MINOR CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last **First** **Middle Initial**

Parent or Legal Guardian's Name: _____
Last **First** **Middle Initial**

Child's date of birth: _____ **Gender:** _____

Parent or Legal Guardian's Social Security #: _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____

INSURANCE INFORMATION

Responsible Party Name: _____**Relationship to Patient** _____

Primary Insurance:_____ID:_____

Group #:_____Policy Holder: _____

Policy holder Date of Birth._____Policy Holder SSN: _____

Secondary Insurance, if applicable: _____ID#_____

Please initial that you have read this page _____

Croup #:_____Policy Holder: _____

Policy Holder Date of Birth.-_____Policy Holder SSN: _____

Relationship to Patient: _____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____ _____
Name **Phone**

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Please initial that you have read this page _____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Do not wish to disclose

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed/Do not wish to disclose

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Please initial that you have read this page _____

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

Please initial that you have read this page _____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Please initial that you have read this page _____

Any additional information you would like to include:

_____

_____

_____

Please initial that you have read this page _____

Lashawn Tuper Counseling EST. 2021

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

I received my bachelor's in Psychology and master's degree in Clinical Mental Health Counseling from Georgia Southern University.. I have been practicing psychotherapy since 2017 in private practice. Prior to private practice, I worked at Coastal Harbor Treatment Center. I'm licensed in the states of Georgia, Florida, and South Carolina. I have specialized training in DBT.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your

Please initial that you have read this page _____

appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with OfficeAlly, a secure storage company that has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible, secure format using point-to-point, Federally-approved encryption. Your PHI will also be kept on my password-protected computer in an encrypted file format. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else, and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If, for some unusual reason, a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential. Since your therapist practices in more than one state, we will make sure to provide you with any additional information related to confidentiality in the state where you are at the time of services as necessary.

Please note that in couples counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Professional Relationship

Our relationship must be different from most other relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. To offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it is useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

There is another dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. My passion is not in forensic work but in providing you with the best therapeutic care possible. Therefore, by signing this document, you acknowledge that I will be providing therapy only and not forensic services. You also understand that this means I will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities. However, if for some reason I am compelled to testify to a court of law, I will require an upfront retainer of $3,000.00 and my billing rate will be $500.00 per hour, plus you agree to be responsible for the reasonable attorney fees I am charged by my counsel. Additionally, if I receive a valid subpoena to produce or a valid request for the production of documents, I will need to charge you reasonable and customary fees based on state and Federal guidelines of $1.00 per page or the

Please initial that you have read this page _____

maximum allowed by law to produce those records. If a summary of treatment is accepted instead of the entire set of records, I charge my prorated hourly rate for the time to produce this summary. I will also need to charge you the reasonable attorney fees associated with that production, which will take place by and through my counsel's office to preserve your confidentiality.

Additionally, since therapists are required to keep the identity of their clients confidential, for your confidentiality, **I will not address you in public unless you speak to me first.** I must also decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times, people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Telemental Health Statement

Telemental Health is defined as follows:

> "Telemental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Telemental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

Telemental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Telemental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in Telemental Health. I have also developed several policies and protective measures to ensure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology.

Please initial that you have read this page _____

Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your name and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. I utilize Text Messaging to confirm appointments and for brief topics. Please note due to the lack of HIPPA compliant technology with text communication, I **can not** attest HIPPA compliance when using text message. Please be mindful when utilizing text messaging.

Email:

I utilize a secure email platform that is hosted by Virtru. I have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. If we choose to utilize email as part of your treatment, I encourage you to also utilize this software for protection on your end. Otherwise, when you reply to one of my emails, everything you write in addition to what I have written to you (unless you remove it) will no longer be secure. My encrypted email service only works to send information and does not govern what happens on your end. I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, does not access the internet through a public wireless network, etc.).

If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that addresses anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites, such as Facebook, Twitter, Instagram, Pinterest, etc., because it may compromise your confidentiality and blur the boundaries of our relationship.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another but may also see each other on a screen. I utilize ZOOM This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA

Please initial that you have read this page _____

means that ZOOM is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, you may access my virtual office at this link [https://us06web.zoom.us/j/9122598046] using password "ASECRET". I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall and anti-virus software installed, is password protected, does not access the Internet through a public wireless network or has the ability for you to turn on a virtual private network, etc.).

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as an adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Billing Purposes:

If I am credentialed with and a provider for your insurance, please know that I utilize a billing service that has access to your PHI. Your PHI will be securely transferred electronically to OfficeAlly. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize Square as the company that processes your credit card information. This company may send the credit card holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Lashawn Tuper LLC

Your Responsibilities for Confidentiality & Telemental Health

Please communicate only through devices that you know are secure, as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Telemental Health sessions.

In Case of Technology Failure

During a Telemental Health session, we might encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number.

Please initial that you have read this page _____

If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service and we are not able to reconnect, I will not charge you for that session.

Limitations of Telemental Health Therapy Services

Telemental health services may have some limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., the phone gets cut off or the video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your well-being. I would never do or say anything intentionally to hurt you in any way, and **I strongly encourage you to let me know if something I've done or said has upset you.** I invite you to keep our communication open at all times to reduce any possible harm.

Identification & Passwords for New Clients

During our first session, I will require you to show a valid picture ID and another form of identity verification, such as a credit card in your name. **At this time, you may also choose a password, phrase, or number that you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.**

Consent to Telemental Health Services

Please check the Telemental Health services you are **NOT** authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may change your mind and authorize the use of any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for you to opt out of, this is because it is a standard feature built-in to the majority of therapy practices, and I will be utilizing that technology unless otherwise negotiated by you (e.g., an encrypted electronic health records platform that includes a portal for communication and scheduling). Again, please **Opt-Out** of any of the following technology you would NOT like for me to utilize in your treatment.

- ☐ Texting
- ☐ Email
- ☐ Video Conferencing
- ☐ Website Portal
- ☐ Recommendations for Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Communication Response Time

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry an emergency phone, nor am I available at all times. If at any time

Please initial that you have read this page _____

this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls, texts, and emails within 36 hours. However, I do not return calls or any form of communication on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Memorial Health University Medical Center: 912.350.8000
- Coastal Harbor Health System: 912.354.3911
- St. Simons-By-The-Sea: 912.638.1999
- Call or text 988 Suicide Prevention & Crisis Line
- Crisis Text Line: Text "Home" to 741741
- Call 911
- Go to the emergency room of your choice

If we decide to include Telemental Health as part of your treatment, there are additional procedures that we need to have in place specific to Telemental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telemental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine it is necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform me of the address where you are at the beginning of every Telemental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Telemental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

Structure and Cost of Sessions

Based on your treatment needs, I may provide face-to-face, phone, text, email, or video conferencing. The structure and cost of both in-person sessions and Telemental Health are $125 per 50-minute session, $175 per 75-minute session, and/or $200 per 90-minute group therapy session unless otherwise negotiated by your insurance carrier. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and I will provide you with a detailed receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $35 fee for any returned checks.

I require a credit card ahead of time to hold your appointment and for ease of billing. Please sign the Credit Card Payment Form, which was sent to you separately and indicates that I may charge your card without you being

Please initial that you have read this page _____

physically present. Your credit card will be charged at the conclusion of each billable interaction. **Again, this includes any therapeutic interaction other than setting up appointments.**

Insurance

Insurance companies have many rules and requirements specific to certain plans. For example, most insurance companies will not cover therapy over text or email, and most require a deductible to be met both in-network and out-of-network. If we have discussed that I do not accept your insurance, it is your responsibility to find out your insurance company's policies and file for insurance reimbursement. If this is the case, I will be glad to provide you with a statement for your insurance company and assist you with any questions you may have in this area. If we have discussed that I am in-network with your provider, please complete the "Insurance Agreement" that has also been made available to you.

Cancellation Policy

If you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for a no show/late cancellation fee of $75. Please note that insurance companies do not reimburse for missed sessions. Additionally, your signature below indicates that you understand if you dispute a cancellation charge on your credit card, I will need to provide this document to your credit card company as proof that you agreed to this policy. This would mean that your credit card company would see that you agreed to be treated in my practice. I would not disclose any PHI other than this Informed Consent agreeing to my policies.

Our Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization, and Consent to Treatment" form, **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me and that you authorize me to begin treatment with you. Please note that this updated "Information, Authorization & Consent to Treatment" replaces any previously signed informed consents.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

The therapist's signature below indicates that they have discussed this form with you and answered any questions you have regarding this information.

Please initial that you have read this page _____

Therapist's Signature	**Date**

Please initial that you have read this page _____

INSURANCE AGREEMENT

(Please read carefully, this is very important!)

As a service to you, Lashawn Tuper Counseling/Lashawn Tuper LLC will bill your insurance company for all applicable outpatient individual and/or family psychotherapy services rendered in-network. Due to the rising costs of healthcare, however, insurance benefits have become increasingly complex. Although the person handling our insurance billing is extremely thorough and spends a great deal of time ascertaining your benefits at the forefront in addition to filing your claims accurately, we still cannot guarantee that your insurance company will follow through with its original statement of benefits. In some cases, insurance companies have been known to change benefits in the middle of a policy year without notification to us as the provider. In other cases, session visit limits, co-payments, co-insurances, deductibles, or maximum allowables may vary from those originally quoted to us, thereby altering, or altogether preventing claims from paying in accordance with the benefits we as the provider have on file.

As a result, it is our policy to have a credit card on file for each client planning to use insurance. Please know that we will only charge your card as last resort, and we will never charge this card without notifying you first.

☐ ← **Please check or initial here**: I would like Lashawn Tuper Counseing/Lashawn Tuper LLC to collect only the percentage I am required to pay according to my insurance company for each visit (e.g., co-payment, co-insurance, deductible). As a courtesy, Lashawn Tuper Counseing/Lashawn Tuper LLC will then file my claim for me to receive the remainder of the payment due. Occasionally, insurance carriers elect not to pay a claim for one reason or another. In the event that this happens, I authorize Lashawn Tuper Counseing/Lashawn Tuper LLC to charge my credit card for the remaining balance. However, I also realize that Lashawn Tuper Counseing/Lashawn Tuper LLC will never charge my card for a claim without first notifying me.

Credit Card Information Required:

Name as it appears on your card: _____

Credit Card Number: _____

Exp. Date: _____ Security Code: _____

Zip code where you receive your credit card bill:_____

Client Signature: _____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Additionally, it is our ethical obligation to be sure that you are aware of the following information regarding insurance companies. Most insurance companies require mental health practitioners to disclose certain information about their clients in order to receive benefits. First and foremost, they always require a diagnosis. Frequently, they require additional information to justify ongoing treatment. This

information may include physical health concerns you discuss during treatment, psychosocial stressors (such as problems in relationships, work, etc.), and your general level of functioning. Insurance companies often require treatment plans, and they occasionally require copies of the therapist's notes. It is our policy to protect your confidentiality by providing only the information that is absolutely necessary. All of this information will become part of the insurance company's records and is usually stored in a computer database.

Also, if your insurance policy changes, terminates, or defaults to a secondary insurance, it is your responsibility to notify either your therapist or call our office at 912-259-8046 or email us at lashawntuper.lpc@gmail.com.

We have a 24-hour cancellation policy. If you cancel an appointment with your therapist with less than 24 hours notice, you will be financially responsible for this session. Since insurance companies do not pay for missed sessions, you will need to pay for the full amount of your session rather than just your co-pay. Again, it is your responsibility to make sure that we always have the most up to date information on file regarding your insurance company as well as your most up to date contact information.

I have read the above policies, and I accept this Insurance Agreement.

_____

Client's Name (Please Print)

_____ _____

Client Signature Date

Lashawn Tuper Counseling EST. 2021

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. COMMITMENT TO YOUR PRIVACY: *LASHAWN TUPER COUNSELING/ LASHAWN TUPER LLC* (henceforth referred to as "This Practice") is dedicated to maintaining the privacy of your protected health information (PHI) and electronic protected health information (ePHI) (henceforth condensed and referred to as simply PHI). PHI is information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that This Practice maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, This Practice is required to ensure that your PHI is kept private. This Notice explains when, why, and how This Practice would use and/or disclose your PHI. Use of PHI means when This Practice shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when This Practice releases, transfers, gives, or otherwise reveals it to a third party outside of This Practice. With some exceptions, This Practice may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, This Practice is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by This Practice. Please note that This Practice reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that This Practice has created or maintained in the past and for any of your records that This Practice may create or maintain in the future. This Practice will have a copy of the current Notice available in a visible location or on our website at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of This Practice's Notice of Privacy Practices.

IV. HOW This Practice MAY USE AND DISCLOSE YOUR PHI: This Practice will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below, you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: This Practice may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed healthcare providers who provide you with healthcare services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, This Practice may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, This Practice will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: This Practice may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: This Practice may use and disclose your PHI to bill

Please initial that you have read this page _____

and collect payment for the treatment and services This Practice provided to you. Example: This Practice might send your PHI to your insurance company or managed health care plan to get payment for the health care services that have been provided to you. This Practice could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for This Practice's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, This Practice will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to This Practice by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, This Practice will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of This Practice.

Note: Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health, and AIDS/HIV,** and may limit whether and how This Practice may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – This Practice may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, This Practice may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement. Example: This Practice may make a disclosure to the appropriate officials when a law requires This Practice to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** This Practice may disclose information about you to respond to a court or administrative order or a search warrant. This Practice may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. This Practice will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate attorney to quash the subpoena or court order protecting the information requested.
3. **Public Health Risks:** This Practice may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** This Practice may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** This Practice may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others and if This Practice determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, This Practice may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), This Practice may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** This Practice may disclose PHI if mandated by local child, elder, or dependent adult abuse and neglect reporting laws. Example: If This Practice has a reasonable suspicion of child abuse or neglect, This Practice will report this to the appropriate authorities.

Please initial that you have read this page _____

8. **Coroners, Medical Examiners, and Funeral Directors:** This Practice may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death, or perform other duties as authorized by law. This Practice may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** This Practice may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, This Practice may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, This Practice may release PHI about you as required by military command authorities. This Practice may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** This Practice may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, This Practice may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
13. **For Research Purposes:** In certain limited circumstances, This Practice may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** This Practice may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** This Practice is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** This Practice may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with laws. Example: When compelled by the U.S. Secretary of Health and Human Services to investigate or assess This Practice's compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, This Practice Will Never Share Your Information Unless You Give Us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, This Practice will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying This Practice in writing of your decision. You understand that This Practice is unable to take back any

Please initial that you have read this page _____

disclosures it has already made with your permission, This Practice will continue to comply with laws that require certain disclosures, and This Practice is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in This Practice's possession or to get copies of it. You will also be allowed to inspect your PHI in person and take notes or photographs of their PHI. However, you must request the above in writing. If This Practice does not have your PHI but knows who does, you will be advised how you can get it. You will receive a response from This Practice within 15 days of receiving your written request. Under certain circumstances, This Practice may feel it must deny your request, but if it does, This Practice will give you, in writing, the reasons for the denial. This Practice will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. This Practice may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that This Practice limit how it uses and discloses your PHI. While This Practice will consider your request, it is not legally bound to agree. If This Practice does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that This Practice is legally required or permitted to make.

3. The Right to Choose How This Practice Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). This Practice is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of Disclosures. You are entitled to a list of disclosures of your PHI that This Practice has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you or to your family; neither will the list include disclosures made for national security purposes or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

This Practice will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. This Practice will provide the list to you at no cost unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

***5.* The Right to Choose Someone to Act for You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that This Practice correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of This Practice receipt of your request. This Practice may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than This Practice. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and This Practice denial be attached to any future disclosures of your PHI.

Please initial that you have read this page _____

If This Practice approves your request, it will make the change(s) to your PHI. Additionally, This Practice will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to This Practice's Director and Privacy Officer, **LASHAWN TUPER**, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision This Practice made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. This Practice will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. This Practice Responsibilities: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 9/22/23

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