Jeremy Frank and Associates
Online and Telehealth Groups and Individual Counseling
2 Bala Plaza, Suite Plaza 13 (Pl-13)
Bala Cynwyd, Pennsylvania 19004

Welcome!

This document contains important information about our professional services and business policies pertaining to online and telehealth groups and individual counseling. **Please read this agreement carefully before your first or second session, and fill out and sign the last page and email that to your therapist**. Please raise any questions or concerns you may have about this document with your therapist/s.

Telehealth is healthcare and therapy provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Depending on the state regulations, telehealth services may include telephone consultation, video conferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring. This consent is applicable to the COVID19 national emergency.

Please read the following and be sure that you understand this form in its entirety. If you agree with the terms and conditions, please sign and return the last page to your therapist.

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that I may opt out of the telehealth visit at any time but am aware that this might affect my ability to receive future care at this office/facility in a timely manner especially during the COVID19 national emergency.

I understand that telehealth services can be provided to patients within their state and during the COVID19 national emergency across state lines per Executive Orders by the Governor in some states. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

I agree that information exchanged during the telehealth visit will be maintained by the therapists at Jeremy Frank and Associates. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access medical records (and copies of medical records). I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform but is allowed during the COVID19 national emergency and I willingly and knowingly wish to proceed.

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. I will interact with my provider/therapist and, in some cases, other group members (if I consent to be in an online support/therapy group) in a private area for confidentiality to the best of my ability. I am aware that the healthcare provider, my therapist, is not responsible for breaches of confidentiality caused by an independent third party or by myself.

I have verified to my healthcare provider my identity and current location in connection with the telehealth services and acknowledge that failure to comply with these procedures may terminate the telehealth visit. I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider. I understand and agree that a medical evaluation via telehealth may limit my therapist's ability to fully diagnose a condition or disease.

As a patient, I agree to accept responsibility for following my therapist's and health care provider's recommendations—including medication prescriptions, frequency of telehealth visits, and when able, further diagnostic testing, such as lab testing, or an in-office visit. I understand that my electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment.

I understand that my therapist or provider may choose to forward my information to an authorized third party only for the purposes of providing receipts for health care billing, for professional collaboration and consultation in treatment. Therefore, I have informed or will inform my provider of any information I do not wish to be transmitted through electronic communications.

I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit. I further understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when psychological and medical care is provided. To the extent permitted by law, I agree to waive and release my therapist and the therapists at Jeremy Frank and Associates from any claims they may have about the telehealth visits.

Group Counseling Specific Agreements

I will not discuss anything shared in group with others outside of the group. I will strive to be on time and stay the entire session. I will notify the group facilitators if I am going to miss a session. I will do my best to attend a minimum of 2 consecutive sessions. I will be respectful of others' thoughts, emotions, and behavior. It is essential that members know that whatever they say or how they act in a group remains in the group and that members will not discuss these things with anyone outside the group.

I understand that this is the best way to create a safe and inclusive space where members can trust one another. I understand that the co-facilitators will break confidentiality under the following circumstances: 1) Indications of imminent or impending harm to self or others 2) Awareness of harm being done to a child, elder, or a person with a disability. I acknowledge that group facilitators have provided the opportunity for group members to discuss and ask questions about the importance and limits of confidentiality and the expectations of the group.

Counseling Services in General (Including In-Person and Telehealth)

Counseling is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to

become empowered to create change. As a client in counseling, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. We, as your counselor/s, have corresponding responsibilities to you. These respective rights are described in the following section.

Counseling has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Counseling often requires discussing unpleasant aspects of your life. However, it has been shown to have benefits for individuals who undertake it. Counseling often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems.

You should evaluate this information very seriously, as well as your own assessment about whether you feel comfortable working with us as a client in the practice of Jeremy Frank and Associates and with me/us in particular as your counselor/s. Counseling involves a commitment of time, money, and energy, so you should be very careful about the counselor you select.

For the first few weeks of counseling, we will check in regularly about the initial treatment plan which may lead to new or different paths for counseling. If you have questions about procedures or plans, we should discuss them as soon as they arise. As much as possible, be honest with me/us about how you are experiencing your counseling. There are many ways of doing counseling and it is your job to tell us how you would like to use the individual or group sessions and what you think might be most helpful to you from us.

Fees, Billing and Payment, and Cancellation Policy

Most group sessions are paid for a month in advance for all the groups during that month. Some of the groups are drop-in, however, payment can be made in advance or directly following the session. Ask your therapist how to make payment as it is your responsibility to make payments promptly.

If you need to cancel or reschedule a session, **it is required that you provide at least 24 hours notice to us directly by calling or texting our cell phone**. **If you miss a session without cancelling, or cancel with less than 24 hours notice, you will still pay for the missed session in full.**

Our practice is on a fee-for-service basis. **Session fees are payable at the time of service** unless alternative arrangements have been made. Fees will be reevaluated periodically. **There is a $180.00 charge per 50 minutes for individual counseling or to prepare documents for disability, legal, work or academic purposes, letter writing or communication to family members, friends, or partners as authorized by you. You are responsible for all charges due to insufficient check funds.**

You will be responsible for paying the entire fee even if your insurance fails to authorize units of service or if no units of service are available to you. You are responsible for payment even if you don't get reimbursed from your insurance company. We can provide you with a statement that you can submit to your insurance company for reimbursement. In the event there is a deductible for out-of-network benefits, you are responsible for the full amount of the deductible.

Should a balance accrue and no payment is received, we reserve the right to seek remuneration by any means legally possibly including, but not limited to, the retention of a collection agency. If you have difficulty paying for counseling under the conditions outlined, then we would be happy to discuss alternative plans. **We accept cash, check, and credit cards (MasterCard, Visa, and American Express).**

Insurance

We do not on principle sign any contracts with insurance companies and third party providers because we believe this compromises our ability to work for you, our clients and patients. If we sign a contract with a third party they become a colleague or partner in our work with you and we are somewhat beholden to them.

Insurance companies sometimes require a formal diagnosis with their claims. Insurance companies sometimes require detailed information about their members' treatment, and often attempt to affect or direct the treatment provided (i.e. type of counseling, length of counseling, etc.). The information they request and obtain can become part of your mental health record. Many people receive their health insurance through their employer.

Please be advised that if your employer is self-insured, your employer may have access to your insurance records. Although many patients have, and use, their mental health insurance benefits, others prefer to pay privately "out-of-pocket." There are various reasons to consider this including your confidentiality and benefit coverage. Your mental health records may impact your ability to obtain other medical, life, and disability insurance in the future.

As a private pay client, you can be assured that treatment records are kept confidential, shared only with your prior written consent. Most insurance plans only cover a limited number of sessions per year. Thus, any sessions scheduled beyond the annual maximum become an out-of-pocket expense. Prior to the start of treatment, you should check with your insurance carrier to see if you have an annual session maximum before deciding to use your insurance.

Confidentiality

The confidentiality of all communication between a client and a counselor is generally protected by law and we, as your counselors, cannot and will not tell anyone else what you have discussed or even that you are in counseling without your permission. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and more restrictive ethical requirements imposed by our ethics code as counselors, social workers, and psychologists.

We are "old-school" in terms of maintaining professional communication with clients and do not text message with clients except to arrange appointment times. If you text us, your text message may not be returned. If you prefer to use email to contact us, please let us know and we can discuss this option next time we meet, keeping in mind that there is no way to ensure confidentiality of emails. The bottom line here is that we do not do counseling via text or email.

We respect your time and will not answer the phone when we are with you or another client, when we are in a meeting, or during our own private time unless in exceptionally rare circumstances. We typically return calls the same day or by the next business day at the latest. We do not check phones after 7:00 PM on weekdays or after 5PM on weekends.

If you feel unable to keep yourself safe, call 911 immediately and/or go to your nearest hospital emergency room and ask to speak to the psychiatrist on call.

Other Rights

If you are unhappy with what is happening in counseling, we hope you'll talk with us so that we can respond

to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that we refer you to another therapist and are free to end counseling at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the counseling and about our specific training and experience. You have the right to expect that we will not have any social relationships with clients or with former clients.

Policy for Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy, however, to treat individuals between the ages of 14 and 17 more or less as adults. To that end, we request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern. Before giving them any information, we will do our best to discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

[IF YOU AGREE WITH THE TERMS/CONDITIONS, PLEASE SIGN AND RETURN THE FORM BELOW]

Jeremy Frank and Associates
Online and Telehealth Groups and Individual Counseling

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may revoke this agreement in writing at any time.

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.

Patient Name: _____

Full Address: _____

Phone (Cell): _____ Phone (Home): _____

Email: _____ Birth Date:_____

Emergency Contact: _____

Patient Signature: _____ Date: _____

Authorization for Credit Card Usage and for Missed or Late Cancelled sessions

This office maintains a 24-hour cancellation policy. It is easiest to pay missed session or late cancellation fees at the next regular session held after the missed session. By signing below, you hereby authorize Jeremy Frank PhD CADC & Associates to keep a valid credit card on file to be used to pay for missed appointments that were not cancelled at least 24 hours in advance that are not paid by check or cash at the next upcoming sessions.

Missed sessions not cancelled prior to 24 hours before your session will be charged to this card if you do not pay the fee by check or cash at an upcoming session. The signed form may also be used to indicate that I agree to allow Jeremy Frank PhD CADC & Associates to bill for sessions regularly using the card on file.

Credit Card Type: Visa _____ Mastercard _____ American Express _____ Other_____

Card Number: _____

Expiration Date: _____

Security Code on back of card: _____

Zip Code for billing address: _____

Print Name: _____

Signature: _____ Date: _____