Youth Crisis Center
Clinical Intake Form

Client Name: _____ DOB: _____ Gender: O M O F

Ethnicity: ☐ African American ☐ American Indian or Alaskan Native ☐ Asian
☐ Caucasian ☐ Native Hawaiian or Pacific Islander ☐ Other

Race: O Hispanic or Latino O Not Hispanic or Latino Marital Status: _____

Address: _____ City: _____ State: _____

Phone #: _____ Email: _____ SSN: _____

School/Employer: _____ Grade: _____ Phone #: _____

Highest Level of Education Achieved: _____ Preferred Language: _____

Primary Care Physician: _____ Phone #: _____

Therapist: _____ Phone #: _____

DFS Worker/Probation Officer: _____ Phone #: _____

O Juvenile Probation O DFS Custody O Protective Custody O Adult Probation/Parole

Legal Guardian's Name: _____ Relationship: _____ Phone #: _____

Legal Guardian's Name: _____ Relationship: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Do you have a Psychiatric Advance Directive: O Yes O No O Not applicable, under 18

Purpose of Visit: _____

_____

Client Info: Height: _____ Weight: _____ Eye Color: _____

Current Medication - prescriptions and over-the-counter (use the back of this form if more space is needed):

Medication	Dosage	Prescribed by	Indication / What does it treat?

Dietary Restrictions: _____ Allergies: _____

Medical Conditions (check any that apply):

☐ Asthma ☐ Disabling Condition ☐ Heart or Blood Pressure ☐ Migraines ☐ Head Trauma
☐ Seizures ☐ Vision Impairment ☐ Hearing Impairment ☐ Diabetes ☐ ADLs / Mobility
☐ Cancer ☐ Positive Tuberculosis Test ☐ Positive Hepatitis Test ☐ Pregnancy ☐ Positive STD Test
☐ Positive HIV/AIDS Test ☐ Other Communicable Disease: _____
☐ Acute/Chronic Pain: _____ ☐ Other Medical Conditions: _____

Other Health Concerns: _____

Safety Concerns: _____

Primary Insurance: _____ Insurance Holder: _____

Policy #: _____ Group #: _____ Copay: _____

Secondary Insurance: _____ Insurance Holder: _____

Policy #: _____ Group #: _____ Copay: _____

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. A new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from our clinicians, by mail, or by accessing our website https://www.casperycc.org.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information for Which Your Authorization Is Not Required. Your PHI may be used and disclosed without your prior authorization for treatment, payment, and health care operations, and any other use required by law.

Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your PHI to support the business activities of the Youth Crisis Center programs or clinical services. These activities include, but are not limited to, quality assessment activities, employee review activities, training of social healthcare students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Opportunity to Object. We may use and disclose your PHI in the following instances. You have the opportunity to object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the

PHI, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Health Care: We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for the care of your location, or general condition. We may use the emergency contact information you provide to contact you if your contact information is longer accurate, if we are unable to reach you and safety is a concern, or if there is an emergency.

Minors – If you are an unemancipated minor under Wyoming law, there may be circumstances in which we disclose health information about you to a parent or guardian in accordance with legal and ethical responsibilities.

Parents – If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.

Emergencies: We may use or disclose your PHI in an emergency situation. For example, in a disaster relief situation, if you are unconscious, or if there is a safety concern.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object. We may disclose your PHI in the following situations without your consent or authorization:

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document, or for emergency purpose. Some examples include: the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Public Safety: Consistent with applicable federal and state laws, we may use or disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Legal Proceedings: We may disclose your PHI pursuant to a subpoena, court order, administrative order, or similar process.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Coroners, Funeral Directors and Organ Donation: We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law: We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

Required Uses and Disclosures: Under the law, we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with requirements of the Code of Federal Regulations, Part 45 Section 164.500 et seq.

Uses and Disclosures of PHI for which Your Written Authorization Is Required. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You make revoke this authorization, at any time, in writing, except to the extent that Youth Crisis Center has already taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

2. **Your Rights**. Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that we use in making decisions about your healthcare.

Under federal law, however, you may not inspect or copy the following records: psychotherapy and psychosocial notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Clinical Director if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. *This* means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You also have a right to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service.

Your health care provider is not required to agree to a restriction that you may request. You then have the right to use another healthcare provider. If your health care provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

You may have the right to have the Youth Crisis Center to amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Clinical Director to determineif you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, disclosures that you agreed to by signing an authorization form, to family members or friends involved in your care, or for general notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive thisinformation is subject to certain exceptions, restrictions and limitations. Requests may not be made for periods of time in excess of six years.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us. You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

You have a right to receive notifications of a data breach. If there is a breach of unsecured PHI concerning you, we are required to notify you of this breach, including what happened and what you can do to protect yourself. The notice must be made within 60 days from when we become aware of the breach. However, if we have insufficient contact with you, an alternative notice method (posting on website, broadcast media, etc.) maybe used.
If you have questions regarding your privacy rights, please contact our Clinical Director.

3. **Complaints.** If you have questions regarding your privacy rights, please contact our Clinical Director. If you believe your privacy rights have been violated by us, you may file a complaint with our Clinical Director or to the Secretary of Health and Human Services. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on or before **February 1, 2022**.

If you have any objections to this form, please contact our Clinical Director in person or at 307-577-5718.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

_____ _____
Client or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

_____

YOUTH CRISIS CENTER, INC.
CLIENT AND FAMILY RIGHTS

As a client of Youth Crisis Center, Inc. services, you have the right to:

1. Be treated with courtesy, dignity, and respect at all times.
2. Privacy and confidentiality. Information about a client will only be release with permission from the client/guardian or as required by law in accordance with YCC policy.
3. Be given information in a manner that the client can understand and in an accessible format, addressing barriers related to language or disability when possible.
4. Be free from discrimination based on race, color, religion, gender, gender identity, national origin, disability, or sexual orientation.
5. Be free from being threatened, humiliated, or exploited in any manner.
6. Be free from sexual, physical, mental, or psychological abuse and/or neglect.
7. A safe and sanitary environment for services which complies with local, state, and federal regulations.
8. Make and receive telephone calls within reasonable limits as permitted by YCC team members and with proper approval from guardian.
9. An individualized service or treatment plan developed by the client/guardian and our providers.
10. Express personal choices regarding services, treatment, and providers of treatment.
11. Participate in treatment team meetings.
12. Make informed decisions regarding care and to include family members in those decisions.
13. Refuse services or treatment. Refusal may jeopardize placement and/or impact treatment.
14. Refuse to sign releases of information. Refusal may impact ability to provide adequate treatment; please speak with the provider regarding impact.
15. Voice disagreement with any situation without fear of retaliation.
16. File grievances through the proper channels and have grievances reviewed.
17. Contact an attorney to request legal representation.
18. Request access to personal case file and records with sufficient time to facilitate this process and in accordance with YCC policy. Providers are available for review and explanation of information.

Crisis Shelter and Group Home Residents Only:

19. Schedule and receive visitors when permissible by YCC and approved by guardian.
20. Send and receive mail.*
21. Wear his/her own clothing and keep and use personal possessions in compliance with program standards unless there is a safety concern.
22. Earn and spend own money or rewards in compliance with program standards (to ensure money is not stolen and assist in learning money management skills, all money is stored in a locked location).

*Postal rules and regulations provide that custodians of juveniles may withhold, delete, or censor mail thought to have contraband or material not suitable to be read.

Youth/Self Signature _____ Date _____

Guardian/Parent/DFS Signature _____ Date _____

Youth Crisis Center Representative _____ Date _____

YOUTH CRISIS CENTER, INC.
CLIENT AND FAMILY RESPONSIBILITIES

As a client of the Youth Crisis Center, Inc. services, you have the responsibility to:

1. Treat providers, team members, and other clients within the agency with courtesy, dignity, and respect.
2. Uphold the privacy and confidentiality of other clients and families within the agency.
3. Respect the property and rights of others.
4. Follow all policies, rules, and requirements of the agency and specific program.
5. Inform providers of any barriers or limitations in communication and/or accessibility needs.
6. Promote a safe and sanitary environment for services, and inform the YCC team of any concerns.
7. Provide correct and complete information for assessments, including health, treatment history, and needs.
8. Report changes in health, symptoms, allergies, and needs to the responsible team member. Therapists and providers must be aware of any other clinical treatment, including medications, individual or family therapy, and group therapy.
9. Fully participate in the development of a service or treatment plan, including setting goals and evaluating progress.
10. Follow through on service and treatment plan goals.
11. Report any confusion or challenges with understanding the service or treatment plan.
12. Ask questions whenever necessary to understand care, treatment, services, plan, or impact on treatment if services are refused.
13. Keep all appointments as scheduled, including counseling sessions, team meetings, family meetings, etc. Contact the provider within sufficient time when an appointment must be cancelled or rescheduled.
14. Respond to all needs within a timely manner.

Youth/Self Signature _____ Date _____

Guardian/Parent/DFS Signature _____ Date _____

Youth Crisis Center Representative _____ Date _____

1656 East 12th Street, Casper, WY 82601 Phone: (307) 577-5718 Fax: (307) 577-5716

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Name: _____ DOB: _____

I authorize the release of any treatment information necessary to process Medicaid/Insurance claims.

To/From:
Name: Claims Organization: Medicaid of Wyoming/ Wyoming medicaid
Address: 6101 Yellowstone Rd. Suite 210 Phone: 307-777-7531
Cheyenne, WY 82009 Fax: 307-777-6964
For the **purpose** of:

Billing of Clinical and wrap around services; including aftercare case management and coordination of care.

Without expressed revocation, this content expires on: _____

I understand that I may revoke this authorization in writing at any time, unless action has already been taken based upon this authorization. Without expressed revocation, this consent expires one year from the date signed. I understand that this information is protected by HIPPA, DHHS, and Wyoming Statute 33-38-113 Privileged Communication and will not be released to anyone outside of this agency without written consent. ***In case of emergency situations, the following information may be released without prior written consent: information requested by law enforcement such as current medications, medical history, court status, mental/emotional status.**

_____ _____
Date Signature of Resident

_____ _____
Signature of Witness Signature of Parent or Legal Guardian

1656 East 12th Street, Casper, WY 82601 Phone: (307) 577-5718 Fax: (307) 577-5716

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Name: _____ DOB: _____

I authorize Youth Crisis Center to **obtain** the following information:

Relevant communication for the purpose of billing

I authorize Youth Crisis Center to **release** the following information:

All information as indicated for billing purposes, including diagnosis, treatment plan, notes and assessments to indicate progress and needs, intake information, and services

To/From:

Name: Claim MD Organization: _____

Address: P. O. Box 1177 Phone: (855) 757-6060 X2 (support)

Pecos, NM 87552 Fax: _____

For the **purpose** of:

Billing for services

Without expressed revocation, this content expires on: _____

I understand that I may revoke this authorization in writing at any time, unless action has already been taken based upon this authorization. Without expressed revocation, this consent expires one year from the date signed. I understand that this information is protected by HIPPA, DHHS, and Wyoming Statute 33-38-113 Privileged Communication and will not be released to anyone outside of this agency without written consent. ***In case of emergency situations, the following information may be released without prior written consent: information requested by law enforcement such as current medications, medical history, court status, mental/emotional status.***

_____ _____

Date Signature of Resident

_____ _____

Signature of Witness Signature of Parent or Legal Guardian

Youth Crisis Center (YCC) - Appointment and Fee Schedule

Practice hours are determined by providers in our agency and may vary. Our hope is to provide an array of options to meet each client's needs. If you're unable to keep an appointment, please notify us by the day prior to the appointment so we can allow another client to be seen during that time. Cancellations can be made via phone, email, or voicemail.

Method of Payment - Initial **one** of the following options:

_____ My child/self has Medicaid and would like for Youth Crisis Center to bill Medicaid.

_____ My child/self has insurance and would like for Youth Crisis Center to bill our insurance provider. Youth Crisis Center is set up for the following insurance options (circle one): Blue Cross Blue Shield, Aetna, Cigna, Mountain Health Co-op, _____

_____ My child/self elect to pay out-of-pocket and request to be considered for reduced payment on sliding fee scale. (see back of this form)

Agreement for Payment – Initial **all** the following to indicate consent and understanding:

_____ I understand I am responsible for any fees not covered by Medicaid/insurance provider due to lapse in service, non-covered services or fees, missed sessions, etc. This also includes any required deductibles or co-pays.

_____ I understand that once the session has been billed, I cannot be considered for reduced payment or a change in reduced payment on the sliding fee schedule.

_____ I understand that if the services are received are out-of-network, I may be charged out-of-network prices (as listed below). I agree to pay the out-of-network prices.

_____ I understand that I am responsible for notifying YCC of any changes to method of payment prior to the service. I also understand that I may request to update or change my method of payment at anytime prior to the service.

Fees for clinical services are as follows:

• 90791 Psychiatric Diagnostic Evaluation / H0031 Clinical Assessment	$180
• 90837 Psychotherapy / H2019 Individual Therapy (60 minutes)	$150
• 90847 Family Psychotherapy / H0004 Family Therapy (60 minutes)	$150
• H0046 Group Therapy (1 session)	$50
• G9012 Ongoing Case Management (15 minutes)	$27.50

No-Show/Cancellation

To provide timely and effective care for clients, there will be a charge for no-show appointments. A no-show appointment is any appointment that is not cancelled prior to the scheduled appointment. No-show fees are not covered by Medicaid/insurance and are the sole responsibility of the client/guardian. These fees include:

• 1st Missed Appointment	$25.00
• 2nd Missed Appointment	$25.00
• 3rd Missed Appointment	$25.00 & potential termination of services

_____ Initials of youth receiving services *(if applicable, youth acknowledge guardian will be charged for missed appointments).*

Frequent cancellations (such as multiple cancellations within a month) and/or missed appointments (no show) can result in termination of treatment. The client is expected to communicate all challenges and crises that may impact treatment with the therapist in order to determine the best course of action.

By signing below, I am acknowledging that I understand and agree to all requirements above.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Signature Date

Complete this side of the form if you are paying out-of-pocket and request to be considered for reduced payment.

Out-of-Pocket Information

- Payment is required at the time of service.
- By paying at the time of service, the cost is reduced by $10.
- If the client fails to provide payment at the time of service, one session will be provided. All subsequent sessions and services will be halted until payment is paid in full.

Sliding Fee Scale

Placement on the sliding fee scale is based on household size and income.

Household size is indicated by one of the following (whichever is greater):

- The indicated household size and family members (including self and dependents) you use for tax purposes.
- The number of family members living in your household that you are financially responsible for, including unborn children if pregnant.

Please list each member of your household (including self/client):

Name	DOB	Relationship to the client	Income

I attest that the above information is true to the best of my knowledge. I acknowledge that any attempt to intentionally provide inaccurate information could lead to an adjustment on the fee scale, inability to use the sliding fee scale, or termination from services.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Signature Date

To be completed by YCC service providers only -

Total Household Size: _____

Total Income: _____

Level indicated on the sliding fee scale: _____

Out-of-Pocket / Sliding Fee Scale

	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	
% Charged	40%	50%	60%	70%	80%	90%	Posted Charge
Assessment	72	90	108	126	144	162	180
Session	60	75	90	105	120	135	150

Household Size	% of FPL / Income	0-100	100% 120%	121% 140%	141% 160%	161% 180%	181% 200%	200%+
	1	0 - *13590*	13591 - 16308	16309 - 19026	19027 - 21744	21745 - 24462	24463 - 27180	27181 +
	2	0 - *18310*	18311 - 21972	21973 - 25634	25635 - 29296	29297 - 32958	32959 - 36620	36621 +
	3	0 - *23030*	23031 - 27636	27637 - 32242	32243 - 36848	36849 - 41454	41455 - 46060	46061 +
	4	0 - *27750*	27751 - 33300	33301 - 38850	38851 - 44400	44401 - 49950	49951 - 55500	55501 +
	5	0 - *32470*	32471 - 38964	38965 - 45458	45459 - 51952	51953 - 58446	58447 - 64940	64941 +
	6	0 - *37190*	37191 - 44628	44629 - 52066	52067 - 59504	59505 - 66942	66943 - 74380	74381 +
	7	0 - *41910*	41911 - 50292	50293 - 58674	58675 - 67056	67057 - 75438	75439 - 83820	83821 +
	8	0 - *46630*	46631 - 55956	55957 - 65282	65283 - 74608	74609 - 83934	83935 - 93260	93261 +
						For each additional member of the family, add:		*4720*

Youth Crisis Center
Telehealth Consent Form

I, _____, hereby consent to participate in telehealth services with _____. Telehealth is the use of an electronic media to link beneficiaries with health professionals in different locations. Telehealth services are provided if it is not possible to meet in person for services.

I understand the following with respect to telehealth services:

_____ I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

_____ There are risks, benefits, and consequences associated with telehealth services, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

_____ There will be no recording (photo, video, or audio) of any online sessions by either party.

_____ Privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth services unless an exception to confidentiality applies.

_____ During a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 307-577-5718 to discuss as we may have to re-schedule.

_____ My therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

_____ If I am in a different time zone than MST, I will coordinate time properly with my therapist and meet at an agreed upon time.

_____ Telehealth sessions cannot be via telephone and must be through video conferencing. I must be visible on camera throughout the session.

_____ I must be in a private location during telehealth services. This means that there may not be any other persons present in my location.

_____ I must have a specific, previously identified, private location at which I meet with my therapist for telehealth services. This means I will always be in the same specific, private location each time I participate.

This location is: _____

_____ I agree to notify my therapist prior to the start of the session if this location will ever be different than above.

Emergency / Safety Planning

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in the event of an emergency.

My emergency contact person's name, address, and phone number:_____

_____

Non-emergency / police contact: _____

_____ _____
Client name (please print) Client Signature Date

_____ _____
Legal Guardian signature Date Therapist Signature Date