside of sessions will also incur a fee for services as outlined in *Forensic/Legal Services Policies and Fees Sheet* (this includes emails, phone calls, review of records, etc. to parent[s]/caregivers, other family members, attorneys, outside professionals, etc.).

Name of Patient(s):_____ **Date:**_____

I, _____, certify that the clinician reviewed these limitations with me and understand the above information and how it applies to my child's treatment.

Signature:_____ **Relation to Minor**_____

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FORENSIC/LEGAL SERVICES POLICIES AND FEES

Payment for Forensic/Legal services is $225 per 45-minute session. Additional services are billed in 15-minute increments. Prior to the beginning of this process, determination will be made as to how payment will be made and by whom. Treatment services include in office meetings with parent(s) and/or child(ren). Additional treatment services include consultations, video conferences, telephone contact and email contact with authorized parties (i.e., attorney, school, parents, parent coordinator, guardian-ad- litem, etc.). Time spent reviewing records and preparing reports/letters, preparing for depositions/court appearance, or any other services rendered by the treatment provider in this matter are also included.

If services involve court appearances or a deposition, the fees are $300 per hour with legal travel fees at $100 per hour (portal to portal). The parent requesting the treatment provider to appear in Court or a provide a deposition will be responsible for a minimum fee of 2 hours or the time frame requested for the provider to be available (plus travel costs if at a different location than the provider's office), payable 72 hours (3 business days) prior to the date of the required Court appearance or deposition. Cancellations less than 24 hours for court or any scheduled appointment will incur the full fee regardless of whether or not the provider testifies in court that day or provides the service.

A credit card on file and a retainer in the amount of $500 is required for services rendered. The credit card will be billed $500 initially for the retainer, as well as billed at the time of each service rendered (with the exception of court/depositions which will be billed 72 business hours prior to the date). Once the retainer balance falls below $100 (credit), an additional retainer of $500 will be charged to avoid a disruption in services. The retainer will be used for additional charges (phone consultations, email communications, letter/report writing, as well as if the credit card is declined. These services cannot, and will not, be billed to any health insurance provider for reimbursement.

If the retainer is not replenished and/or the credit card is not working, any amounts not paid within 30 days at the time of services, shall incur interest at the rate of eighteen percent (18%) per annum and computed monthly. A lien for the amount of the fee and expenses advanced shall exist in favor of the said provider, and said lien continues if said treatment provider is discharged. Failure to pay amount billed within thirty (30) days will be the basis for the treatment provider to withdraw from further services, and to do so without objection or complaint from the parent with a remaining balance. If you have any further questions, do not hesitate to discuss this directly with your treatment provider.

Patient(s) Name:_____ **D.O.B.:**_____

Signature:_____ **Date:**_____

Responsible for payment ☐ No ☐ Yes - If Yes,_____% responsible

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CREDIT CARD PAYMENT CONSENT FORM

Patient Name:_____

Parent/Guardian:_____

Please charge my credit card: *(initial those that apply)*

_____ One-time retainer in the amount of $_____

_____ Recurrent charges after every service and for any outstanding balances

Type of Card: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder's Name (*as printed on card*):_____

Credit Card Number_____-_____-_____- _____

Expiration Date _____ CVV Number _____ 3-digit # back of the card (AMEX 4-digit # front of card)

Card Holder's Billing Address for Credit Card Statements:

Street Address:_____

City:_____State:_____Zip Code:_____

Best Contact Phone Number:_____

Best Contact Email Address:_____

Signature:_____ **Date:**_____

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HIPAA NOTICE OF PRIVACY AND HEALTH INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review this document carefully and keep it for your records.

Introduction

At Pediatric Psychology Associates, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information

Each time you visit Pediatric Psychology Associates, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communicating among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
- Source of information for public health officials charged with improving the health of the State and the Nation, as required by law (i.e., reporting child abuse and neglect or reporting domestic violence),
- Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
- Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Pediatric Psychology Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record, as provided for in 45 CFR 164.524,
- Amend your health record, as provided for in CFR 164.528,
- Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Our Responsibilities

Pediatric Psychology Associates is required to:

- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Pediatric Psychology Associates at (305) 936-1002. If you believe your privacy rights have been violated, complaints should also be directed to Pediatric Psychology Associates. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either, Pediatric Psychology Associates or the Office of Civil Rights.

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Acknowledgment of Receipt of HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____(print name of adult patient, parent or guardian of minor), understand that as a part of my or my family's health care, Pediatric Psychology Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professions who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer (i.e., insurance) can verify that services billed were actually provided, and
- A tool for assessing quality and reviewing the competence of healthcare professionals.

I have been presented with a copy of Pediatric Psychology Associates' Notice of Privacy Policies detailing how my information may be used and disclosed under Federal and State law. I understand the contents of the Notice. Further, I permit a copy of this Acknowledgment to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply. I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this Consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this Consent or revoking this Consent, Pediatric Psychology Associates may refuse to treat me, as permitted by section 164.506 of the Code of Federal Regulations. I understand that Pediatric Psychology Associates reserves the right to change its notice and practices prior to implementation, in according with section 164.520 of the Code of Federal Regulations. Should Pediatric Psychology Associates change its practices, it will send a copy of any revised notice to the address I have provided by U.S. mail, or e-mail, if I agree.

I understand that as a part of Pediatric Psychology Associates' treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of Patient (Printed):_____ **Date:**_____

Patient, Parent or Guardian Signature: _____

If refused, reason for refusal:_____ **Restrictions noted:** _____

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TELETHERAPY POLICIES AND PROCEDURES

Pediatric Psychology Associates provides Teletherapy Services to individuals and families to supplement in-office sessions, as well as to individuals that may have transportation or scheduling conflicts to attend sessions in the office. In the event that you or your family decides to use our Teletherapy Services, this document has procedures for those services along with important information about Pediatric Psychology Associates' Teletherapy Polices. ***Please read this document completely and save it for your records.***

1. Pediatric Psychology Associates uses HIPAA compliant platforms (i.e www.doxy.me & Ring Central) for its Teletherapy Sessions. These platforms are accessible through a web browser on your computer and/or free app download on mobile devices.

2. In the case of a disconnection please call the office at 305-936-1002 and your therapist will either resume your session via phone or may choose to reschedule the appointment.

3. The convenience of teletherapy sessions along with our tendencies to multitask while communicating via technology often leads patients to see teletherapy sessions differently than an in-office visit (e.g. try to get their session done "on the go" or while doing other things). Approaching a teletherapy session in this manner frequently leads to distractions, interruptions during the session, loss of privacy, and an overall reduction in efficacy of treatment. **It is very important that you treat your teletherapy session just the same as an in-office visit.** That means that you will need to be in a quiet, private place that is free of distractions and interruptions. If at the time of your session your therapist finds that you are not in a suitable location for the appointment, he or she may choose not to continue with the session, at which point you would be responsible for payment for the session as though it were a no-show.

4. In cases where telehealth services include remote administration of psychological, neuropsychological or academic tests, patients must refrain from recording, photographing, reproducing, publishing or otherwise maintaining copies of testing materials. Further, both the patient and the examiner are prohibited from using recording capabilities to record live test administrations.

5. Your therapist is not permitted to conduct telehealth sessions via any means other than Doxy.me and Ring Central (i.e. Skype, FaceTime, etc.) as these do not meet our required criteria for HIPAA compliance.

6. Because you are not physically in the office to remit payment, arrangements for payment for Teletherapy Sessions must be made in advance of the session.

If you have any questions regarding our Teletherapy Policies and Procedures, please do not hesitate to discuss them with your therapist or to give us a call at the office.

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TELEHEALTH SERVICES AGREEMENT AND INFORMED CONSENT

I_____(patient/guardian name/s) hereby consent to participating in Telehealth Services with *Pediatric Psychology Associates* (PPA).

Telehealth services are defined as communication between yourself and our practice via telephone, email, text message, video conferencing, or any other remote means that utilizes electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g. emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative). I have read and understand the following important information regarding Telehealth Services:

1. I have a right to confidentiality with telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy, as noted in PPA's Informed Consent Form.
2. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective, and this includes Telehealth Services.
3. I agree to maintain the integrity of testing procedures/materials used in my telehealth sessions. To that end, I agree to refrain from recording, photographing, reproducing, publishing or otherwise maintaining copies of testing materials. I acknowledge understanding that any recording of live test administrations is prohibited.
4. I understand that Telehealth Services risk technological failure that could cause distortion or complete disruption.
5. I understand that if my therapist believes Telehealth Treatment Services (e.g. psychotherapy via videoconferencing) are not an appropriate intervention, he/she will make an appropriate referral for services they judge to be more appropriate for my circumstances. This may include a referral for in-person treatment.
6. I have the right to withhold or withdraw this consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
7. I understand that PPA uses HIPAA compliant methods for Telehealth Services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any text messages, emails, or voicemails I choose to keep is my responsibility and not the responsibility of PPA.

_____	_____	_____
Client/Guardian Printed Name	**Client/Guardian Signature**	**Date**