CONSENT FOR TREATMENT

Find Your Center, A Therapy Collective

Michele Goldberg, LMFT #97528

An Individual, Marriage and Family Therapy Professional Corporation

Licensed Marriage and Family Therapist #97528

Locations: East: 1555 W. Sunset Blvd., Unit C
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Please thoroughly review the following information prior to your first session. Sign and date where indicated and bring a copy with you to your initial appointment. Feel free to address any questions or concerns you have directly with your counselor.

CONSENT FOR TREATMENT

Client: _____

Psychotherapy is a collaborative partnership between you and your counselor. As the client, it is your responsibility to bring an attitude of active participation and commitment to the therapeutic process. While there are no guarantees regarding the outcome, your motivation and degree of cooperation have the greatest impact on your journey. It will benefit you to take risks in treatment by exploring and disclosing your inner experience.

You may expect that therapy will increase your awareness of feelings, thoughts, and behaviors that you may not have previously examined. As a result, you may experience some discomfort throughout the process in your movement toward growth. Some symptoms may increase in intensity in the near term as you become activated on your way toward greater health and deeper healing. I encourage you to discuss any change in your symptoms or other feelings about the therapy directly with me.

CONSENT FOR TREATMENT

I. Fees and Appointments

1. Appointments are 50 minutes in length and take place on a weekly or twice weekly basis. I hold your specific hour open for you each week.

2. **You must pay in full in advance of each session. Please bring a check made out to Michele Goldberg in the amount of $275.00 on each occasion that we meet.** You have the option to bring cash or pay via Venmo immediately following session. You may elect to pre-pay for future sessions. You will also need a credit card on file prior to your initial` appointment. I will not bill your credit card without notifying you. I reserve the right to suspend therapy if services are rendered and not paid for after two sessions, and to charge the card on file for missed or attended sessions that you have not paid in full within 24 hours. You may also elect to pay with credit card via PayPal or Ivy Pay. With these options, your fee will reflect the addition of a 3% processing surcharge.

3. Please notify me as soon as possible if you are unable to attend your appointment. **Failure to cancel 48 hours prior to session will result in a no show charge for the full fee in your absence**. You will be allowed to cancel four sessions within a one-year period with no charge, so long as you do so 48 hours in advance of session. The year begins on the date of your intake appointment. After four cancelled appointments, you will be responsible for payment of all missed sessions. In addition, at the therapist's sole discretion and with an eye toward clinical considerations, you may be given a longer cancelation period. This may be due to frequent reschedule and cancelation requests, no shows, or any reason deemed appropriate by your counselor.

4. If you have planned a trip that places you outside of Los Angeles for several weeks, you may request telephone or teleconference sessions during your regularly scheduled time. Should your requests for remote sessions extend beyond what is clinically appropriate, I reserve at my sole discretion the right to discontinue this client privilege. Please see the Telemedicine

Consent enclosed herein.

5. There may be some additional case management fees added throughout your treatment. Case management is considered time spent speaking with anyone other than you to collaborate care.This includes communication with family and other professionals that extends beyond ten minutes and is billed at your hourly rate, rounding up, in ten-minute increments. Outside psychiatrists, nutritionists, life coaches, parents, teachers, etc., are all considered outside of your treatment unit.

6. Telephone calls with your therapist that discuss any matter aside from billing and scheduling will also be considered additional treatment and will be billed at your hourly rate, rounding up, in ten minute increments.

7. I reserve the right to reasonably increase your fee so long as I email or otherwise provide you written notification of my intention to raise your rate no less than thirty days in advance.

8. There is a $14.00 service fee for any returned checks.

9. If determined that therapy will continue when you have an unpaid balance, including those circumstances due to bounced checks, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.

10. If you become ill during regular program hours, please let me know. You will be assisted to return home or to visit the emergency room as appropriate. This will not abrogate your duty to pay for your session in full.

11. You are expected to comply with your treatment fully; regular or more than a few absences may result in your discharge.

12. Group sessions must be paid in full and in advance for all sessions during the next calendar month. There are no make-up group sessions. You pay to hold your place in the group and thus will not be refunded any portion of your payment, even for absences

that are entirely legitimate and communicated in advance.

13. I may notify you in advance of my inability to attend session, in which case you will not be responsible for the cost of the missed session. I will make every effort to reschedule and will make an alternate therapist available for any emergencies that may arise for clients during that time.

14. Should there be any reason that I suddenly become unavailable and unreachable for an extended period (exceeding two weeks without response), you may contact Nicole Perkins, Timothy Norton, and Carla Litto as potential substitutes during my absence, pending my return. You may locate their information via web search combining their first and last names and the term therapist.

II. Confidentiality

1. Communication between you and your counselor is confidential. This means that I will not discuss your case with any identifying information to any third party, orally or in writing, without your express written consent. (Please see authorization form.) Excluded from this is any parent or legal guardian that requests information about the care of a minor or dependent adult, as they have consented on your behalf and have the right to be apprised of certain themes that we discuss.

2. I have an ethical and legal obligation to break confidentiality and disclose information you have shared in session to third parties under the following circumstances, and additional situations not listed:

a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect, including the capture or transmission of any image depicting a minor engaging in an obscene act.

b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.

c. If you introduce your emotional condition into a legal proceeding.

d. If your records are subpoenaed by a court of law.

e. If you maintain or transmit images depicting a minor engaged in an obscene act.

f. Other legally or ethically permissible or mandatory reasons.

3. In order to ensure that you receive the best possible care, sessions may be video or audiotaped with your advance express consent. Tapes may be viewed by myself and other clinical staff at Find Your Center only, and are erased in a timely manner. The exception is that, from time to time in order to help you to the fullest extent possible, I may enlist the support of another highly experienced and trained mental health professional to talk through how I can best serve you. This will be done exclusively in the context of a confidential relationship and will minimize any reference to potentially identifying information.

4. If you have received or will receive treatment from a psychiatrist, or if you have received or will receive treatment with a medical doctor or other practitioner that I deem relevant to your care, it is expected that you will sign a written authorization enabling both me and this third party to discuss your care in order to assist in achieving your therapeutic goals. Refusal to do so may compromise my effectiveness and frustrate a collaborative approach to your treatment. I believe it is in your best interest to coordinate care with the treating parties. To that end, I prefer to involve your other care providers in your treatment in any way that you allow.

5. To maintain a safe and trusting environment, I require that all information shared by or about other patients from group counseling here remain within the confines of this program. Additionally, I require that you respect the confidentiality of any patient you may see or come in contact with during your course of treatment here. This means that you do not disclose any identifying information about any other client in our practice to anyone else, aside from your direct counselor.

CONSENT FOR TREATMENT

III. Child Care Release

This therapy office does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 14 may not be left without supervision in the waiting room.

IV. Additional Rights and Responsibilities

1. In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided, sessions within **48 hours**, or registered group. You must communicate this intent to me as soon as feasible.

2. It is encouraged that you bring any ambivalence around therapy and any initial considerations of termination into the therapy as soon as you become aware of them. Discuss your feelings, concerns, disappointments, and expectations with your counselor. This can often lead to increased growth, an expected phase of resistance that occurs on the eve of breakthrough and positive change.

3. You have the right to question any aspect of your treatment with me. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

4. I reserve the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by me of your therapeutic needs, my ability to address those needs, or other circumstances that lead me to conclude in my sole and absolute discretion that your counseling needs would be better served at another counseling facility. Under such circumstances, I will suggest appropriate counselors or counseling agencies.

CONSENT FOR TREATMENT

V. Safety & Security

1. I request your participation in maintaining the safety and security of our premises. I invite you to immediately report any safety or security problems to the nearest staff member.

2. You must be sober for 24 hours prior to session. If it appears that you arrive intoxicated for your session, I will cancel our appointment and you will be responsible for paying for the entirety of the missed session.

3. Also, in order to maintain both safety and confidentiality, the following items are not allowed on the premises:

- Recording devices
- Cameras
- Alcohol and all non-prescribed drugs and substances
- Weapons of any kind
- Unnecessary sharp objects

4. Alcohol and illegal substances are never permitted in the clinic. Use of such substances or bringing them onto the clinic grounds will inhibit your participation in the program and may be cause for administrative discharge.

5. The above list is not meant to be all-inclusive and I may request that you not bring certain items or personal belongings. If in my judgment these items in any way compromise the safety, security, or confidentiality of any program participant or staff member, a member of the staff may request your cooperation by leaving such items at home.

VI. Rules for Session

1. You are responsible for being on time for the start of session.

CONSENT FOR TREATMENT

2. Once the session has begun, I suggest that you stay for the entire session. Painful, difficult, or uncomfortable feelings or sensations may occur during therapy. This is not a reason to leave the therapy, but rather, a natural by-product of dealing with serious issues. Let me help you cope with difficult feelings.

4. Profanity or verbal meanness toward me, group members, or staff is not allowed.

5. Cellular phones and pagers should be turned off during session. Cellular phones should ONLY be used during appropriate breaks.

6. No eating during session. Clear beverages in covered containers are acceptable.

7. You are financially responsible for any damage you cause to the office or its contents.

CONSENT FOR TREATMENT

Your signature below indicates that you have read and understand this information and have received a copy of this consent form in its entirety and give permission to your counselor to provide counseling services. This contract is binding for all this and all future sessions you may have with this entity.

I, _____, have received and understand the above Consent for Treatment:

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

_____ _____

Parent/Guardian 1 Signature Date

_____ _____

Parent/Guardian 2 Signature Date

EMDR INFORMED CONSENT

EMDR is a simple, efficient form of therapy utilizing Bilateral Stimulation (BLS)- usually in the form of eye movements, tapping, or auditory tones in order to accelerate the brain's capacity to process and heal a troubling memory, thought, feeling, phobia, etc. BLS stimulates the same eye movements which occur during Rapid Eye Movement (REM) or dream sleep. BLS causes different parts of the brain to work in conjunction in order to reintegrate a memory. Some clients can experience relief or positive effects in just a few sessions. EMDR can be effective in alleviating trauma-related symptoms, whether the traumatic event occurred many years ago or yesterday. It often yields desired results with little talking, without the necessity of pharmaceuticals, and does not require "homework" in between sessions.

Scientific research has established EMDR as potentially effective for the treatment of Post-Traumatic Stress, phobias, panic attacks, anxiety disorders, stress, sexual and physical abuse, disturbing memories, complicated grief, addictions, chronic pain, and migraines.

The possible benefits of EMDR treatment include the following:

· The memory is remembered, but the painful emotions and physical sensations/disturbing images/thoughts are diminished or no longer present.

· EMDR may help the brain reintegrate the memory and store it in a more appropriate place in the brain. The client's own brain reintegrates the memory and does the healing.

The possible RISKS of EMDR treatment include the following:

· Reprocessing a memory may bring up associated memories, whether pleasant, painful, or neutral. This is normal and those memories may also be reprocessed.

CONSENT FOR TREATMENT

· During EMDR, the client may experience physical sensations and retrieve images, emotions, and sounds associated with the memory or other memories that may be pleasant, unpleasant, or neutral.

· Reprocessing of the memory normally continues after the end of the formal therapy session. This may or may not result in some emotional or physical effects that endure after the session has ended. Other memories, flashbacks, feelings, and sensations may occur. The client may have dreams associated with the memory. Frequently the brain is able to process these additional memories without help. It is recommended that the client communicate such normal responses to the therapist and, if the client feels they exceed her or his capacity to cope, they request and are willing to utilize skills to address them.

As with any other therapeutic approach, reprocessing traumatic memories can be uncomfortable; that means some people won't like or won't be able to tolerate EMDR treatment well. Others need more preparation, offered by the therapist, before processing traumatic events using EMDR.

· There is no known adverse effect for interrupting EMDR therapy; therefore, a client can discontinue treatment at any time.

· Alternative therapeutic approaches may include individual or group therapy, medication, or a different psychotherapy modality on an individual basis.

· EMDR treatment is facilitated by a licensed psychotherapist having EMDRIA-Approved training.

HISTORY & SAFETY FACTORS

The client must...

· Be willing to tell the therapist the truth about what he/she is experiencing.

CONSENT FOR TREATMENT

· Be able to tolerate high levels of emotional disturbance, have the ability to reprocess associated memories resulting from EMDR therapy, and to use self-control and relaxation techniques (eg. Calm place exercise).

· Remember debriefing instructions and call his/her therapist, connect with supportive family/friends, or use meditation or other techniques (e.g., calm place, container, other EMDR resources) he/she has agreed to in therapy, if needed.

· Disclose to therapist and consult with his/her physician before EMDR therapy if he/she has a history of current eye problems, a diagnosed heart disease, elevated blood pressure, or is at risk for or has history of a stroke, heart attack, seizure, or other limiting medical conditions that may put him/her at medical risk. Due to stress related to reprocessing some traumatic events, pregnant women should consult with their OB/GYN before discussing EMDR therapy. Postponing may be appropriate in some cases.

· Inform therapist if he/she is wearing contact lenses and remove them if they impede eye movements due to irritation or eye dryness. The therapist will discontinue BLS if client reports eye pain. Other forms of stimulation can be substituted if appropriate.

· Assess his/her current life situation to determine EMDR approach. Client may need the ability to postpone demanding work schedule immediately following an EMDR session.

· Before participating in EMDR, discuss with therapist all aspects of an upcoming legal court case where testimony is required. The client may need to postpone EMDR treatment if he/she is a victim or witness to a crime that is being prosecuted because the traumatic material processed using EMDR may fade, blur, or disappear and his/her testimony may be challenged.

· Understand disagreements with family and/or friends may occur as client learns new skills such as assertiveness or social skills after

processing problems and disturbing material using EMDR. Vulnerable clients may choose to be protected.

· Be willing to explore the issue(s) that may arise as change occurs. For example, changes regarding identity, finances, loss of identification with a peer group, and/or attention.

· Consult with his/her medical doctor before utilizing medication. Some medications may reduce the effectiveness of EMDR. For example, benzodiazepines may reduce effectiveness possible due to state- dependent processing and/or regression may occur after ceasing antidepressants.

·Address with the therapist client's ability to attend to EMDR due to recent cocaine dependence, long-term amphetamine abuse, seizures, and/or other neurological conditions. EMDR is contraindicated with recent crack cocaine users and long-term amphetamine users.

· Discuss with the therapist any dissociative disorders; Dissociative Identity Disorder, unexplained somatic symptoms, sleep problems, flashbacks, derealization, depersonalization, auditory/visual hallucinations, unexplained feelings, memory lapses, multiple inpatient psychiatric hospitalizations, multiple diagnoses with little treatment progress. EMDR may trigger these symptoms, but may also be helpful in attempting to resolve them.

Repressed memories surface more by the use of EMDR than with other modalities. It is not unusual for a target memory to be linked to other, unexpected material. It is important to note that traumatic material retrieved in any psychotherapy may or may not be historically accurate and is subject to contamination, as are all memories. EMDR does not, in itself, guarantee the accuracy of retrieved material. The only way to actually validate retrieved material as historically accurate is through independent verification.

CONSENT FOR TREATMENT

Those with limiting or special medical conditions (pregnancy, heart conditions, ocular difficulties, seizure disorders, etc.) should consult with their medical professional before participating in this therapeutic method. For some people, this method may result in sharper memory, for others fuzzier memory following the treatment. If you are involved in a legal case and need to testify, please discuss this with your therapist before treatment.

Before commencing EMDR treatment, I have thoroughly considered all of the above. I have obtained whatever addition input/professional advice I needed before beginning this therapy. I herewith give my consent to receive EMDR treatment free from pressure or influence from any person or entity.

I HAVE READ AND UNDERSTAND THE POSSIBLE OUTCOMES OF EMDR LISTED ABOVE AND UNDERSTAND THAT I CAN END EMDR THERAPY AT ANY TIME. I AGREE TO PARTICIPATE IN EMDR TREATMENT AND I ASSUME ANY RISKS INVOLVED IN SUCH PARTICIPATION.

Name
(printed)_____
_____
Signature_____
Date:_____

CONSENT FOR TREATMENT

WEEKEND & AFTER HOURS CONTACT LIST

Your therapist is: Michele Goldberg

In the event of an emergency when you need to reach someone and the Clinic is closed, please use this list of referral phone numbers:

1. If you have a true, life-threatening emergency, please call 911 or head to your nearest emergency room.

   Otherwise, you may wish to contact:

2. Your attending physician: _____

3. Cedars-Sinai Medical Center Emergency Room: (310) 423-2295

4. National Suicide Prevention Hotline: (800) 273-8255

*If you wish to contact your attending therapist, you may also text or call her directly at 818.631.3379 and leave a voicemail or text message. Please note that messages left on this voicemail will be picked up the next business day. I may take 24 hours to respond. I encourage you to be mindful about the length, frequency, and detail of your communications.

CONSENT FOR TREATMENT

Notice Of Patient Rights

As a patient, you have the right to:

1. Participate in the development and implementation of your plan of care.

2. Make decisions regarding your care that fall within my treatment guidelines.

3. Have your personal privacy respected.

4. Receive care in a safe setting free from verbal or physical abuse or harassment.

5. Expect confidentiality of your clinical records and right to access information contained in your clinical records within a reasonable time frame (except in certain circumstances specified by law).

6. Be treated with respect and dignity, and to be made comfortable.

TELEMEDICINE INFORMED CONSENT

Teleconference and Telephone Sessions

I hereby consent to engaging in telemedicine with Michele Goldberg, LMFT #97528 or other clinical staff at Find Your Center, A Therapy Collective, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

III. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

IV. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding, as outlined above.

I also understand that the dissemination of any personally

identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may feel different from face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

VII. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

VIII. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I agree to give cancellation notice to my therapist in order not to be billed for the session. I understand that all the conditions of the Consent for Treatment attached hereto apply in full to any services rendered remotely.

CONSENT FOR TREATMENT

Further Clarification on Telepsychology

Telehealth

Variously dubbed telemedicine, teletherapy, distance therapy, e-therapy, internet therapy, or online therapy, “telehealth” is defined as the use of electronic transmission to provide interactive real-time mental health services remotely, including consultation, assessment, diagnosis, treatment planning, counseling, psychotherapy, coaching, guidance, education, and transfer of medical information with an experienced psychotherapist. This can include both video and audio forms of communication, via the internet or telephone.

Office Agreements

Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological service. So, all other policies and consents in the psychotherapist's office agreement forms apply to telehealth services. This document is an addendum to, and does not substitute for, our standard in-office services agreements.

Advantages & Disadvantages

The advantage of telehealth is that it can flexibly provide continuity of care when an in-person treatment session cannot be conducted in the office. Similar to a regular in-person therapy session, telehealth allows for both verbal and non-verbal communication.

Prerequisites

Telehealth is not suited to all circumstances. Telehealth is only part of your psychotherapy. Telehealth services in this office are only provided to previously established patients who continue to have at least intermittent in-person sessions in the office, or under circumstances that warrant reliance on virtual delivery of services. Initial consultations are preferred in-person in the office where possible.

Professional services are being provided under a license issued by and limited to practice within the state of California. Therefore, the patient affirms they reside in the state of California at the time of telehealth services, absent national crisis, recent relocation, or other specific emergency circumstances.

CONSENT FOR TREATMENT

Emergencies

Telehealth is not recommended for a general psychological emergency. Telehealth services are only provided when it is unlikely that a mental health emergency could arise during the session. Overwhelming or potentially dangerous challenges are best addressed with in-person professional support. In the event that in-person sessions are recommended due to symptom severity, the patient is asked to arrangements for an in-person session.

Just like in-person services, if an emergency should occur during a telehealth session, the psychotherapist may consider taking any steps necessary to ensure the safety of the patient or of others, including communication with third parties and the enlistment of emergency services at the sole discretion of the clinician.

Scheduling

Just like an in-person appointment, telehealth sessions are scheduled in advance by prior arrangement.

Scheduling a telehealth appointment involves reserving time specifically for you. Just like in-person appointments, you are responsible for keeping all telehealth appointments.

We should usually start and end on time. In all telehealth sessions, the therapist will initiate the telehealth session, unless other arrangements have been made. A window will remain open around the starting time of your appointment. Just like an in-person session, if your psychotherapist doesn't hear from you, they will attempt to reach you but will discontinue after several attempts.

Cancellations and unkept appointments are treated just like in-person cancellations and unkept appointments. The psychotherapist is not responsible for the patient's ability to participate in the session, including technological limitations.

Confidentiality

The laws that protect the confidentiality of your medical information in the office also apply to telehealth sessions, including mandatory and permissive exceptions to confidentiality.

CONSENT FOR TREATMENT

The patient and psychotherapist both agree to keep the same privacy safeguards as during an in-person session. The environment should be free from unexpected or unauthorized intrusions or disruptions to our communication. There is a risk of being overheard by a third party near you if you do not conduct the session in an enclosed private room, with reasonable sound barriers, and with no one else present or observing.

The patient and psychotherapist both agree to not record the telehealth sessions without prior written consent of both parties.

Consent

You have the right to opt in or opt out of the methods of telehealth communication at any time, without affecting your right to future care or treatment.

It is your responsibility to discuss prior to the telehealth session which medium will be used, how to use it, and any necessary login codes.

Security

No electronic transmission system is considered completely safe from intrusion. Interception of communication by third parties remains technically possible.

Due to the complexities of electronic media and the internet, risks of telehealth include the potential for release of private information, including audio and images. So, your psychotherapist cannot fully guarantee the security of telehealth sessions. You are responsible for information security on your computer, laptop, tablet, or smartphone. As a policy, we ask for your agreement to not electronically record telehealth sessions withour prior written consent.

While a variety of software programs are available for video conferencing, such as Skype, Facetime, or GoToMeeting, not all are encrypted, or compliant with Federal law to protect the privacy of your health communication. We use software with encryption to maximize your confidentiality.

Telephone

Telehealth can include telephone sessions. When using the telephone,

remember to be in a place you feel comfortable speaking about personal and private matters. If you are using a cellular telephone, remember that not all calls or telephones are absolutely secure and may be compromised by various detection devices. A landline is preferable because it is more secure, more reliable, and often offers clearer audio quality.

Video Conferencing

The patient is responsible for their own hardware and software, audio and video peripherals, and connectivity and bandwidth considerations.

At the time of the telehealth appointment, it is your responsibility to have your electronic device on, video conferencing software launched, and be ready to start the session at the time of the scheduled telehealth appointment.

Before an initial telehealth session, a test call up to 10 minutes can be arranged to ensure that technology is functioning properly.

If a video telehealth session is blocked after several reasonable attempts, be open to having a telephone session for that time.

Payment

Just like in-person services, telehealth services are a professional service, and a fee is charged at the same rate as in-person services.

Even when health insurance covers in-person services, health insurance may limit or deny coverage of telehealth services. You are responsible to confirm and know in advance what your insurance may or may not cover. If your insurance does not cover telehealth services, you will personally be responsible for full payment.

Technical Instructions for Telehealth Video Conferencing

Below are specific technical instructions for preparing for your initial telehealth session. Please read this carefully. If you have any questions, please contact your therapist in advance of your first telehealth appointment.

Hardware

You are responsible to provide your own hardware and software, audio and video peripherals, and internet connection.

CONSENT FOR TREATMENT

Software

In our office, we use VSee videoconferencing software. VSee downloaded from www.vsee.com is free and allows secure communication via text, screen share, picture share, and real-time audio/video. It is fully compliant with federal telecommunication security protocols.

VSee runs on any operating system, and any hardware including desktop computer, laptop, tablet, or cellular telephone.

Set-Up

Telehealth videoconferencing can take increased set-up time and requires reasonable comfort with technology. Please test all of your systems and technical capabilities ahead of time.

Before your first session with the therapist, we recommend that you ensure that your software and hardware are working together properly and that you know how to operate them.

Confirm your internet connection and wireless router are fast enough to provide a full signal and will not be saturated.

We recommend you shut down all unnecessary other programs and apps before installation and during use. Go to www.vsee.com and download the free “messenger” software.

Despite VSee being very simple, learn the basic menus, try all the features, test your settings. Click on “Settings,” then “Audio and Camera Setup.” Make sure that your camera and microphone are working.

Provide your therapist with your VSee contact address.

Environment

Make sure your video conference session is in a private place, free from distraction or intrusion. A room with a door that closes is best.

Confirm there is plenty of even light with minimal glare.

Aim your camera. Check your camera angle. Check to see that your face can be seen. Avoid positioning your camera too low or too high. Try to fill the screen as much as possible.

CONSENT FOR TREATMENT

To maximize audio quality, freedom from extraneous noise, and privacy, a headset or earbuds may be better than a speaker and microphone.

The most important part of a video conference is not the video—it is the audio. Speak in your normal voice, without shouting.

Avoid "double talk." Double talk is when both people talk at the same time. Double talk may cause audio feedback and echo. Allow the other person to finish speaking before you speak. Since audio has a very slight delay, you may want to pause briefly for the therapist to respond or to make comments.

Your therapist will initiate the call at the appointment time.

Distortion or Disruption

If the connection is distorted or interrupted by a technical malfunction, we may reconnect and try again. If a video telehealth session is blocked after several reasonable attempts, please be open to having a telephone session for that time. The therapist will initiate each connection and re-connection.

You must confirm your address, safety, and the privacy of your location at the outset of each session.

This temporary transition to telehealth may bring up challenging thoughts and feelings. You are encouraged to discuss this in session and it is usually only a temporary adjustment.

Efficacy

Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something can be lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely. Note that treatment will be most effective when sessions occur at your regularly scheduled times and that telepsychology sessions will be treated in the same manner as in-person sessions: beginning and ending on time, 48-hour/two-business day cancellation policy, etc.

We will decide together which kind of telepsychology service to use. You may require a certain computer or cell phone system in order to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

CONSENT FOR TREATMENT

Email Communication
Email contents cannot be guaranteed to be secure or confidential. If you wish to communicate in this way, please be mindful of this and do so at your own risk.

If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone would look at these logs, they are, in theory, available to be read by the system administrator/s of the internet service provider. Any emails containing clinical content which I receive or exchange with you become part of your legal record.

Note that in the case of email communications, I check email on an intermittent basis so there can be delays in my response times. I may also choose to respond via phone or during our next session if I believe that is most appropriate.

Text Messaging

I cannot guarantee the confidentiality of any information communicated by text. Please be mindful not to overuse this and be aware that it may take 24-48 hours for me to respond, that I will not respond in the late evenings and have very limited response times on weekends.

Confidentiality

You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). Maintaining confidentiality also means that you will not record sessions in any way unless agreed to in writing by mutual consent.

Any family member or other individual that you would like to have present during the telepsychology session must also sign this document and must either announce themselves or be in view of the camera, if being utilized, so that I am aware of who is participating in the session.

Emergencies and Technology

CONSENT FOR TREATMENT

When conducting a telepsychology session, assessing and evaluating threats and other emergencies can be more difficult than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person/support person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask you to sign a separate authorization form allowing me to contact your emergency contact/support person as needed during such a crisis or emergency.

If our session is interrupted in the case of an emergency, I will attempt to call you back. If I do not immediately reach you, do not call me back; instead, call 911 or go to your nearest Emergency room. Please call me back, though, after you have called or obtained emergency services.

Records

In accordance with my standard policies, I maintain records of telepsychology sessions in the same way I maintain records of in-person sessions.

Informed Consent

The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This agreement is intended as a supplement to the Consent for Treatment and Office Policies that we agreed to at the outset of our clinical work together and does not amend or replace other agreements, contracts, or documentation of informed consent.

For Patients Choosing Facetime:
I understand that if I choose to use Facetime or Google for my telepsychology session(s) I am consenting to possible compromises of my privacy and confidentiality because they are not secure, HIPAA compliant services.

Client and Guardian Signatures: Date

CONSENT FOR TREATMENT

In case of a videoconferencing failure I understand that my therapist will attempt to resume initial mode of contact and failing that, will reach out to me by phone.

* Preferred Phone Number:
  Alternate Phone Number:

* I agree to inform Find Your Center of the address of my physical location at the beginning of each session if different from the one listed below.
___Yes, I agree ___ No, I do not agree

* Address of the location I intend to be for most of our telepsychology meetings at this time:

* Name, address, and phone number of closest Emergency Room:

Support Person

A support person is someone accessible to you (nearby, willing to help) during your telepsychology session. This individual could help in case of emergency. You will need to sign a release of information to allow me to contact this person if needed in such a situation.

* Support Person Name:

* Support Person's relationship to you:

* Telephone Number(s) of Support Person:

* In case of emergency I give consent for Michele Goldberg to contact my support person. I understand
  that this may involve disclosure of private and confidential information.
  ___Yes, I consent ___ No, I do not consent

Standard Emergency Plan

If you have a mental health emergency, please follow the guidelines agreed to in the Informed Consent for Telepsychological and Electronic Services and in the Consent for Treatment and Office Policies you have previously signed and agreed to and call 911 or go to your nearest emergency room.

CONSENT FOR TREATMENT

Signature of Patient and Guardian Date

* indicates a required field

Your signature below indicates that you have read this form, that you fully understand its contents, including the risks and benefits of utilizing telepsychological and electronic services, that you have been given the opportunity to ask questions, and that any questions have been answered to the best of your satisfaction.

Signature of patient/parent/guardian/conservator:

_____

Date: _____

If signature is other than patient, indicate relationship:

_____

Date: _____

CONSENT FOR TREATMENT

Authorization for Release of Information

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I authorize the following entity:

_____
Name of Facility & Provider, Family Member, Emergency Contact, or Other

_____
Telephone Number || Fax Number

_____
Address, City, State, Zip

To release information to:
Michele Goldberg, LMFT #97528 and Find Your Center, A Therapy Collective

and/or

To obtain information from:
Michele Goldberg, LMFT #97528 and Find Your Center, A Therapy Collective

PURPOSE OF THIS REQUEST: (check one) Healthcare Insurance Coverage
Personal Other:_____

TYPE OF RECORDS AUTHORIZED:
Psychiatric/Psychological Evaluation and/or Treatment, and/or
Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)
Assessments Progress Notes Laboratory Test Results: _____

Diagnostic Impressions Discharge Summaries Treatment Plans

Treatment Summaries Other: _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire:
When the requested information has been sent/received.
90 days from this date.

CONSENT FOR TREATMENT

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:
Date: _____
One year from this date.
___# years from this date.

Signature of Client/Representative: _____

Date: _____

CONSENT FOR TREATMENT

Client Credit Card Authorization Form

I authorize Find Your Center, A Therapy Collective, pursuant to Michele Goldberg, LMFT, An Individual, Marriage and Family Therapy Professional Corporation, to keep my signature and card information on a virtual terminal that is password protected in order to charge appropriate fees including, but not limited to, therapy sessions (individual, group, workshop, couples, family, etc.), consultation as delineated above, and any fees related to therapy materials. Any appointments with my therapist that are not effectively canceled 72 hours before the scheduled appointment time will be charged to my credit or debit card in full, and any charges that remain unpaid for 48 hours after the time the service was rendered and/or the charge incurred, will similarly be charged in full to my credit or debit card, both with a 3% surcharge. All payments made by credit card will similarly incur an addition 3% processing fee. This card will be maintained on file and it is my responsibility to update my therapist with any changes to the information that may impact processing of said charge. This may not be my preferred method of payment and may simply be maintained as a security against any failure I make to pay my bill in fill at the time of service or the time the charge was incurred. I consent to the use of my information in this way.
(INITIAL) _____

I understand that this authorization is valid until canceled in writing. I understand that thought his information is secured in a password protected file and is unlikely to be accessed, I assume the risk that is security will be compromised. I understand that charges for ongoing services or materials will normally be delivered and completed via my preferred method of payment. I agree that the card listed may be charged by my therapist in order to settle any outstanding balances accrued both during the course of my treatment and upon termination of therapy services. I also understand that if a chargeback fee, retrieval fee, or any additional fee is incurred, I alone am responsible for these fees.
(INITIAL) _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post, I will contact my therapist for disclosure and assistance immediately, within 24 hours. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. (INITIAL) _____

CONSENT FOR TREATMENT

Further, if I am assuming session payment responsibility for the client above whose name is listed, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions except as clearly identified above.
(INITIAL) _____

I understand and agree to these terms in full. I understand the conditions of this payment policy and agree to the conditions stated above.
(INITIAL) _____

Note that the information on this form will be securely entered and stored in a HIPAA compline online virtual terminal that is password protected for your safety. While secure methods to protect your information are in place and we take your safety seriously, no company can guaranty that any online system cannot be breached. Emailing the completed consent entails risk as gmail and most email platforms entail their own degree of vulnerability. You thus accept responsibility and risk in allowing Find Your Center, A Therapy Collective to receive and store your information for therapy charges.
(INITIAL)_____

Cardholder Name (print):

Signature:

Date:

Relationship to client:

Billing Address:

Card Type: (Visa, MasterCard)

Account Number:

Exp. Date:

Security Code:

Cardholder Signature: