THE OFFICE OF LISA GRAFF-MARSH, LCSW (LIC. #LCS 16077)
4985 Park Rim Drive, San Diego, CA 92117 858-272-9812

# PATIENT TELEHEALTH INFORMED CONSENT

**Please supply the information requested below for**

**record-keeping and billing purposes.**

**It is kept confidential except as indicated on the second page.**

## PATIENT INFORMATION

**Date: _____**

**First Name: _____Initial:_____Last: _____**

**Street Address: _____**

**City: _____ State:_____ Zip: _____ Phone: _(___)_____**

**eMail: _____**

**Age: _____ Date of Birth: _____ Sex: M F Soc. Sec.#: _____**

**Marital Status: S M W D**

**Employer: _____ Position: _____**

**Business Phone: (___)_____**

**If the patient is a child, what school do they attend? _____Grade Level: _____**

## Responsible Person Information

**Responsible Person: _____Soc.Sec.# _____**

**Address: _____Phone: _(____)_____**

**City: _____ State: _____Zip: _____**

**Employer: _____ Position: _____**

**Business Address: _____**

**Business Phone: _(____)_____**

**Please turn to page 2 to add insurance and other information →→→**

## INSURANCE INFORMATION

**(If you have insurance cards available to be photocopied, you do not need to fill in all of the details In this section.)**

**PRIMARY INSURANCE COMPANY:** _____
**Address:** _____ **Phone:**_(___)_____
**City:** _____ **State:**_____ **Zip:** _____
**Insured's Name:** _____ **Relationship:** _____
**Insured's Date of Birth:** _____ **Insured's Soc.Sec.#**_____
**Group Number:** _____ **Member Number:** _____
**Employer:** _____

**SECONDARY INSURANCE COMPANY:** _____
**Address:** _____ **Phone:**_(___)_____
**City:** _____ **State:**_____ **Zip:** _____
**Insured's Name:** _____ **Relationship:** _____
**Insured's Date of Birth:** _____ **Insured's Soc.Sec.#**_____
**Group Number:** _____ **Member Number:** _____
**Employer:** _____

**RELEASE OF INFORMATION FOR INSURANCE BILLING PURPOSES:**
By signing here, you authorize me to release information to your insurance company for billing purposes. This information includes diagnosis codes and other basic information about the problems for which you are seeking help (each insurance company asks for different kinds of information). *I make every effort to protect your privacy and to minimize the details I release.* **Please ask if you have questions about this.** *As an alternative, some people choose to pay me directly, and then submit claims to the insurance company themselves, ensuring complete control over their personal information.*

**Release signature:** _____ **Date:** _____

**Please turn to page 3 for confidentiality and fee information →→→**

This form is provided to give you important information regarding your rights and responsibilities as a client. After you have read this material, I will be happy to answer any questions you might have.

## CONFIDENTIALITY

Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing. If you request that I release information about you, I will tell you at that time if I believe making your records public could be harmful to you.

Please be aware, however, that there are certain situations in which I am required by law to reveal information without your permission. These are listed below:

1. Serious threats to harm yourself (i.e., suicidal).
2. Serious threats to harm another person or their property (i.e. homicidal).
3. Child, elder, or dependent adult abuse. This includes perpetrators who have abused people in the past and still have access to the victim or type of victims (e.g., children) at the present time.
4. Some information is often requested by your insurance company (if you use insurance) such as diagnosis, progress, prognosis, and treatment plan.
5. Court ordered requests for information about you.

## EMERGENCY COVERAGE

You may leave a message for me 24-hours a day at (858-272-9812). When I am out of town, I will make arrangements for another qualified therapist to cover any crisis that may arise. That individual's name and contact information will be on my voicemail message. In the event that I cannot be reached quickly, you should call your physician or psychiatrist, dial 911, go to the emergency room of a local hospital, or call the San Diego Crisis Line at (619-479-3339).

## PSYCHOLOGICAL SERVICES, FEES, AND PAYMENT INFORMATION

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation. You will be charged for all appointments for which you fail to appear at my full fee disclosed below. If you usually pay a co-pay, or your insurance carrier pays for your entire treatment, please note that your insurance company cannot be billed for any missed or cancelled sessions. Therefore, you will be responsible for the hourly rate of your therapy. Therapy sessions are 45 minutes with an additional 5 minutes to schedule additional sessions, pay, co-pays, etc.

My first session, which is a diagnostic interview is charged at $175.00. My hourly fee for 50 minute sessions thereafter is $150.00. My hourly fee for couples and family sessions is $175.00. You will be expected to pay for each session at the time it is held with cash or check, unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Should additional services be provided or should fees be changed, fair notice will be given to you.

The forms of payment I accept are ACH bank transfers, cash, and check. I also reserve the right to utilize a collection agency for outstanding balances not paid in full be the time therapy is terminated.

It is my policy to request payment at the time services are provided, unless other arrangements are made in advance. Although I will assist in billing your insurance carrier and accept assignments of benefits on our behalf, your fees are a contract between you and me. You will be responsible for those fees, including those not paid by your insurance carrier. If circumstances have lead to a time of difficulty for you, I urge you to contact my office so we can make appropriate financial and session arrangements.

**Please turn to page 4 for patient's rights →→→**

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## PATIENT RIGHTS AND THERAPSTS LIMITED LIABILITY

1. You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment nor risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. The laws that protect the confidentiality of your personal information also apply to online therapy with Telehealth. As such, the information disclosed to me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you make my mental or emotional state an issue in a legal proceeding. Dissemination of any personally identifiable images or information from the Telehealth interaction to other entities shall not occur without your written consent.

3. There are risks and consequences from the use of Telehealth online therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, the transmission of my personal information could be disrupted or distorted by technical failures. That the transmission of your personal information could be interrupted by unauthorized persons. That the electronic storage of your personal information could be accessed by unauthorized persons.

   Telehealth online based services and care may not be as complete as face-to-face services. If your psychotherapist believes you would be better served by another form of intervention (e.g. face-to-face services) you will be referred to a mental health professional who can provide such services in your area. Finally, there are potential risks and benefits associated with any form of psychotherapy, and that despite your efforts and the efforts of your psychotherapist, your condition may not improve, and in some cases may even get worse.

4. Understand that you may benefit from Telehealth online psychotherapy, but that the results cannot be guaranteed or assured. There may be issues with wifi connectivity. All attempts to keep information confidential while using online communication will be made, but a guarantee of 100% confidentiality cannot be assured. By signing this form it shows you have an awareness of these issues and if you choose to use Telehealth video conferencing, you will not hold your therapist liable for any gathering or use of client confidential information by Telehealth video conferencing providers.

5. You have a right to access your personal information and copies of case records in accordance with California law.

6. By signing this document you agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If you are in crisis or in an emergency, you should call 911 or seek help from a hospital or crisis oriented health care facility in your immediate area. By signing this document you understand that emergency situations include: if you have thought about hurting or killing either yourself or another person, if you have hallucinations (see or hear things others don't or beliefs others may consider unrealistic), if you are in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if you are dysfunctional due to abusing alcohol or drugs. By signing this document, you acknowledge you have been told that if you feel suicidal, you are to call 911 or the National Suicide Hotline Toll Free Number 1-800-784-2433 or another suicide hotline.

If you have chosen the option to receive services via telemedicine (also known as "online, remote services" or "Telehealth"), you should be aware of some specific requirements. First, all services are provided via Vsee, a HIPAA compliant live online meeting site. Should you decide to utilize this service, please note that while I ensure confidential meeting space on my end, you will need to ensure you have a space that is confidential where ever you choose to hold a session. By signing this agreement, you acknowledge that if you choose to have a session where another person(s) can hear you, then the breach of confidentiality is your choice and I am not held liable for such a breach. _____ (initial here)

Additionally, you are consenting via written authority to allow contact with identified family and other treating professionals in your local area in case I need emergency backup, or in the case in which you are in need of services beyond the scope of Telehealth practice (i.e., hospitalization).

## PROFESSIONAL CONSULTATIONS OUTSIDE OF CALIFORNIA

My policies and procedures comply with applicable state regulations. Lisa Graff-Marsh is a licensed Clinical Social Worker in the state of California. By engaging with Lisa Graff-Marsh, you understand that the services provided are licensed in the state of California only. You agree to the terms and conditions of the State of California and the services provided within this state. You agree and understand that the service you are receiving is licensed therapy within this state. If you reside outside of the state of California, you understand that it is not licensed services, but rather a confidential consultation. Lisa Graff-Marsh holds responsibility only to the state in which she is licensed in and cannot be held accountable for any rules or regulations of other states outside of her licensure and residence. Some sessions may consist of counseling, psycho-education, coaching, or other wellness activities including nature-based interventions. You understand that you are receiving services at your own risk and hereby release Lisa Graff-Marsh from any legal ramifications should you injure yourself in any way including but not limited to physical, emotional, metal, or psychological distress or injury. _____ (initial here)

## ABOUT PSYCHOTHERAPY

Assisting you to reach your goals in therapy is the purpose of our work together. You can do your part openly and honestly communicating your thoughts and feelings, although this may be difficult at times. These communications may make you feel worse before you feel better. There is a risk that you may recall unpleasant events or come to painful conclusions, which may cause you to feel anxious, depressed, frustrated, or hopeless at times. These feelings are a normal part of the therapy process and are usually temporary. We will work together to get through the difficult times. If you are ever concerned that our work is not helping, please discuss this with me.

**Please turn to page 5 to sign the treatment consent form→→→**

The law requires that you sign a written statement prior to delivery of health care via Telehealth, indicating that you or your legal representative understands the written information provided in paragraph 1 through 6 above and that this information has been discussed with me or his/her designee.

By signing below, I _____ (printed name) acknowledge that I have read this informed consent and have received answers to any questions to my satisfaction.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent (#1) Date

_____ _____
Signature of Parent (#2) Date

_____ _____
Signature of Therapist Date