Adult Telehealth Intake Form

Please read the following information regarding my policies. By signing this form, you agree that you have read and agree to these policies.

1. Insurance, Payment and Claims Authorization Policy
2. Cancellation Policy
3. Electronic Communication Policy

Please read the Consent Forms that follow. By signing this form, you give permission for treatment from Celina Pipman, LCSW

1. Telehealth Consent
2. Informed Consent to Individual Psychotherapy

- **In addition to the policies that follow, Please you have been sent a Notice of my Privacy Practices. By signing the form, you acknowledge that you have read the Notice.**

Insurance, Payment and Claims Authorization Policy

Payment and Insurance Policy:

Payment and copayments are due at the time services are rendered. My office will be glad to complete and submit the insurance claim electronically to assist with the insurance process. It is the obligation of the client to make payment and not that of the insurance carrier.

Claims Authorization:

"I hereby authorize the release of any medical or other information necessary to process insurance claims.

Cancellation Policy:

Therapy is a commitment between the clinician and the client . When the client and the clinician begin treatment, they are making a commitment to a therapeutic process and also to a specific and reserved time. If you miss an appointment or are unable to provide at least 24 hours notice when you cancel, you will be charged a $70.00 cancellation fee for an individual session and $100 for a couples session.
Insurance does not cover missed appointment fees. A missed session cannot be submitted on a claim form.

Couples: Couples therapy requires the presence of both partners at the same time. Discuss any issue that may impair this from happening with sufficient time at least 24 hours. I do not advise partners to come individually when a request for couple's therapy has been made. A couple's session lasts 90 minutes. If only one partner comes to the session and the session shortens to only one period (50 or 60 minutes) I will bill for the entire cost of the couple session (90 minutes).

Electronic Communication Policy:

I try my best to ensure the privacy and confidentiality of email and tex messaging. However, this is not something I can guarantee. I ask that text messaging only be used for scheduling purposes unless otherwise specified. I will send to you an appointment reminder via email or text 24 hours prior the appointment. At that time you will have the option to opt out.

Telehealth Consent Introduction:

Telehealth is the delivery of healthcare services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location. The interactive electronic systems used in Telehealth incorporate network and software security protocols to protect the confidentiality of patient information and audio

and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits

- Increased accessibility to mental healthcare.
- Patient convenience.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of Telehealth.

These risks include, but may not be limited to:

- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Every effort will be made to overcome technical difficulties.
- While every effort is made to ensure the confidentiality of tele-communications security protocols can fail, causing a breach of privacy of confidential health information.
- Alternatives to the Use of Telehealth: Traditional face-to-face sessions in your provider's office.

Patient's Right

I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth.

Patient's Responsibilities

- I will not record any Telehealth sessions without written consent from my provider.
- I understand that my provider will not record any of our Telehealth sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins.
- The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used of my computer that is used for Telehealth.
- I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be present in the State of New York to be eligible for Telehealth services from my provider.

- I understand that in the case of an emergency I must contact my local emergency services by calling 911 from my own location.

Informed Consent to Individual Psychotherapy/ Couples Therapy

This section of the form is to document that I give my consent to the psychotherapist Celina Pipman, LCSW to provide psychotherapeutic treatment to me. (initial)

This section documents that we give our consent to the psychotherapist Celina Pipman, LCSW to provide couples psychotherapy treatment to us.(Initial)

While I/We expect benefits from this treatment, I/We fully understand that no particular outcome can be guaranteed. I/We understand that I/ We are free to discontinue treatment at any time but that it would be best to discuss with Celina Pipman, LCSW any plans to end therapy before doing so. I/We understand that therapy can sometimes cause upsetting feelings to emerge, and that I/We may feel worse temporarily before feeling better, and that I /We may experience distress caused by changes I/We may decide to make in my life as a result of therapy.

I/We understand that the psychotherapist cannot provide emergency services. The psychotherapist has told me/us whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I/We understand that in any emergency, I/we may call 911 or go to the nearest hospital emergency room.

I/We have received the HIPAA Notice of Privacy Practices from the psychotherapist.

I/We understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent.

There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities.

2. If I tell the psychotherapist that I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

If you are completing this Intake Form on paper or through email, please sign here acknowledging that you
have read and agree to all of the policies detailed above.

Print Name or Names: _____

Signature/ Signatures: _____

Date:_____