MINOR INTAKE FORM

IDENTIFYING INFORMATION

Name of Minor_____ Gender Identity:_____

Birth Date_____ Place of Birth_____ Age_____

Address_____

City/Zip/State_____

Telephone_____ (of responsible party)

Can we call to leave a message? ___Yes ___No

Can we text for scheduling purposes? ___Yes ___No

Insurance Information:

Birth Gender:_____

Subscriber (primary card holder):_____

Subscriber's Date of Birth_____

Primary Insurance Company_____

Primary Insurance Company Phone No (on back of card)_____

Subscriber's Policy No_____ Group No_____

Insurance Co-Pay Amount_____ Deductible_____

The below section can be used for clients who are minors

If someone other than the client is responsible for payment, please complete this section.

Name_____ Relationship to Client_____

Address_____ Phone:_____

SSN:_____ Employer_____

Religion(optional)_____

Education(grade)_____ School_____

Referral Source:_____

Provider_____ Phone No._____

Date of last Physical_____

Dentist_____ Date of last Dental Exam_____

Eye Doctor (if applicable)_____ Date of last Exam_____

Is there a family member that is in the military?_____

Name of Mother_____

Name of Father_____

Guardian (if applicable):_____

Step-parents names_____

Parent Signature_____ Date:_____

Need signatures of both parents if parents are divorced/separated (unless court order states otherwise and please bring document to prove this: example one parent has legal custody).

Parent Signature_____ Date:_____

PRESENTING PROBLEMS:

(check all that apply)

___Very Unhappy	___Slow	___Stubborn
___Irritable	___Short Attention Span	___Disobedient
___Temper Outbursts	___Distractible	___Infantile
___Withdrawn	___Lacks Initiative	___Mean to Others
___Daydreaming	___Undependable	___Destructive
___Fearful	___Peer Conflict	___Trouble with the Law

___Clumsy	___Phobic	___Running Away
___Overactive	___Impulsive	___Self-Mutilating behavior
___Head Banging	___Lying	___Sleeping Problems
___Rocking	___Sexual Promiscuity	___Frequent Illness
___Shy	___Academic Problems	___Drug Use
___Strange Behavior	___Truancy	___Alcohol Use
___Strange Thoughts	___Bed Wetting	___Suicide Talk
___Fire Setting	___Soiled Pants	___Other
___Stealing	___Eating Problems	___Anxious

___Other:

Explain:

How long have these problems occurred?(weeks, months, years)

How frequently do these problems occur?

What happened that makes you seek help at this time?

Problems perceived to be: ___very serious ___serious ___somewhat serious ___not serious

What are your expectations/hopes for your child in therapy?

What changes would you like to see in yourself?

What changes would you like to see in your family?

PSYCHOSOCIAL HISTORY:

Current Family Situation

Mother-Relationship to Child ___natural parent ___relative

___step-parent ___adoptive parent

Occupation_____

Education_____

Birthplace_____ Age_____

Father-Relationship to Child ___natural parent ___relative

___step-parent ___adoptive parent

Occupation_____

Education_____

Birthplace_____ Age_____

Marital History of Parents:

Natural Parents: ___Married When_____

___Separated When_____

___Divorced When_____

___Deceased When_____

Step-parents: ___Married When_____

___Married When_____

___Other Information

Explain:

Please explain relationship with parents/step-parents or any other parental figure living at the home:

If child is adopted:

Adoption Source_____

Reason & Circumstances_____

Age when child first came into home:_____

Date of legal adoption:_____

What has the child been told?_____

Living Arrangements:

Number of moves in child's life_____ Places Dates

_____ _____

_____ _____

_____ _____

_____ _____

Present Home: ___Renting ___Buying ___Other

___House ___Apartment ___Other

Does the child share a room with anyone? ___Yes ___No

If yes, with whom?_____

How is this relationship?_____

If no, how long has he/she had own room?_____

Was the child ever placed, boarded, or lived away from the family?

Explain:_____

Who lives in the home other than siblings/parents?_____

What are the major family stresses at the present time, if any?_____

_____

_____

What are the sources of family income?_____

Brothers & Sister (indicate if step-brother or step-sister)

Name	Age	Sex	living at home	drug use
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Health of Family Members

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, anxiety, or any other mental illness or legal problems.

1.

2.

3.

4.

5.

6.

Name	Relation	Type of Illness	Length of Illness
1.			
2.			
3.			
4.			
5.			
6.			

Does or did any family member(including child) have any problems with:

___Reading ___Spelling ___Math ___Speech ___Writing ___Sensory Problems

If yes, please explain_____

Is there any history in child's family of:

___intellectual functioning ___epilepsy ___birth defects ___Autism

If yes, please explain_____

CHILD HEALTH INFORMATION

	Age		Age
___High Fevers	___	___Dental Problems	___
___Pneumonia	___	___Weight Problems	___
___Chronic Flu	___	___Allergies	___
___Encephalitis	___	___Skin Problems	___
___Meningitis	___	___Asthma	___
___Convulsions	___	___Headaches	___
___Unconsciousness	___	___Stomach Problems	___
___Concussions	___	___Accident Prone	___
___Head Injury	___	___Anemia	___
___Fainting	___	___Blood Pressure Issues	___
___Dizziness	___	___Sinus Problems	___
___Vision Problems	___	___Heart Problems	___
___Hearing Problems	___	___Frequent Ear Infections	

Other Illnesses:_____

Surgeries:_____

Hospitalizations:_____

Has child ever been seen by a medical specialist (other than primary care provider)?

Has child ever taken, or is he/she taking presently, any prescribed medication?

Name(s) of specialists currently working with or working with in recent past:_____

DEVELOPMENTAL HISTORY

Parent-Child Wanted? ___Yes ___No Planned for? ___Yes ___No

Normal Pregnancy? ___Yes ___No

Explain:_____

If mother was ill or upset during pregnancy, please explain:_____

Length of Pregnancy:_____

Paternal support and acceptance(explain):

Birth:

Length of Active Labor: ___Hours ___Easy ___Moderate

Full Term: ___Yes ___No

If premature, how early?_____

If overdue, how late?_____

Birth Weight: ___lbs. ___oz.

Type of Delivery: ___Spontaneous ___Cesarean ___With Instrument

___Head First ___Breech

Was it necessary to give the infant oxygen? ___Yes ___No If yes, how long?_____

Did infant require a blood transfusions? ___Yes ___No

Did infant require X-ray? ___Yes ___No

Physical Condition of infant at birth:_____

Anorexia?

Trauma?

Other complications:

Newborn Period:

			How Long
Irritability	___Yes	___No	_____
Vomiting	___Yes	___No	_____
Difficulty	___Yes	___No	_____
Breathing	___Yes	___No	_____
Sleeping Prob.	___Yes	___No	_____
Convulsion	___Yes	___No	_____
Colic	___Yes	___No	_____
Normal Weight Gain	___Yes	___No	_____
Breast Fed	___Yes	___No	_____

Any other information:

Developmental Milestones:

Age at which Child:

Sat up:

Crawled:

Walked:

Spoke Single Words:

Spoke Single Sentences:

Bladder Trained:

Bowel Trained:

Weaned:

COMMUNITY RESOURCES

Is the child engaged in any resources including, but not limited to case management, behavior support, physical therapy, occupational therapy, and speech?

Is the child involved in any extracurricular activities?

SCHOOL

Child's favorite subject:

Child's least favorite subject(if any):

How does child get along with peers?

Is child involved in any after school activities?

Has the school district ever administered any psychological tests to your child?

Findings?

Is child involved in any school resources (tutoring, counseling, speech, 504 plan, etc)?

Are there any academic concerns?

STRENGTHS

What are your child's interests/hobbies?

What are your child's strengths?

****Any other pertinent information, please explain****

MINOR CONSENT FORM

Client_____ D.O.B._____

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Most of the time it is best to conduct therapy in a family systems context with other family members involved. Sometimes, minors benefit from the counseling experience when they are seen alone. This therapist will assess which might be best for your child and make recommendations to you. The support of all of the child's caregivers is essential as well as their understanding of the basic procedures involved in the counseling process.

The therapist's role is to support the child, therefore this therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. This therapist will make every effort to protect the child in a court of law and not release minor's records or other information when to do so could cause physical, emotional, or psychological harm. By signing this form you acknowledge that therapist will work closely with the family of a minor except when to do so could cause harm to the minor.

Confidentiality and privilege are limited in cases involving child abuse, neglect, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

Minors, age 14 years of age or older, may independently enter into therapy. They may also claim privilege of confidentiality in cases involving abuse, neglect, pregnancy, or communicable diseases. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder. Therapist believes that under these circumstances parents should be made aware of their minors conditions unless doing so would harm the minor.

To increase the effectiveness of therapy, I the parent/legal guardian, agree to the following:

1. I will do my best to ensure that therapy sessions are attended.
2. If my child prefers not to volunteer information about the sessions, I will respect this.

I, (name of parent/guardian)_____ (relationship to child)_____ agree that my child,_____ should have privacy in his/her therapy sessions if minor and therapist deem this appropriate.

Child/Client Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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OFFICE POLICIES & AGREEMENT FOR PSYCHOTHERAPY SERVICES

Your first visit to a new therapist is very important. This letter is to introduce myself and give you information to help you decide whether we can work together. Please take time to read it carefully and let me know if you have any questions or need more information.

Qualifications

I received my Masters in Counseling Psychology at Loyola Marymount University in Los Angeles in 1994. I am a Licensed Marriage and Family Therapist. I work from an integrative perspective and rely on a broad range of counseling skills. I also draw from my life experience of raising three children, one of which is on the autism spectrum. As a therapist, I bring a certain level of expertise to our collaboration while you bring self-knowledge, the ability to learn from your life experiences, and a vision of what you want your life to be. I enjoy working with a diverse range of individuals, couples, and family systems.

The Process of Therapy

During our first meeting, I will assess whether I can be of benefit to you. I do no accept clients who I believe I cannot be helpful to, and if this is the case, I will refer you to others who work well with your particular issue. Within a reasonable period of time after starting treatment, we will discuss my working understanding of your issue, we will collaborate on a treatment plan, and discuss therapeutic objectives. If you have any questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan in general, please ask me. You also have a right to ask about other possible treatment options for your issue and their risks and benefits. If you could benefit from any treatments that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination & Follow-Up

Deciding when to work together or to complete therapy is a mutual process and I value your input in this process. Before we “stop” services, we will discuss how you will know if or when to come back or a regularly scheduled “check-in” might work best for you. If it is not possible for you to phase out of therapy, I recommend that we have closure on the therapy process within two sessions.

Noncompliance with treatment recommendations may necessitate early termination of services. I will review your issue with you and exercise my educated judgment about what treatment will be in your best interest. Your responsibility is to make good faith effort to fulfill the treatment recommendations to which you have agreed. If you have any concerns about my treatment recommendations I will be open to discuss these concerns.

If during our work together I assess that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss this with you. If I deem it appropriate, I will give you referrals that may be of service to you. If at any time you wish to consult with another therapist, I will assist you in finding somebody qualified. You have the right to terminate treatment at any time.

Dual Relationships

Therapy never involves business, sexual, close friend, or any other relationship that could cloud my objectivity, clinical judgment, or therapeutic effectiveness or could be exploitive in nature. It is possible that during the course of treatment, I may become aware of other preexisting relationships that my effect our work together, and I will do my best to resolve these situations ethically, this may entail our needing to stop working together and me referring you to another therapist who can meet your needs. Please discuss this with me if you have any further questions or concerns.

Payment & Financial Arrangements

I do currently take insurance. I am credentialed with Blue Cross of Idaho, and Blue Cross Kootenai Care Network, Regence Blue Shield, Asuris, and Aetna and Mountain Health Co-op. I do not take Medicare. So if you have Blue Cross or Aetna Medicare or a Medicare supplement I cannot take this insurance. The co pay/co insurance fee is to be paid at the start of each session unless other arrangements have been made. If you decide to do cash pay, my fee is $125 per session. If you are late we will end on time and not run over into the next client's session. Full payment of co-pay is expected at the time of service and the currency used can be: cash, check, or visa/mastercard. There will be a $35 charge for late payments and a $35 charge for returned checks. Checks can be made out to Natalie Keese-Hamm.

I do not permit clients to carry a balance of more than 1 session and if you are unable to pay this balance, we will discuss whether it makes sense to pause your care or develop another strategy so that you can avoid incurring additional debt. Please let me know if any problem arises during the course of therapy regarding your ability to make timely payments.

I offer some low fee slots based on income and circumstances, but I prefer to hold these slots for current clients who are experiencing life transitions. If my fee is a concern, please discuss this with me. If I am unable to accommodate your financial situations, I can offer you some referrals.

You will receive a receipt of payment for the co-pay if requested. There will be a fee for any records/invoices that you need and this cost will be $5 fee (copy fee) per assessment/treatment plan, other than for insurance purposes (example: needing a copy of plans for your personal use). Therapist does not disclose progress notes. Some or all of your fees will be covered by your health insurance, however, insurance companies do not reimburse all conditions that may be the focus of psychotherapy. It is your responsibility to verify the specifics of your coverage and have pre authorization for counseling services. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your primary and/or secondary claims. If your insurance company does not pay me within a reasonable period of time, you will be responsible for payments. The payment billed to your insurance company may not be the same as the cash rate, it will be at the rate of what is billed to your insurance which is typically a higher fee than the cash rate. The cash rate is a discounted rate. Bottom Line: If you go through your insurance and your insurance does not pay for your services, or only pays for a part of your services, you are responsible for the rest of the payment which could be higher than my cash rate. Please remember that my services are provided and charged to you, so you are responsible for payment. If for some reason your insurance does not cover therapy and this is discovered after appointments are made, you are responsible for paying for these appointments at the insurance billable rate (it is this therapist's discretion to arrange a payment plan when appropriate). As described below in the section

Health Insurance and Confidentiality of Records, be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. If you elect not to have your insurance company be billed for psychotherapy then there is a separate form to fill out stating that you are electing to opt out and your will be responsible for the cash rate of $100 per session at the time of service. Please note that if you elect to sign this form, you are bound to pay cash only throughout the entire therapeutic process. If you fill out this form, you cannot at anytime change your mind and switch over to your insurance and have them pay for therapeutic services, for this will place this therapist in jeopardy of violating a contract set forth by the insurance company.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time and services even if I have been called to testify by another party. Because of the difficulty of legal involvement and the interruption to my regular practice, I charge $350 per hour for preparation and attendance at any legal proceeding. If there is any letters that I need to write regarding any legalities I will charge $100 per hour or $50 per letter if writing a letter takes less than an hour. I will provide bills/receipts at the end of each session and I expect to be paid upon receipt unless otherwise agreed upon. If you need any additional letters or paperwork from me, like a letter for a companion animal, the cost will be $50 per page.

I will not take on patients who are looking to apply for short or long term disability services and request that I spend extra time outside of the counseling session filling out forms and supplying extra documentation to apply for these service. Please let me know up front if you plan on applying for disability services and I can either refer you to an agency who can meet your needs or take you on as a patient and make sure that we are both contractually aware that I will not fill out extra forms and supply documentation to the state or insurance in order to make a determination for long term disability.

If you need additional services, including coordinating care, I will not charge for these services unless the communication between therapist and outside professionals exceeds the 10 minute window per week (similar to billing for phone contact, see below). For example, if your doctor (with a release of information/your written permission) needs a copy of your assessment therapist will mail this to your doctor's office. Therapist will charge client at the going hourly rate if client requests therapist to be present at any out of the office meetings pertaining to client (example: school IEP).

Emails, Phone Calls, & Emergencies

If you need to contact me between a session, please leave me a voicemail. I check my messages every day unless I am out of town. If I am planning on being out of town, I will let you know in advance. I will also let you know who I have covering for me in my absence. Phone consultations are usually free within a 10 minute window of time. However, if we spend more than 10 minutes a week on the phone, if you leave more than 10 minutes worth of phone messages in a week, if I spend more than 10 minutes a week of coordination of care, I will bill you for every minute you are over this time at $1 per minute. If you feel the need for many phone calls and cannot wait for your next appointment, we may need to schedule more sessions to address your needs. If an emergency situation arises, please indicate it clearly in your message to me and I will advise you to utilize your safety plan that we develop. If your situation is an acute emergency and you need to talk to someone right away:
-Call 911

-If you can, safely go to the crisis center or ER. The number for the crisis center is: 208-625-4884.

****Please do not text me, unless it is for scheduling purposes only, for this is not a secure form of communication****

I will only respond back to you through telephone conversation. You can email me, as long as it is not an emergency situation or for scheduling purposes. Please be advised that I may not respond in a timely manner if you email me for I check my email once every other day. Please see more information regarding emails and the option of tele therapy with my tele therapy and email informed consent.

Cancellations & Lateness

Missed and cancelled sessions pose some issues for both of us. First, the work of psychotherapy is sometimes challenging and when we hit a difficult place together, it can feel easier to want to avoid coming in for treatment. I would prefer we speak about this intentionally rather than you canceling sessions. Also, I hold your scheduled appointment time specifically for you and you alone. I also see a limited number of clients so that I can give you the focus and attention you deserve. When you do not show as scheduled, this effects three people: 1. You, because you do not get the counseling service you deserve. 2. The therapist who now has an un-paid space in their schedule because the time was reserved for you. 3. Another patient who could have been scheduled for treatment if you had given proper notice. It is extremely difficult for me to fill your last minute cancelled session on a short notice. Therefore, I charge for appointments cancelled with less than 24 hours notice and you will be charged the full rate of the session. For clarification, you will be charged for this missed appointment/no show and expected to pay the full amount by your next scheduled appointment, I cannot charge insurance companies for missed appointments. If you no show on a session and do not call within 24 hours after your session then you may forfeit your ongoing time slot. If you cancel less than 24 hours in advance two times or more in a month time frame then you run the risk of losing your scheduled time slot. In order for you to keep your regularly scheduled time slot you have to make 70% or more of your sessions. This is to your benefit because psychotherapy works best with consistency. If you are late for your session, we will still end at our regular time so that I have time to prepare for my next appointment and I can be on time for them. If you are a Medicaid or Tri-Care client I cannot bill you for missed appointments or no shows so I do have a separate policy regarding missed appointments for these clients. If you no show at any time or you do not make at least 70% of your appointments, you are subject to be taken off my schedule and you can get back on my schedule if we have a phone conversation regarding the reason that you no showed and we evaluate your motivation for treatment at this time.

Confidentiality

As a psychotherapy client, you have privileged communication. This means that your relationship with me as my client, all information disclosed in our sessions, and the written records of those sessions may not be revealed to anyone without your written permission, except where law requires disclosure. Most of the provisions explaining when the law requires disclosure are described in the enclosed Notice of Privacy Practices.

When disclosure is required by law: Disclosure is required when there is a reasonable suspicion of child, dependent, or elder abuse or neglect and when a client presents a danger to self, to others, to property, or is gravely disabled.

When disclosure may be required by law: Disclosure may be required in a legal proceeding. If you place your mental status at issue in litigation that you initiate, the defendant amy have the right to obtain your psychotherapy records and/or my testimony. If you have not paid your bill for treatment for a long period of time, your name, payment record, and last known address may be sent to a collection agency or small claims court.

Emergencies: If there is an emergency during our work together or after termination in which I become concerned about your personal safety I will do whatever I can within the limits of the law to prevent you from injuring yourself or another and to ensure that you have appropriate medical care. For this purpose I may contact the person whose name you have provided on your general information form.

Health Insurance and Confidentiality of Records: Your health insurance carrier may require disclosure of confidential information in order to process claims. Only the minimum necessary information will be communicated to your insurance carrier. Often the billing statement and your company's claim form are sufficient. Sometimes Diagnosis and treatment plans are needed. While insurance companies claim to keep this information confidential, I have no control over the information once it leaves my office. Please be aware that submitting a mental health invoice of reimbursement carries some risk to confidentiality, privacy, and/or future eligibility to obtain health or life insurance.

Consultation: I consult regularly with other professionals regarding my clients in order to provide you with the best possible service. Names or other identifying information are never mentioned; client identity remains completely anonymous and your confidentiality will be fully maintained.

Release of Information: Considering all of the above exclusions, upon your request and with your written consent, I may release limited information to any person/agency you specify, unless I conclude that releasing such information might be harmful to you. If I reach that conclusion, I will explain the reason for denying your request.

Benefits and Risks of Psychotherapy

Participation in therapy can result in a number of benefits to you, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy and its progress. Change can sometimes be quick, but more often than not it can be gradual and even frustrating. There is no guarantee that psychotherapy will yield the intended results.

Complaints

If you have any concerns or complaints about your treatment, please talk with me about it. I will take your feedback seriously and respond with care and respect. If you believe that I have been unwilling to listen and respond, or that I have behaved unethically, you can contact the Board of Occupational Licenses which oversees licensing and they will review the services I have provided.

Private Practice Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking sites (I have deleted my Facebook page after concluding that the potential risks of maintaining such a page outweigh any potential gains from a professional standpoint). I believe that adding clients as contacts on these sites can compromise our confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please feel free to bring them up when we meet and we can discuss this.

Interacting

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites to contact me. These sites are not secure and I may not read these messages in a timely fashion. Please do not use any means of engaging with me in public online if we have already established a client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone.

Use of Search Engines

It is not a regular part of my practice to search for clients on Google or Facebook or any other search engines.

Business Review Sites

You may find my therapy practice on business review sites which lists businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites combine search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites. I urge you to take your own privacy seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy,

even if you decide we are not a good fit. If you feel that I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Occupational Licenses, which oversees licensing, and they will review the services I have provided.

Board of Occupational Licenses of Idaho
700 West State Street
Boise, ID 83702
Phone Number: (208) 334-3223

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have any questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, please bring them to my attention so that we can discuss them.

Notice of the HIPAA Privacy Practices

Introduction

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review this document carefully.

For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, secure in the knowledge that the information you share will remain confidential. You have the right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about these practices, please feel free to discuss this with me.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (example, billing services), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operation described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the tasks will be shared.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes. The following should help clarify these terms:

-PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.

-Use applies only to activities within my office such as analyzing information that identifies you.

-Disclosure applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

` -Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.

-Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you and for continuing care.

-Payment. Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service and providing you documentation of your care so that you may obtain reimbursement from your insurer.

-Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities.

Written Authorizations to Release PHI

Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing.

Uses and Disclosures without Authorization

The ethics code of the American Marriage and Family Therapy Association and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do not require your authorization. I may use or disclose PHI without your consent in the following circumstances:

-**Child Abuse**. If I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.

-**Adult and Domestic Abuse**. If I have reason to believe that an individual such as an elderly or disabled person protected by law, has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.

-Health Oversight Activities. I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

-**Judicial and Administrative Proceedings.** If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law, and is not to be released without a court order. Information about all other mental health services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

-Serious Threat to Health or Safety. If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is a clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosure I consider necessary to protect you from harm.

Worker's Compensation. I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Special Authorizations

Certain categories of information have extra protection by law, and thus require special written authorizations for disclosures.

-Psychotherapy Notes. I will obtain a special authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, couples, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

-Right to Receive Confidential Communications by Alternative Means. You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your records to another address that you provide).

-Right to Inspect and Copy. You have the right to inspect or obtain a copy of PHI in my records as these records are maintained. In such cases I will discuss with you the process involved.

-Right to Amend. You have the right to request an amendment of PHI for as long as it is maintained in the record. I amy deny your request. If so, I will discuss with you the details of the amendment process.

-Right to an Accounting. You generally have the right to receive an accounting of all disclosures of PHI. I can discuss with you the details of the accounting process.

-Right to a Paper Copy. You have the right to obtain a paper copy of the Notice of Privacy Practices from me upon request.

Therapist's Duties:

-I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

-I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

-If I revise my policies and procedures, I will notify you at our next session, or by mail at the address hour provided me.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be discriminated against for filing a complaint. If you have any questions about this Notice, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me. You can file a complaint with the US Department of Health and Human Services which provides an OCR Health Information Privacy Complaint Form Package on its website. You can download this form, fill it out and submit it to the appropriate regional office that you find online.

ACKNOWLEDGEMENT OF NOTIFICATIONS

I acknowledge the receipt of both Natalie Keese Hamm counselor at Resilience Psychiatric Medicine Office Policies and Agreement for Psychotherapy Services as well as Natalie's Social Media Policy and the HIPAA Notice of Privacy Practices. I understand and agree to comply with these policies. I understand that these policies will always be available to me but I may always request a hard copy if I am unable to access them.

I understand that Natalie Keese-Hamm is a Licensed Marriage and Family Therapist (LMFT-3073) in the state of Idaho and is an employee of Resilience Psychiatric Medicine.

Signature of Client_____ Date_____

INFORMED CONSENT FOR TELETHERAPY

This informed consent for teletherapy contains important information focusing on doing psychotherapy using the phone or internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreed supplement to our initial **Informed Consent, Agreement** for therapy.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using secure forms of technology such as video conferencing and/or telephone. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks.

Electronic Communications

We will collaborate together on which kind of therapy, including teletherapy will benefit you. You may need certain computer or cell phone systems to use teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment to take part in tele therapy. The HIPAA compliant electronic health record that I currently utilize is Kareo and it has an option for telemental health, otherwise known as tele therapy. This is a secure and encrypted form of communication. This therapist is trained in this platform of communication and will make every effort to make you feel comfortable in this platform as well if this is the choice of communication that you choose to communicate with. I can further discuss with you this user friendly, and secure, way of communicating (similar to Skype and it is secure). I want to ensure you that the internet network that I use is secure and reliable. Furthermore, I have completed multiple trainings in the field of teletherapy and I am competent in this arena.

There are many ways that technology issues might impact telethereapy. For example, technology may stop working during a session. If this occurs, disconnect from the session and then reconnect, or I will wait two minutes and then re-contact you through the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two minutes, please call me at the number I give you for our contact.

Efficacy and Appropriateness of Teletherapy

Most research shows that teletherapy is about as effective as in-person psychotherapy. There is debate about a therapist's ability to fully understand non-verbal information when working remotely. It is not usually indicated for clients who are currently in a crisis situation or who require high levels of support or intervention. We will discuss whether teletherapy continues to be appropriate for you. I will let you know if I decide, clinically, that teletherapy is no longer the most appropriate form of treatment for you.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect communications that are a part of our teletherapy. However, the nature of electronic communication technologies, even if it is HIPAA compliant, is such that our communications could be compromised or accessed by others. I will use secure methods to help keep your information confidential. I also recommend you take reasonable steps to ensure the security of our communication, for example, by using only secure networks and having password protection on the device that you use.

Furthermore, because teletherapy sessions take place outside of my office, there is potential risk for other people to overhear our sessions if you are not in a private place during session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone, computer, or other device.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my office policy and initial agreement of notifications that you signed still apply to teletherapy. Please let me know if you have any questions about the limits of confidentiality.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties, we will create an emergency, safety plan, before engaging in telethereapy services.

Location

There are legal restrictions on the state you can be in during our teletherapy sessions. I am licensed in the state of Idaho. You will need to be in the state of Idaho during our sessions. I will require that you follow this rule when we telecommunicate.

Fees

The same fee rates will apply for tele therapy as they apply for in-person psychotherapy. Most insurances pay for telecommunication services, however, it is your responsibility to know if your insurance company or plan will pay for tele therapy and you are also responsible to pay for any other fees for example, a co-pay or co-insurance. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of our actual session time. Currently, the insurances that I know that pay for tele therapy are: United Health Care, Medicaid, Blue Cross and Cigna.

Records

The tele therapy sessions shall not be recorded in any way unless agreed upon in writing with mutual consent. I will maintain a written record of our session in progress notes in the same way that I maintain my records for in person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the **Agreement** that we agreed to at the onset of our clinical work together and does not amend any of the terms of that **Agreement**. Your signature below indicates agreement with this document's terms and conditions.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian/Responsible Party (Minor) Date

Teletherapy and Email Consent

nataliekeesehamm@protonmail.com

Teletherapy may involve the use of email as another form of communication. In order to conduct teletherapy in this manner I strongly recommend that you utilize an encrypted, secure, email service. This will help ensure that your privacy is kept confidential. If you do not have an encrypted email, I cannot guarantee the security of our emails as they travel between our computers. If you choose to not have an encrypted email and you choose to pursue teletherapy through email then you can sign this document to waive your right to receive protected health information in a secure format. While the encryption of email is required by HIPAA, the 2013 HHS Omnibus rule states, "If individuals are notified of the risks and still prefer unencrypted email, the individual has the right to receive protected health information in that way, and covered entities are not responsible for unauthorized access of protected health information while in transmission to the individual based on the individual's request. Further, covered entities are not responsible for safeguarding information once delivered to the individual. (US Department of Health and Human Services, 2013)." You are responsible for information security on your computer. If you decide to keep copies of our emails or communication on your computer, it's up to you to keep that information secure. Unfortunately, I cannot guarantee the security of our emails as they travel between our computers if you do not use an encrypted platform. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails.

By signing this document you recognize that Teletherapy does not provide emergency services, please call me directly on my cell phone, or call 911, or go to the nearest emergency room if you are in an emergency situation. Also, by signing this document you recognize that if you email me more than one time during the course of the week when it is not your scheduled teletherapy session time than I will discuss the need to have you set up more sessions so you can get my undivided attention and get your counseling goals met. If you continue to email me in between sessions after we have set up additional appointments or if you email me very lengthy emails (more than a few paragraphs) in-between sessions more than once a month then I may charge you for my time to respond to lengthy emails (similar to my phone policy stated in my office policy). The best way to get a hold of me in between sessions is to call me at my office. I typically respond to phone calls within 24 hours on a business day. I typically respond to emails within 3 business days.

I agree to this aforementioned information and I want to pursue teletherapy by email. I will be using an encrypted email.

_____	_____	_____
Client Print Name	Client/Parent Signature	Date

I agree to this document and I want to pursue tele therapy by email. I will not be using an encrypted email and I waive my right to have my protected health information to be kept confidential while using this platform.

_____	_____	_____
Client Print Name	Client/Parent Signature	Date