Christian Counseling Services
Client Intake Form

Name: _____ **Today's Date:** _____

DOB _____ **Age** _____ Is client under 18 years of age? Yes ☐ No ☐

Name of Person filling out this form and reason: _____

_____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Mailing Address (if different): _____

Phone: (C) _____ (H) _____ (W) _____

Email: _____

May we leave a voice/text message? Yes ☐ No ☐ If yes, by ☐ cell ☐ home ☐ work ☐ email
May we send you an appointment reminder? Yes ☐ No ☐ If yes, by ☐ text ☐ v-mail ☐ email

Employer: _____ **Occupation:** _____

Are you a student? Yes ☐ No ☐ If yes, name of school: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referred by: _____ May we send them a thank you? Yes ☐ No ☐

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling: _____

_____

_____

When did these problems or issues develop? _____

_____

_____

What are you hoping to achieve through counseling? _____

_____

_____

Client Problem Assessment

Presenting Problem – Precipitating Stressors: "In recent months, I have been concerned about…"
Please check all that apply, past or present

☐ Marriage ☐ Spouse/Partner ☐ Parent/Child ☐ Family of Origin ☐ Extended Family
☐ Abuse (☐ physical ☐ sexual ☐ psychological ☐ neglect) ☐ Guilt ☐ Shame
☐ Cultural/Ethnic/Race ☐ Health ☐ Job ☐ Financial
Other: _____

Symptoms *Please check all that apply:*

☐ Decreased Concentration ☐ Decreased Motivation ☐ Decreased Energy
☐ Disturbance in Sleep Patterns ☐ Increased Stress ☐ Loss of Control
☐ Decreased Interest in Activities ☐ Numbness or Tingling ☐ Chest Pains / Discomfort
☐ Unexplained Physical Problems ☐ Body Tension ☐ Thoughts of Death/Suicide
Other _____

Major Life Events *Please check all that apply:*

☐ Death of a family member/friend ☐ Divorce ☐ Separation ☐ Imprisonment
☐ Personal injury/illness ☐ Marriage ☐ Job loss ☐ Pregnancy/complications
☐ Career change ☐ Legal problems ☐ Relocation ☐ Holidays ☐ Financial
Other: _____

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes ☐ No ☐
Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ☐ No ☐
Are you presently suicidal/homicidal? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ☐ No ☐
Have you ever subjected another person to physical harm? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses.

Strengths	**Weaknesses**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Living Arrangements

Current Address: _____ How Long: _____

With whom do you live? _____

Current relationship with others where you live: _____

_____

_____

Relationship History

Sexual Orientation: _____

Are you married? Yes ☐ No ☐ If not married, are you in a relationship? Yes ☐ No ☐

Name and age of spouse/partner: _____

Date of marriage/cohabitation: _____

Previous marriage/relationship: Yes ☐ No ☐ If yes, name of spouse/partner: _____

If yes, date of divorce/end of partnership: _____

Where children involved in the previous marriage/partnership: Yes ☐ No ☐

What is your perception of the status of your *current* relationship? *(include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.)* _____

_____

_____

Name, ages, and relational history of children from marriages/partnerships.

Name	Age	Comments	Bio, Step, Adopted
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental History

List the members of your family of origin/adoption and your compatibility with each one now.

Family Member	Comments
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order: # ____ of ____ children. Who primarily raised you? _____

How would you describe your childhood? ☐ Uneventful ☐ Boring ☐ Traumatic ☐ Painful
☐ Unhappy ☐ Ignored ☐ Neglected ☐ Withdrawn ☐ Other _____

What was life like for you as a child? *(Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)* _____

_____

_____

_____

Did you experience any traumatic events as a child or adult? *(Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)*

Date	**Age**	**Event**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Who do you depend on for support? *(Check all that apply)*

☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Employer ☐ Church ☐ Pastor
☐ Therapist ☐ Extended Family ☐ Neighbor(s) ☐ Close Friend(s) ☐ Co-Worker(s)
☐ Doctor(s) ☐ Support Group(s) ☐ Community Services ☐ Other: _____

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes ☐ No ☐
If yes, explain who and why *(complete release of information consent form if needed)*: _____

_____

_____

Legal History *(Please explain all that apply, past and present)*

Charges as a minor: _____

Current Charges: _____

Arrests: _____

Convictions: _____

Parole/Probations: _____

Bankruptcies: _____

Divorce/Separation: _____

Foreclosures: _____

Civil Suits: _____

Financial Situation

Briefly describe your financial situation: _____

_____

_____

Work History

Describe your current job/career: _____

_____

What do you like or dislike about your job and/or career?

Like	**Dislike**
_____	_____
_____	_____
_____	_____
_____	_____

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

_____

_____

Have you ever been fired from a job? Yes ☐ No ☐ If so, please explain: _____

_____

Educational History

Describe what school was like for you: _____

_____

Highest level of education: _____ What kind of grades did you make? _____

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

_____

_____

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background: _____

_____

_____

Do you have a religious/spiritual background? Yes ☐ No ☐ Preference _____
Do you attend religious/spiritual services? Yes ☐ No ☐ If so, where and how often? _____

_____

Medical History

How would you describe your current health? _____

Are you currently on medications? Yes ☐ No ☐ If yes, please provide information.

Name of Medication	Dosage/Frequency	Prescribing Physician

Has it been more than a year since your last physical exam, including blood work? Yes ☐ No ☐

Have you had or were you involved with an abortion? Yes ☐ No ☐ Miscarriage? Yes ☐ No ☐

List any previous health issues including surgeries, procedures, and medical hospitalizations:

Problem	Date	Treatment

Counseling History *(Please list all previous psychotherapy experiences.)*

Are you or have you ever participated in counseling or psychotherapy treatment? Yes ☐ No ☐

If yes, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

Psychiatric History *(Please list all previous inpatient / outpatient experiences.)*

Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes ☐ No ☐

Have you ever been hospitalized for mental health related issues? Yes ☐ No ☐

Have you ever been hospitalized for mental health issues related to substance abuse? Yes ☐ No ☐

If you answered yes to any of the above, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep: _____

_____

Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes ☐ No ☐ If yes, please explain.
Has anyone in your family had problems with alcohol or drugs that was not treated? Yes ☐ No ☐
If yes, please explain.

Family member	**Problem/Disorder**	**Treatment Results (if any)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Use / Abuse History

Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

Substance	**Amount**	**Frequency**	**Age of 1st use**	**Age regular use started**	**Age last used**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced an increase in the use of alcohol and/or other substances? Yes ☐ No ☐
Do you see your usage as a problem? Yes ☐ No ☐ If yes, when did it become problematic?

_____

_____

Please describe any previous experience with substances or alcohol _____

_____

_____

Please describe any family history of substance and/or alcohol use _____

_____

_____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes ☐ No ☐ If so, please describe _____

_____

_____

Nutrition

Have your eating habits changed recently? Yes ☐ No ☐ If so, please describe _____

_____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes ☐ No ☐
Do you often eat out of depression, boredom, and/or anger? Yes ☐ No ☐ If yes, please describe

_____

Do you use laxatives, water pills (diuretics), or diet medications? Yes ☐ No ☐ If so, how often and for what purpose do you use them? _____

_____

Additional Information

Is there any other information that can be helpful for us to know about you? _____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

For Office Use Only – Clinician Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Adverse Childhood Experiences Questionnaire
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **OFTEN** . . .
Swear at you, insult you, put you down, or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?
Yes ☐ No ☐ If yes enter 1 _____

2. Did a parent or other adult in the household **OFTEN** . . .
Push, grab, slap, pull your hair, or throw something at you?
OR
EVER hit you so hard that you had bruises, marks, or were injured?
Yes ☐ No ☐ If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **EVER** . . .
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to or actually have oral, anal, or vaginal sex with you?
Yes ☐ No ☐ If yes enter 1 _____

4. Did you **OFTEN** feel that . . .
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?
Yes ☐ No ☐ If yes enter 1 _____

5. Did you **OFTEN** feel that . . .
You didn't have enough to eat, had to wear dirty clothes, and had no on to protect you?
OR
Your parents were too intoxicated to care for you or take you to a doctor if you needed it?
Yes ☐ No ☐ If yes enter 1 _____

6. Were your parents **EVER** separated or divorced?
Yes ☐ No ☐ If yes enter 1 _____

7. Was your mother, stepmother, grandmother, or other significant female caretaker . . .
OFTEN pushed, grabbed, slapped, had her hair pulled, or had something thrown at her?
OR
SOMETIMES or **OFTEN** kicked, bitten, hit with a fist or hit with something hard?
OR
EVER repeatedly struck over several minutes or threatened with a gun or a knife?
Yes ☐ No ☐ If yes enter 1 _____

8. Did you **EVER** live with anyone who was a problem drinker, an alcoholic, or used drugs?
Yes ☐ No ☐ If yes enter 1 _____

9. Has a household member **EVER** been depressed, mentally ill, or attempted suicide?
Yes ☐ No ☐ If yes enter 1 _____

10. Has a household member **EVER** been arrested, gone to jail, or been in prison?
Yes ☐ No ☐ If yes enter 1 _____

Now add up your "YES" answers: _____ This is your ACE score.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Name: _____ ***Date:*** _____

Patient Health Questionnaire (PHQ–9)

1. Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score: _____

2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	☐	☐	☐	☐	☐
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being "superalert" or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐
20. Trouble falling or staying asleep?	☐	☐	☐	☐	☐

INFORMED CONSENT FOR TREATMENT
& HIPAA GUIDELINES

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your therapist needs to communicate with another about your case, you must give written permission to do so. The only exception to this is, if in accordance with law such communication appears needed to protect you or others from harm or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceases. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide or homicide. The "Health Insurance Portability and Accountability Act (HIPAA)" provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. ****Please read full HIPAA guidelines located under forms on the website prior to your first session.** **

GRIEVANCES

If you feel your privacy rights have been violated in any manner, please communicate this to your therapist to resolve any issues. If the matter is unresolved and you wish to file a complaint please contact the Arizona Department of Health Services at: 1740 West Adams-Room 101, Phoenix, AZ 85007.

INFORMED CONSENT

Christian Counseling Services is a biblically based practice integrating Christian principles with sound psychological techniques. Therapy is an interactive process between client and therapist, and the results of therapy depend heavily on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While we will use our best efforts to assist you, the nature of psychological services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provides. You should question the rationale of any services, intervention, and discussion if these seem unclear to you. In the case that your therapist is unavailable, or an emergency please call EMPACT at (480) 784 – 1500.

FEES/PAYMENT

Our fees are based on 50-minute sessions. *Longer or shorter sessions are prorated accordingly*. We are an out of network provider. Payment is due at the time of service. FEE: $ _____ per 50-minute session. * *Emergency sessions outside of therapist's standard business hours or workdays, may incur an additional charge of $_____ at therapist discretion.* ***

If you are unable to keep an appointment, please notify the office immediately. **If an appointment is cancelled or missed WITHOUT 24 hours prior notice, you WILL be charged for the missed session. We require a credit card on file for all clients. **By signing you authorize use of this credit card for missed sessions and/or unpaid balances on your account.**

***** CLIENT INITIALS _____ *****

CREDIT CARD# _____ - _____ - _____ - _____ EXP_____ CVV#_____

Zip Code _____ Email address for receipt_____

RESPONSIBILITY

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. I acknowledge that I have read and understand my HIPPA rights and consent for treatment.

_____ _____

Client OR Parent/Guardian Signature **Date**

Christian Counseling SERVICES

THERAPIST SERVICES LIMITATIONS

It is out of the scope of practice/competence for me as your therapist to make recommendations based on the confidential information arising in your counseling sessions.

Therefore I DO NOT:

***WRITE LETTERS RECOMMENDING/CERTIFYING AN EMOTIONAL SUPPORT ANIMAL

*** MAKE RECOMMENDATIONS/FILL OUT FORMS FOR DISABILITY/FMLA/ LEAVE OF ABSENCE FROM WORK OR SCHOOL (Please see your medical provider)

***PROVIDE FORENSIC SERVICES INCLUDING MAKING CHILD CUSTODY AND VISITATION EVALUATIONS/RECOMMENDATIONS OR COURT ORDERED SERVICES. MY ROLE IS LIMITED TO PROVIDING THERAPEUTIC INTERVENTIONS FOR MY CLIENTS.

***TESTIFY ON BEHALF OF MY CLIENTS IN COURT OR IN ANY OTHER LEGAL PROCEEDINGS. I WILL NOT EXPRESS AN OPINION ABOUT PARENTAL FITNESS.

***IN THE EVENT THAT MY PRESENCE IS REQUIRED IN COURT, MY RATE FOR ALL ACTIVITIES RELATING TO THE LEGAL PROCEEDING INCLUDING BUT NOT LIMITED TO PREPARATION FOR COURT, REVIEW OF RECORDS /OTHER NOTES, TRAVEL TIME AS WELL AS TIME SPENT IN COURT SHALL BE AT THE RATE OF $500 PER HOUR.

I understand and agree to the limitations of my therapist as mentioned above.

_____

Client signature

_____

Date

Social Media/Electronic Communications Consent Form

Email Policy: Email is a convenient way to maintain a stream of communication between clients, especially with parents who are not present during their child's individual session. However, some potential risks of using email:

- Typos and errors of email to an incorrectly typed email address, tone interpretation and errors in details or data.
- Email accounts can be "hacked," giving a 3rd party access to email content and addresses.

Texting Policy: Texting is acceptable, only to communication regarding non-clinical issues. These include topics such as scheduling an appointment, changing an appointment, notification of running late to an appointment, receipt requests, and directions to the office. Texts regarding clinical issues, such as a family issue, personal difficulties, etc., are not acceptable. I will not respond to these texts and will delete them immediately.

Social Media/Internet

So much information about a person can be found online, either through company websites, social media, business reviews, and more. It's the age we live in, and therefore it's important we understand boundaries with regards to social media and any other information online.

- Client and therapist will NOT perform online researches on one another for gathering personal information. To maintain the unbiased commitment of the counseling relationship, the counselor agrees to refrain from prior subjective researching of clients that could create a bias *(This does not pertain to a client researching the professional background of a therapist and other service/practice information).*
- Client and therapist will not request or agree to be "friends" on personal social media sites, including Facebook, Twitter, Instagram or others. Clients may "like" or "follow social media pages that are offered by the therapist as a part of their professional work *(i.e. a professional Twitter page the counselor has can be "followed" by the client or the Facebook page of the site you are receiving services at can be "liked").*
- If a client follows the therapist on a professional social media site, comments should not indicate there is a client-therapist relationship. Any comments made that potentially disclose such a relationship will be removed immediately.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

CONSENT TO RECORD COUNSELING SESSIONS

I, _____, hereby give my counselor,
(client's name)

_____, in cooperation with Christian Counseling Services, consent to record counseling sessions through electronic or other means. These recordings will be used to aid the counseling process with supervisors, faculty, peers, interns, or others within the Christian Counseling Services training environment. The recordings will aid further understanding of important aspects of counseling therapies and client treatment in keeping with the Christian Counseling Services policy on privacy and confidentiality.

The recordings will not be included as part of the official client file and will only be shared under the supervision of **Jennifer Cecil, M.Ed, LPC**. Recordings will be deleted with the completion of supervision and training.

_____ I acknowledge that I have discussed this procedure with my counselor and give my
(INITIAL) consent to record my counseling sessions for supervisory purposes.

_____ I give my permission for said recordings to be used for training purposes as described
(INITIAL) within the contents of this consent form.

I understand that refusal to sign this form will <u>not</u> affect my eligibility for receiving services at this agency.

Signed: _____ Date: _____

For Minor (if applicable): _____
Relationship (circle one): Mother Father Guardian

Counselor: _____ Date: _____

Christian Counseling SERVICES

CONSENT FOR TELEHEALTH CONSULTATION:

Telehealth is any electronic means of communicating with my therapist, including phone calls, text messages, emails, and video-conferencing. Telehealth is utilized with any communication that is not considered administrative in nature (i.e. scheduling, office location, paperwork, etc.).

1. I understand that my provider is able to offer telehealth consultation, including video services, when appropriate and with my expressed consent. I have the right to use and refuse these services for some or all of my therapy.
2. My therapist has explained to me how the video conferencing technology will impact my sessions and therapeutic care. I acknowledge that video sessions will not be the same as an in-person appointment, due to the fact that I will not be in the same room as my provider and that this implies a variety of limitations and differences related to indirect contact.
3. I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. In the case of a video session, I understand that I am responsible for ensuring that my location is private and quiet, so that the telehealth session can be completed effectively. I understand that I must provide details about my location (such as: the physical address, online map pin/link, or a visual of the room) and my identity (such as confirming details about myself against my record or giving a predetermined password) at the onset of a telehealth session. This is necessary to protect my confidentiality and ensure that the coverage of my provider's license extends to my location.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that provider or I can discontinue a telehealth appointment if it is felt that the Internet connections are not adequate for the situation or my confidentiality is compromised.
6. I understand that there are some legal and ethical limitations and considerations regarding telehealth sessions, including: risk assessment, technology competence, effectiveness of the therapeutic model, long-term sustainability, national emergencies, and more. My therapist has the right to refuse to offer telehealth sessions, in accordance with state and board statutes.
7. I understand that there are innate risks to my privacy and confidentiality associated with using any telehealth service, specifically video conferencing technology. In offering telehealth for my convenience, I acknowledge that my provider cannot be responsible for these risks, though they will do their best to maintain my confidentiality whenever possible
8. I understand that I have the right to request the use a safe word, if I feel that my situation warrants extra protection or if I am not confident that my confidentiality will be maintained during a telehealth session (for example: conducting a session with children or a spouse in another room who could interrupt). The safe word selected should be easy to insert into conversation, if the safety or privacy of either location is compromised. If a safe word is needed, it should be established with my provider before the start of a session.
9. If a scheduled telehealth session cannot be completed as planned (due to complications such as, but not limited to: technical difficulties, confidentiality issues, or client discomfort), I

understand that I MAY be responsible for a fee, in accordance with my provider's late cancellation policy. These instances are few and far between and should this problem arise, I will need to discuss the implications with my provider to determine whether a full/partial fee or waiver applies.

10. I acknowledge that telehealth is NOT an emergency/crisis service and in the event of an emergency, I will use a phone to call 911.
11. I acknowledge that the developers/administrators of the telehealth platform used for my sessions are not responsible for the delivery of any healthcare, medical advice, or care.
12. I do not assume that my provider has access to any or all of the technical information related the use of a telehealth service. Specifically, I will not rely on my therapist to provide technical support for using a video platform. If a technical issue arises, a reasonable amount of time can be spent trying to resolve the problem, so that the session can be completed. However, if the issues are not resolvable after 10 minutes, the session may need to be rescheduled or moved to a different telehealth platform. If we get unexpectedly disconnected and cannot rejoin the conference room, I can contact my provider via text, phone call, or email to discuss an alternate platform and/or rescheduling.
13. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. My session will also not be recorded by my therapist without my consent.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this service and respective policies. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me, in a language in which I understand.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me.

· That I fully understand its contents including the risks and benefits of the procedure(s).

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature _____

Printed Name _____ Date _____