



Welcome to **Kindred Therapy Center**! It is the goal of our entire staff to assist you in every way we can. Please read the following information carefully and fill out the forms to the best of your ability. If you have any questions, we will be happy to help you.

Client Name(s): _____ **Date:** _____

Form 1: Client Registration Form

This form helps us get to know you and ensures that we can contact you as needed. Your personal information is confidential and voluntary.

Form 2: Insurance Information Form

This form gives us information about your insurance provider for billing purposes.

Form 3: Consent to Treatment Form

This form gives your consent to receive therapeutic services at Kindred Connections Therapy Center. Please sign the Consent to Treatment Form.

Form 4: Authorization for Release of Information

This form gives us permission to communicate with third party providers regarding your treatment. Completing this form ensures that you received comprehensive and quality mental health care.

Form 5: Policies and Procedures Regarding Treatment

Please review **Kindred Connections Therapy Center's** policy regarding treatment, which outlines confidentiality, payment, client rights and responsibilities and our cancellation policy.

Form 6: Notice of Privacy Practices (NPP)

We fully comply with all HIPAA regulations. Please read our Notice of Privacy Practices carefully.

Form 7: Acknowledgement of NPP and Consent Form

In accordance with all HIPAA regulations regarding the privacy of your health information, please sign the Acknowledgement of NPP and Consent Form to indicate your awareness of this policy.

Form 8: Audio/Visual Consent to Record Form

We often record sessions to review the tapes for our notes and to present cases to our supervisor.

Form 9: Electronic Communication Consent Form

This form gives us permission to communicate with you electronically.

Form 10: Teletherapy Consent Form

We offer teletherapy as an option for clients in transition, on extended travel or for those who do not readily have access to therapeutic services.



CLIENT REGISTRATION FORM (Youth)

Contact Information			
Name (First, M.I., Last):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date:
Address:	City:	State:	Zip:
Address 2:			
Home Phone:	Cell Phone:	May we leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address:	DOB:	Age:	SS No:
Ethnic Cultural Background:	Name of School:		Grade:
Person financially responsible for this account:			
Primary Care Physician:			
How did you hear about us:			
Parent/Guardian 1 Information (can indicate same as above)			
Please indicate: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Other			
Name:		Relationship to client:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	May we leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address:	DOB:	SS No:	
Would you like email reminders for appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Please refer to email consent form included in the packet</i>	
Parent/Guardian 2 Information (can indicate same as above)			
Name:		Relationship to client:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	May we leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address:	DOB:	SS No:	
Would you like email reminders for appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Please refer to email consent form included in the packet</i>	
Emergency Contact Information			
Name:		Relationship to client:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	May we leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	



INSURANCE INFORMATION FORM

Insurance Information		PRIMARY INSURANCE <i>(can indicate same as above)</i>	
Name of Insurance:			
Policy Number:		Group Number:	
Name of Policy Holder:		Policy Holder Social Security Number:	
Policy Holder Address:			
Home Phone Number:		Policy Holder Date of Birth:	
Employer:			
Employer Address:		Employer Phone:	
Client Name:		Relation to Policy Holder: <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other	
SECONDARY INSURANCE			
Name of Insurance:			
Policy Number:		Group Number:	
Name of Policy Holder:		Policy Holder Social Security Number:	
Policy Holder Address:			
Home Phone Number:		Policy Holder Date of Birth:	
Employer:			
Employer Address:		Employer Phone:	
Client Name:		Relation to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Did you call your insurance company and receive an authorization number? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, what is the authorization number?			



CONSENT TO TREAT

I the undersigned, give consent to receive therapeutic services at Kindred Connections Therapy Center for myself and/or my minor child. I understand that treatment offered by Kindred Counseling Center is voluntary, except when mandated by the court, and may be ended by me at any time.

FEE RESPONSIBILITY OF THE CLIENT

As a service to you, our billing office will file all of your charges with your insurance company. **It is the responsibility of the client to be aware of their insurance coverage. The client is responsible for copays and any services not covered by their insurance.** A fee may be charged on overdue accounts. Additionally, you are responsible for informing our office of all insurance coverage that you or the client may have. If we are not informed of all insurance coverage, the insurance coverage you give to us may not cover costs and you may be responsible for all charges. I authorize payment directly to Kindred Connections Therapy Center of the benefits specified. I understand that I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance.

MEDICARE CLIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorized KCTC to release to the Social Security Administration and/or Medicare program any information needed for this or a related Medicare. If for any reason Medicare (or my insurance company) denies payment, I authorized KCTC to act on my behalf to appeal for payment.

APPOINTMENT OBLIGATIONS

After three No Shows or Late Cancellations of appointments, clients may be referred out. Clients will be provided with written notification if this applies, as well as an opportunity to discuss concerns with the Clinical Director.

CONFIDENTIALITY

You, as the client, have the right of confidentiality in your communications and records. Any contact by your therapist with other parties will occur only with your written consent. However, there are circumstances when your therapist has a legal obligation to share information with others. These include the following:

1. My intention to inflict physical harm to myself or another person;
2. Incidents of physical or sexual abuse or serious neglect of an elder or minor child
3. If my therapists receives a signed, valid court order requesting records; and
4. If my therapist communicates with other therapists or the supervisors about my treatment;
5. When KCTC submits a claim for health insurance coverage, information regarding services rendered, fees, and diagnoses may be released to your insurance carrier.

AGREEMENT

I understand that therapy has both benefits and risks associated with it. On the beneficial side, therapy has been shown to produce lasting change and reduce overall feelings of distress. There are, however, no guarantees of success. Risks include intermittent feelings of discomfort (such as sadness, guilt, anxiety, or anger) during and after some sessions as problems are brought to the surface. I may be asked to recall difficult and unpleasant aspects of my personal and family history in order to loosen the grip of these past events on my life now. This consent agreement will remain in effect until therapy has been terminated or there is a lapse in treatment of longer than six (6) months.

My signature, or that of my authorized representative shows that I understand and agree with all of these statements and have provided accurate information.

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date



AUTHORIZATION FOR RELEASE OF INFORMATION

*Charges for this request may apply. Allow 7-10 business days for processing.
All requests will be mailed unless other arrangements are specified.*

Communication between behavioral health providers and third party providers is important to ensure that you receive comprehensive and quality mental health treatment. This form will allow Kindred Connections Therapy Center to provide and receive protected health information (PHI). This information will not be released without your signed authorization. This information may include diagnosis, treatment plan and progress, if necessary.

Client First and Last Name

Date of Birth

Social Security Number

Telephone Number

Client Address

City, State, Zip

Date of treatment: From _____ to **KCTC Discharge date.**

I hereby grant permission for release, review and exchange of the following information relating to my evaluation and treatment from and to the parties named here:

Kindred Connections Therapy Center

2699 Salem Ave.

Dayton, OH 45416

Phone: 937.421.1268

Fax: 937.736.0075

AND

Name:

Address:

Address 2:

Phone:

Fax:

The purpose of this request is for: Continuity of Care Court Records SSI/Disability Insurance Claim
 Mental Health Assessment Consultation Correspondence MH Progress Notes Treatment Plan
 Discharge Summary School Records/IEP Other (specify) _____

Client Rights

- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.
- I understand that this authorization may be withdrawn at any time in writing (see Notice of Privacy).
- This authorization will be in effect for one year after I sign and date the form below unless I specify an earlier expiration date in this space _____.

Printed Name (Client or Parent/Guardian)

Signature of Client

Date

Witness Name

Signature of Witness

Date

I DO NOT give my authorization to release or receive any applicable mental health information



Kindred Connections Therapy Center Policies and Procedures regarding Clients

Please retain this information for your records

OFFICE HOURS

Our receptionist's hours are from 10:00am-7:00pm Monday thru Friday. Our office does have a voicemail system and we encourage you to use this service during non-business hours. You can leave messages to change or cancel appointments, as well as to leave your therapist a message.

COURT MANDATED TREATMENT

When treatment is mandated by the court, it is my responsibility to share the court order with my therapist at the outset of treatment, so that the purpose and terms of the therapy can be clarified, including how communications and information about the therapy are to be shared. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

PARTICIPATION IN TREATMENT

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist. I understand that I am fully responsible for my own participation in any and all exercises and activities suggested by the therapist. I agree not to hold the therapist legally responsible for the effect of these exercises on me, either during the session or later.

EMERGENCIES

This office is not equipped to handle emergency services. In the case of a medical emergency, including the concern of someone's safety, please call Crisis Care at 937-224-4646 or go to your nearest emergency room.

APPOINTMENT OBLIGATIONS

After three No Shows or Late Cancellations of appointments, clients may be referred out. Clients will be provided with written notification if this applies, as well as an opportunity to discuss concerns with the Clinical Director.

CONFIDENTIALITY

You, as the client, have the right of confidentiality in your communications and records. Any contact by your therapist with other parties will occur only with your written consent. However, there are circumstances when your therapist has a legal obligation to share information with others. These include the following:

1. My intention to inflict physical harm to myself or another person;
2. Incidents of physical or sexual abuse or serious neglect of an elder or minor child
3. If my therapists receives a signed, valid court order requesting records; and
4. If my therapist communicates with other therapists or the supervisors about my treatment;
5. When KCTC submits a claim for health insurance coverage, information regarding services rendered, fees, and diagnoses may be released to your insurance carrier.

FEE RESPONSIBILITY OF THE CLIENT

As a service to you, our billing office will file all of your charges with your insurance company. It is the responsibility of the client to be aware of their insurance coverage. The client is responsible for copays and any services not covered by their insurance. A fee may be charged on overdue accounts.

Additionally, you are responsible for informing our office of all insurance coverage that you or the client may have. If we are not informed of all insurance coverage, the insurance coverage you give to us may not cover costs and you may be responsible for all charges.



CLIENT'S RIGHTS AND RESPONSIBILITIES

Client's Responsibilities

- Provide staff with the information they need. This is so they can deliver the best possible care.
- Let their therapist know when the treatment plan no longer works for them.
- Let their therapist know of any medications provided by medical providers.
- Treat those giving them care with dignity and respect.
- Ask their therapist questions about their treatment plan. This is so they can understand their care and their role in that care.
- Let their therapist know about problems with paying fees.
- Follow the plans and instructions from their treatment plan. The treatment plan is to be agreed upon by the client and the therapist.
- Inform their therapist of all changes regarding personal information (e.g. changes to address, contact telephone number, and/or insurance).

Client's Rights

- The right to be treated with dignity and respect.
- The right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- The right to have their treatment and other member information kept private. Only in an emergency, or if required by law, can records be released without member permission.
- The right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not by insurance.
- The right to get information about insurance's services and role in the treatment process.
- The right to know about the complaint, grievance and appeal process.
- The right to know about State and Federal laws that relate to their rights and responsibilities.
- The right to know of their rights and responsibilities in the treatment process.
- The right to share in the formation of their plan of care.

I have read the above policies and procedures regarding clients and understand the implication, scope and limitation of service.

Printed Name (Client or Parent/Guardian)

Signature of Client

Date

Printed Name, Age (Minor)

Signature of Minor

Date



OHIO NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We (the therapists at Kindred Connections Therapy Center) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

1. "PHI" refers to information in your health record that could identify you.
2. "Treatment, Payment and Health Care Operations"
 - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
3. "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
4. "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

1. We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record.



2. You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as in billing. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
3. We may also enter into contracts with attorneys, an accountant, collection agency, shredding company and answering service. As required by HIPAA, we will have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

There are some situations where we are permitted or required to disclose information without your consent.

1. If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-client privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
3. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
4. If a client files a worker's compensation claim, the client typically must execute a release so that we may release the information, records or reports relevant to the claim.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual in our practice.

- **Child Abuse:** If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer. Once such a report is filed, I may be required to provide additional information.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your persona or legally-appointed representative, 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 will be informed in advance if this is the case.



- **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we are required by law to take one or more of the following actions in a timely manner:
 1. Take steps to hospitalize you on an emergency basis,
 2. Establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional,
 3. Communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.

IV. Client's Rights and Psychologist's Duties

Client's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing one of us, so you may not want us calling your home and leaving messages on an answer machine. Upon your request, we will send your bills to another address/or place calls to another number.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances. On your request, we will discuss with you the details of the request process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process. Accounting is only required to be kept for a six year period.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.



Kindred Connections Therapy Center Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will make available a copy of the revised notice to you. You may also request a copy of your signed Notice of Privacy Practices at any time.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may contact Manicka Thomas, Clinical Director for Kindred Connections Therapy Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on March 9, 2018.

VII. Privacy Officer

The privacy officer for Kindred Connections Therapy Center is Manicka Thomas. 2699 Salem Ave. Dayton, OH 45416, (937) 421.-1268. You may contact her if you have any questions about any Privacy Policies or if you wish to file a complaint with the practice.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____



Acknowledgement of NPP and Consent Form

This form is an agreement between you, _____ (Client), _____
(Parent/Guardian, if applicable) and **Kindred Connections Therapy Center**.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, kindredcounselingcenter.com, by calling us at 215.622.9628, or from your therapist.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing to your therapist. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
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Printed Name, Age (Minor)	Signature of Minor	Date
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This is a strictly confidential client record. Redisclosure or transfer is expressly prohibited by law.



Audio/Visual Consent to Record and Use Case Materials Form

By signing the Consent to Treatment Form, I freely give my consent to allow my counseling sessions with my therapist at **Kindred Connections Therapy Center**, to be electronically recorded.

- I further consent that s/he may share this recording with other therapists in her consultation group. I understand that any other therapist who watches this recording for training purposes is under the same confidentiality requirements as my therapist.
- I understand that if by chance any therapist knows me socially or personally, s/he will immediately leave the session and will not observe, seek or be given any information about my situation.
- Furthermore, I freely give my consent to allow my therapist to use information about my case in order to promote the development of the mental health field.
- I understand that my therapist will at all times conceal my identity by withholding any and all identifying details about my case.
- I understand that I may request the electronic recording to be discontinued at any time—either temporarily or permanently.
- I understand that my therapist may retain, but is in no way required to retain any electronic recordings produced in this process.
- I authorize my therapist at her/his sole option, to erase or otherwise destroy any and all recordings after they have been used for the intended purpose, or at any other time, whether they have been used or not. I understand that these recordings are not part of my treatment record.
- I understand that my decision about whether or not to permit electronic recording is completely voluntary, and will have no impact on the treatment I will receive.
- I understand that I may withdraw this consent at any time.

Printed Name (Client or Parent/Guardian)

Signature of Client

Date

Printed Name, Age (Minor)

Signature of Minor

Date



Electronic Communication Consent Form

Electronic communication, defined here as email and texting, offers an easy and convenient way for clients and therapists to communicate. In many circumstances, it has advantages over telephone calls but also presents risks.

Below are our rules for contacting us using electronic communication:

- Electronic communication is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the nearest hospital emergency room.
- Appropriate uses of electronic communication include appointment scheduling requests and billing/insurance questions.
- Electronic communications should not be used to communicate sensitive medical/clinical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse, etc.
- **Electronic communication is not confidential.** It is like sending a postcard through the mail. Kindred Connections' staff may read your electronic communications. If you are sending electronic communications from work, your employer has a legal right to read your electronic communication if he or she so chooses. We take every precaution to make sure we use electronic communication methods that are HIPAA compliant; however, there is always a risk of data breach.
- Electronic communication will become a part of the medical/clinical record.
- Electronic communication is not a substitute for seeing your therapist. If you think that you might need to be seen, please book an appointment.

In some rare circumstances, your therapist may allow for you to send information that goes beyond the categories described above via email, if it is determined that doing so would be clinically beneficial. However, your therapist has the discretion in determining when such times are appropriate and will charge you at the normal session rate for reading emails outside of session. You must be aware of the risks to confidentiality in sending such emails. These emails will also become part of your medical record.

Finally, either the client or therapist can revoke permission to use the electronic communication system at any time. **By signing the Electronic Communications Consent Form, I agree to the guidelines stated above and give my permission for my therapist to contact me electronically.**

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date



Teletherapy Services Agreement and Informed Consent

Teletherapy is neither a universal substitute, nor the same as, face-to-face psychotherapy treatment. Teletherapy from Kindred Connections Therapy Center therapists occurs in the state of Ohio, (USA), and is governed by the laws of that state. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. The laws that protect the confidentiality of my medical information in accordance with HIPAA privacy rules and applicable state law also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential.
2. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapists, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
3. In addition, I understand that teletherapy services may not be as complete as face- to-face services. I also understand that if the therapist believes I would be better served by another form of therapy (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
4. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I accept that teletherapy does not provide emergency services. During our first session, the therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call Crisis Care at 937-224-4646 for 24 hour support.
5. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. I understand that while email may be used to communicate with the therapist, confidentiality of emails cannot be guaranteed.

I _____ hereby consent to engage in teletherapy at Kindred Connections Therapy Center. I understand that "teletherapy" includes treatment, transfer of medical data, emails, telephone conversations and psychoeducation using interactive audio, video, or data communications.

The cancellation policy for teletherapy is consistent with KCTC's in-office policies.

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date