New Client Telephone Intake

Provider Name: _____ In-Network: _____ Out-of-Network: _____

Today's Date: _____ Date and Time of Appt: _____

Client's Name: _____Client's D/O/B: _____

Responsible Party Home Phone Number: _____Cell Number: _____

Is it ok to leave message at these numbers: Home ❑ Yes ❑ No Cell: ❑ Yes ❑ No

Email _____

Mailing Address: _____

Name of Insured: _____SSN of Insured: _____ DOB Insured: _____

ID# from Card: _____ Group #: _____

Primary Insurance Co Name: _____ Benefits/Eligibility Phone: _____

Precertification Phone: _____

Secondary Insurance Co Name: _____ Benefits/Eligibility Phone: _____

Precertification Phone: _____

Will client be utilizing EAP Benefits? _____ EAP Co: _____ EAP Phone: _____

Other Info: _____

_____

Benefit Information:

Pre-existing/Exclusionary Riders: _____

Policy Effective Date: _____Calendar Year or Plan Year: _____

MH Ded: _____ Ded Met:_____ OOP: _____OOP Met:_____

Collect until Ded Met:_____

Collect After Ded Met: _____Co-pay or Co-ins:_____

Auth Required: _____ Visits per year: _____ Visits Used Current year: _____

If Auth Required:

Managed by: _____ Phone #_____Fax # for OTR's:_____

Authorization #: _____ Date Start: _____ End: _____Visits Auth: _____

Address for Claims: _____

EAP Benefits Available: _____ 1500/Special Forms/Special CPT code: _____

Authorization #: _____ Date Start: _____ End: _____Visits Auth: _____

Address for EAP Claims:_____

Contact at Insurance Co: _____Verified by: _____Date:_____

Revised 10/02/2013

Dx Codes: _____ (Provider Only) Dr Keisha Bean, PhD

CLIENT INFORMATION

Client Name: _____ Gender: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S / M / D / W Student: Y / N

Race Circle: American Indian or Alaskan Native / Asian / African American / Caucasian / Pacific Islander / Other / Declined

Ethnicity Circle: Hispanic / Non Hispanic / Declined Language: _____

Street Address: _____

City: _____State: _____ Zip Code (9 digits): _____

Email Address: _____ _____ Ok to send e-mail

Home Phone: _____ Work #:_____ Cell #:_____

_____ Home ok leave message _____Work ok to leave message _____Cell ok to leave message

Employer: _____ Occupation: _____

Complete Work Address: _____

Person Responsible for Payment: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Complete Address (if different):_____

Home Phone: _____ Work #: _____ Cell #:_____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work #: _____ Cell #: _____

Referred by: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

→ → **To file insurance I must have the following information:**

Primary Insurance

Insurance Company Name _____ Phone: _____

Name of Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

Policy #: _____ Group #:_____Effective Date: _____

Secondary Insurance

Insurance Company Name _____ Phone: _____

Name of Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

Policy # _____ Group #: _____Effective Date: _____

→→ *PLEASE READ & COMPLETE THE BACK OF THIS SHEET*

PAYMENT/INSURANCE AGREEMENT & AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

Agreement to Pay. I agree to pay fees/co-payments for service at the time of each visit. I understand that I am personally responsible for payment of all charges. If the patient has coverage under a managed health plan (HMO, PPO etc.) to which I subscribe and in which the provider is a participating provider, I am responsible for the co-payment as determined by the insurance plan. I understand that the provider will file insurance as a courtesy; however this does not release me of my responsibility for payment of the charges for services. I am responsible for payment even if a divorce settlement dictates that medical bills are to be paid by a former spouse. Appropriate documentation will be provided with which reimbursement may be sought from the ex-spouse. I understand that delinquent balances are subject to collection procedures and I am responsible for any collection agency or court fees. If the provider must utilize a collection agency to collect on a delinquent account, such action could require that the provider release to the collection agency, attorneys and/or the court information including but not limited to the identities of the parties involved, the dates and nature of the charges, and any other information contained on any claim filed.

Fees: Services are charged based on the time spent and complexity of the session. In addition to regularly scheduled appointments, there may be a charge for other services such as report writing, telephone conversations which last longer than 15 minutes, requested attendance at meetings/consultations with other professionals, or preparation of treatment summaries. These are charged on a prorated basis. Some of these costs are not covered by insurance.

Missed appointments. I understand that once I have made an appointment, the time is reserved just for me. Therefore, I understand and agree that **I will be charged the full fee** for the scheduled visit and required to pay for missed appointments not cancelled 24 hours in advance. Insurance does **not** reimburse for broken appointments and I will be fully responsible for this fee.

Legal Services. If I am here for that purpose, I will discuss this with the doctor ahead of time and discuss fees for such services. Insurance also does not typically cover services performed for legal purposes, such as custody evaluation etc. I understand that I will be expected to pay for professional time required even if the provider is compelled to testify by another party. If I am here as a result of a court order I understand that this is an agreement between me and the courts, not the provider, and I am responsible for payment of all charges. Because of the complexity and difficulty of legal involvement, the fee is $225.00/hour for preparation for and attendance at any legal proceeding.

Insurance Reimbursement. I understand that I am responsible for knowing exactly what health care services my insurance plan covers and securing any pre-certification that my insurance may require for reimbursement. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for health care services. I understand that securing benefits under health insurance or other health plans will require that the provider provide the plan management with confidential patient information including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the provider to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the patient. I also understand that I have the right to pay for services myself and avoid the complexities of filing insurance all together. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Insurance to be filed by ☐ Dr Keisha Bean, PhD ☐ Client ☐ Neither

By signing below I authorize Dr Keisha Bean, PhD, to file insurance claims and to pay Dr Keisha Bean, PhD directly. I authorize payment of medical benefits to Dr Keisha Bean, PhD by my insurance company. By signing below I also acknowledge that I have read, understand and agree to the above information.

_____ _____

Signature of patient, parent or legal guardian Date

INTAKE FORM

Please take the time to fill this out carefully. Fill all items out as completely as possible.

Identifying Information

Name _____

Address

_____

_____

Telephone #1 _____ May I leave a message? Y N

Telephone #2 _____ May I leave a message? Y N

Social Security Number _____

Date of Birth _____

From whom did you learn of me? _____

May I thank this person for this referral? _____

Emergency contact information

Name and relationship to you _____

Telephone _____

Vocation

Current occupation _____ Full-time or Part-time

Are you currently in school? N Y Where?_____

Are you an undergraduate or graduate student? (circle)

Full-Time or Part-Time? (circle) What is your GPA? _____

What is your major/department/degree program? _____

Current Needs and Treatment History
Why are you seeking services at this time?

_____

_____

How long have you been concerned about the situation that brings you to therapy now?

__ <1 month __ 1-3 months __ 3-6 months __ 6-12 months __ 1-2 years __ >2 years

Do you have any specific goals for therapy?

How much counseling or psychotherapy have you had?

__ None __ <1 month __ 1-3 months __ 3-6 months __ 6-12 months __ More than 1 year

Are you now or have you ever considered ending your own life? Y N

If the answer is Yes to the previous question, please further explain details surrounding these related thoughts and feelings._____

Marital/Partnership Status

Do you find yourself sexually attracted to men, women, or both genders? M W B

What is your relationship status? (circle one)

Single Married Living in a committed relationship

Separated Divorced/Divorcing Widowed Partnered

Do you have children? N Y What are their ages? _____

Family History

How do you describe your ethnic identity? _____

How do you describe and/or practice your spiritual orientation?

Are your parent(s)/caregiver(s) living? Y N
If not, how old were you when they died? _____

Are your parents currently in a relationship? Y N
If not, how old were you when their relationship ended? _____

Do you have siblings? N Y If so, what are their ages? _____

Do you believe you experienced verbal or emotional abuse in your childhood? Y N

As a child or adult, have you ever had an unwanted sexual experience? Y N

Medical History

Are you currently taking any psychiatric medications (e.g., antidepressants)? Y N

If so, what are the names and dosages of these medications?

_____

From whom did you receive this prescription and when?

_____

Are you currently seeing a psychiatrist? Y N

Please list name and contact information for the psychiatrist you are seeing.

_____

Please list all the psychiatric medications you have taken in the past:

Have you ever been hospitalized for psychiatric reasons? Y N

How would you describe your physical health?

By signing below, I agree that I am responsible for full payment of all co-pays and/or session fees at the time of service (using cash or check). If I cancel a session without providing a 48-hour notice, I understand that I will be charged and be responsible for paying a full session fee for that cancellation.

_____ _____

Client Signature Date

Confidentiality

The law protects the privacy of all communications between a client and a psychologist. This means that all of our exchanges—with a few specific exceptions—are kept **confidential and private**. In most cases, I can only release information about your treatment to others if you sign a written authorization form.

There are some situations in which I am required to disclose information without your consent. Although these situations are unusual in my practice, I want you to know that I am **legally obligated** to take action to protect the client and others from harm, even if this means revealing some information about a client's treatment. These situations include:

- If I have reason to believe that a child has been/is being abused, the law required that I file a report with the appropriate governmental agency. Once a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder is being abused, neglected, or exploited, I must report this to the appropriate agency. Once a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to himself/herself **or** to another person, I am required to take protective actions. These actions might include notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.

If any of these situations arise, although I am not legally obligated to do so, I will make an effort to discuss the disclosure with you before taking any action and I will limit my disclosure to what is necessary. Once the information is released, the use of information in such circumstances is beyond the control of this office.

Client Rights

In addition to confidentiality, as spelled out above, you have the right to question any aspect of treatment. You can expect that, if you request a referral to another therapist for alternative treatment, you will receive a referral. You have the right to end your therapy at any time for your own reasons, without any moral, legal, or financial obligation except for fees already incurred.

I understand and agree to these policies, and I have received a copy of this policy statement.

Client's Signature: _____

Date: _____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data (Transaction Rules), the keeping and use of patient records (Privacy Rules), and storage and access to health care records (Security Rules). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one fro your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Keisha L Bean, PhD
Psychologist

I, _____ understand and have been provided a copy of Keisha L Bean, PhD's, Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this acknowledgment form.

_____ _____

Patient Signature, or parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I. Preamble

The Psychology Licensing Law provides extremely strong privileged communication protections for conversations between your psychologist and you in the context of your established professional relationship with your psychologist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very carefully defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient him/her self.

HIPAA provides privacy protections about your personal health information, which is called "Protected Health Information" [PHI], which could personally identify you. PHI consists of three components: *treatment, payment,* and *health care operations*.

Treatment refers to activities in which I provide, coordinate, or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided to you.

Health Care Operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The *use* of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. *Disclosures* refers to activities you authorize which occur *outside* my office such as sending your protected health information to other parties (e.g. your primary care physician, the school your child attends)

II. Uses and Disclosures Of Protected Health Information Requiring Authorization

Tennessee requires authorization and consent for treatment, payment, and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment, and health care operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct the administrative steps associated with your care (i.e. file insurance for you).

Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your

child's school counselor about her eating disorder and what she might do to be of help to your child. Before I talk to that counselor, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychologist-patient in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you, hence the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modality of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which includes the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests which are protected by copyright laws and the need to protect patients from unintended, potentially harmful use are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclosure of protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative services for my practice and refers to these people as "Business Associates." In my practice, "business associates" include the billing service I use, Proper Billing Services, which provides services such as verifying insurance information and preparing and mailing claim forms and monthly statements – all activities which bring them into some measure of contact with your protected health information. ONLY I have access to your full designated mental health records as I have purposefully separated your administrative and clinical records in an attempt to further enhance your privacy. The only other "business associates" in my office are the cleaning crews. In compliance with HIPAA, I have signed a formal contract with my business associates which very clearly spells out to them the importance of their protecting your mental health information as an absolute condition for employment. I train them in my privacy practices, monitor their compliance, and correct any errors, if they should occur.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization in the following cases:

- Suspected child abuse, physical or sexual

- Elder and domestic abuse
- Health Oversight Activities (i.e. licensing board for psychology in TN)
- Judicial or administrative proceedings (e.g. if you are ordered here by the court)
- Serious threat to Health or Safety (e.g. threat of suicide, "duty to warn" law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Patient's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- The right to inspect and have a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the record;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your privacy rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointments. My duties as a psychologist on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing privacy practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

I am the appointed "privacy officer" for my practice per HIPAA regulations If you have any concerns of any sort that my office may have somehow compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services.

VII. This notice shall go into effect 4/14/2003 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

AGARDO

Practice Management Solutions

Credit Card Payment Authorization Form

Billing Information

Credit Card #: _____ Exp: _____

CVV# (three digits on back right hand side of card): _____

American Express _____ ***Discover*** _____ ***MasterCard*** _____ ***Visa*** _____

Name on Card: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Client Information

Client Name: _____

Provider Name: _____

I authorize Agardo LLC to charge my Credit Card in the following manner:

❑ Set my account to automatically charge my Credit Card for the balance due at each visit.

❑ Set my account to have my Credit Card on file, in the event I fail to pay the balance due on my account by cash or check at each visit, charge my Credit Card for the balance due.

I understand that this charge will show up on my credit card statement as a charge by "Agardo LLC", who will process my card on behalf of my provider.

_____
Signature of Card Holder

_____
Printed Name of Card Holder

_____
Date

Internal Use Only

Chart: _____

DOS:_____

Pvd Code:_____Amt: _____

Conf#:_____

Dep: _____PD: _____

Processor:_____

K. L. Bean, PhD - Psychologist
810 Dominican Drive
Nashville, TN 37228
Klbean.phd@gmail.com | 615.400.6938
Website - Dockeisha.com

By signing this document, I understand that I will be assessed a $95.00 no show fee in the event that I do not cancel my appointment within 24 hours.

This notification must be made either via email or voicemail. A text to 615.400.6938 is requested IN ADDITION to the email or call but is not required. The text message does not replace the email or call.

This no show fee must be paid prior to the next session and before scheduling additional sessions.

Signature **Date**

Revised (1.1.2020)

K. L. Bean, PhD - Psychologist

810 Dominican Drive
Nashville, TN 37228
Klbean.phd@gmail.com | 615.400.6938
Website - Dockeisha.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize the Dr. Keisha Bean to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results/assessments/evaluations
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR
Date of Birth:_____

_____
Signature of Witness Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ____
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in office. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___

- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Psychologist Date