Jacqueline Wilson
MA, LMHC
Your Story Therapy

CONFIDENTIAL CLIENT INFORMATION FORM

PERSONAL INFORMATION

Date: _____

Full Name: _____ Birth Date:_____

Email: _____Home/Cell Number:_____

Home Address: _____

Occupation: _____

RELATIONSHIP INFORMATION

Partner's Name (if you're in a primary relationship): _____

If you're living together/married, how long? _____

Please list the names and ages of any children from this relationship: _____

_____

If previously married, indicate former spouse's name: _____

How long had you been married? _____

Please list the names and ages of any children from this relationship: _____

_____

FAMILY INFORMATION

Has anyone in your family experienced the following? (select all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Mental illness
- ☐ Domestic violence
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Drug abuse
- ☐ Suicide attempt
- ☐ Sexual addiction
- ☐ Alcoholism
- ☐ Chronic illness
- ☐ Other:

Have you experienced any of the following? (select all that apply)

- ☐ Death of mother
- ☐ Death of father
- ☐ Sibling Death
- ☐ Loss of child
- ☐ Neglect by mother
- ☐ Neglect by father
- ☐ Parents divorce
- ☐ Domestic violence
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Sexual addiction
- ☐ Chronic illness
- ☐ Eating disorder
- ☐ Other

MEDICAL/PSYCHOLOGICAL INFORMATION

Primary Care Physician _____ Phone_____

Psychiatrist _____ Phone _____

Have you had a formal psychological assessment? Yes No

Are you willing to sign a release to obtain information from medical/psychological professionals you have worked with?
Yes No

Are you currently in other counseling? Yes No

Counselor Name _____ Phone_____

Have you had previous counseling or psychotherapy? Yes No

Counselor's name(s)_____

Length of Time: _____When:_____

Brief Reason(s): _____

Have you been diagnosed with any of the following? If yes, when? Please briefly explain.

- ☐ Anxiety Disorder
- ☐ Borderline Personality Disorder
- ☐ Obsessive/Compulsive Disorder
- ☐ PTSD
- ☐ Anorexia
- ☐ Bulimia
- ☐ Schizophrenia
- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Seasonal Affective Disorder
- ☐ Dissociative Identity Disorder
- ☐ Bipolar Disorder
- ☐ Social Phobia
- ☐ ADHD
- ☐ Other:_____

Is there anything about the above diagnoses that you think I should know? Please explain: _____

_____

_____

Have you ever been suicidal? No Yes When? _____

Have you ever been homicidal? No Yes When?_____

Have you ever attempted suicide? No Yes When?_____

Please list any major or chronic illnesses, operations or injuries incurred_____

_____

_____

Please list all medications you are currently taking with dosage and frequency:_____

_____

Have you experienced recent changes in the following? (select all that apply)

☐ Sleep	☐ Appetite	☐ Weight	☐ Amt of Exercise	☐ Sexual desire
☐ Nightmares	☐ Eating habits	☐ Energy	☐ Alcohol Intake	☐ Stamina
☐ Panic	☐ Mood swings			

How would you rate your overall health? Excellent Good Fair Poor

Chemical Use Information:

Have you ever felt the need to decrease your consumption of alcohol? No Yes

Have you ever felt annoyed by criticism of your drinking? No Yes

Have you ever felt guilty about your drinking? No Yes

Have you ever been in an alcohol or drug treatment program? No Yes

Do you use recreational marijuana? No Yes Frequency _____

On average how much beer, wine, or hard liquor do you consume each week?_____

_____

Please indicate the following that pertain to you:

☐ Anxiety	☐ Depression	☐ Fears or Phobias	☐ Eating disorder
☐ Sexual problems	☐ Suicidal thoughts	☐ Separation/divorce	☐ Relationships
☐ Finances	☐ Drug or alcohol use	☐ Career choices	☐ Anger
☐ Self control	☐ Unhappiness	☐ Insomnia	☐ Religious matters
☐ Work stress	☐ Health concerns	☐ Cutting:self-mutilate	☐ Thought patterns

How would you rate the severity of your concerns? Mild Moderate Severe Incapacitating

Please indicate any following events that have occurred in the last 12 months (select all that apply):

☐ Injury or illness	☐ Death of a friend	☐ Separation or divorce	☐ Job change
☐ Major illness in family	☐ Death of a relative	☐ Gain new family member	☐ Relocation
☐ Other:			

Religious or Church Affiliation (if any): _____

Describe the primary reasons you have come to see me and how I may be of help to you: _____

_____

_____

_____

PERSONAL GOALS & DESIRES

At this time, how would you describe your personal goals and desires for your life? _____

_____

_____

What is your desired outcome of our time together in therapy? _____

_____

_____

How did you hear about my practice? _____

_____

YOUR SIGNATURE: _____

DATE: _____

THERAPIST SIGNATURE: _____

DATE:_____

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IN CASE OF EMERGENCY

Client Name: _____

I give my permission to contact the following person in case of an emergency:

Name: _____

Address:_____

Work Phone: _____ Home Phone: _____

Relationship: _____

CLIENT SIGNATURE: _____

If the above person is unavailable, I give my permission to contact this person in case of emergency:

Name: _____

Address: _____

Work Phone: _____

Home Phone:_____

Relationship: _____

CLIENT SIGNATURE: _____

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DISCLOSURE STATEMENT

Welcome! Before we begin counseling it is both my desire and a requirement of Washington State law to provide you with the following information.

LICENSURE

I am a fully Licensed Mental Health Counselor (license number LH61223377) in the State of Washington. I opened my private practice in Kirkland, Washington in September 2017.

EDUCATION AND TRAINING

I graduated from The Seattle School of Theology and Psychology with a Master of Arts in Counseling Psychology degree in April 23, 2017. I completed my internship at Compass Health in Snohomish, Washington. Some additional coursework and post-graduation training I have completed include:

- EMDR Training
- Gottman Marriage Institute Level I
- Emotionally Focused Therapy
- Attachment-based Intervention for Couples in Crisis
- Complex Trauma Treatment Competency Certification
- Effective Healing Interventions for the Mind and Body

MY COUNSELING APPROACH

I believe that the human experience is fundamentally fulfilled in relationship. Your Story Therapy is driven by your narrative and is a client-centered and relational approach. This psychodynamic orientation is a synthesis of various psychoanalytic approaches, attachment theory, and interpersonal neurobiology. In my assessment of need, I also take into account the impact of trauma which I will seek to resolve through current well-studied techniques in which I am trained. Clients typically seek therapy to reduce relational distress or for relief from harmful symptoms. This therapy approach seeks symptom relief through discovering the deeper meanings and motivations for behavior and offering corrective experiences in the context of trust. Together we will explore the patterns that emerge in the relational style of the client and seek to address early influences in the emotional experiences that drive behavior, leading to long term change. This means that I will adapt my approach to your therapy in ways that are specific to your needs. I work from an assumption that healing and wholeness will come about through a collaborative relationship which fosters self-knowledge, security, and skills for success.

Initial acknowledgement here_____

CONFIDENTIALITY

You have the right to confidentiality of your therapy both legally and personally. All issues discussed in the course of counseling are strictly confidential. There are certain exceptions to these rights as listed below.

1. If I have good reason to believe that you will harm another person, I am required to attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I am ethically and legally responsible to try to keep you safe. Therefore, I will speak with you about making your relational support system aware. In some cases, I may need to break confidentiality and contact police or the county crisis team.

4. If you give written permission for me to share confidential information.

5. In response to a court order requiring disclosure.

In the unlikely event of my death or my own medical emergency, my colleague, Michelle Ellis, MA, LMHC will assume possession of your file and will be contacting you to coordinate arrangements for further care. Her phone: (206) 890-2417.

Initial acknowledgement here_____

CASE CONSULTATION AND SUPERVISION

I desire to give my clients the best possible counseling service. I may at times discuss your situation (without sharing your name) with other professionals within a confidential consult group as well as during individual and/or group supervision.

Initial acknowledgement here _____

FEES & PAYMENT

My fee for 53 minute sessions are: $170 for consultation & initial intake, $155 for an individual, $165 for a couple. Payment is due at the beginning of each session. See page 10 for additional explanation of fees and services.

Initial acknowledgement here _____

SESSIONS AND ATTENDANCE

Sessions begin at the scheduled time and will be approximately 53 minutes in length. If you are late, we will end on time and not run over into the next person's session. Clients are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement (WAS 246-810-031(2)(iii)). **Initial acknowledgement here** _____

Cancellation Policy. You are committing to a scheduled session. If you miss your scheduled appointment which has been reserved exclusively for you (except in case of emergency), you will be charged for that appointment. Insurance will not be billed for that session. If you must have an interruption to your scheduled session, you must call to cancel 48 hours ahead to avoid being charged for your session. Grace will be extended in cases of emergency or sudden illness.

Initial acknowledgement here _____

DIAGNOSIS

Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. I will be referring to the DSM-5 manual, The Diagnostic and Statistical Manual of Mental Disorders, 5th edition,

for any diagnostic issues. I will only utilize a diagnosis in the course of your treatment if I believe it will be beneficial to your therapy or to your healing or if your insurance company requires it. **Initial acknowledgement here_____**

AFTER HOURS OR IN MY ABSENCE

If you are experiencing an emergency when I am out of town or outside of my regular office hours, please call one of the following numbers:

General Emergencies: 911

Snohomish County Care Crisis Response Service (a 24-hour crisis line offering emotional support, crisis intervention, and referral assistance through Volunteers of America): 800-584-3578 or 425-258-4357

King County Crisis Clinic (provides crisis intervention, information, and referrals to all people of King County)
800-244-5767 or 206-461-3222 **Initial acknowledgement here_____**

LENGTH OF COUNSELING

Every client has a unique story and unique situation. Therapy is an investment in yourself that requires time, energy, and thought. Short-term therapy is very helpful for many issues, but in general, issues of abuse, trauma, or deep heartbreak require longer-term commitments to therapy. Together, we will come up with personal goals and expectations for the end of treatment, and will discuss together the estimated length of therapy. **Initial acknowledgement here_____**

TERMINATION

It is every client's right to disengage from counseling with or without notice to the treatment provider. However, I have learned the importance of marking endings and would appreciate the opportunity to do so with you. I find it helpful to arrange a final session to explore termination and review counseling goals and progress.

Initial acknowledgement here_____

RECORD-KEEPING

I may or may not take notes during our sessions, but will make notes after each session. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else. Billing records, invoices, and statements are password protected and comply with all HIPAA standards for your protection.

Initial acknowledgement here_____

ONLINE/TEXT COMMUNICATION

Any e-mail I receive or send to you becomes a part of your legal record. If you need to change or modify appointments, you may text or call me on my cell phone (206.850.4159) or e-mail me at jacqueline@yourstorytherapy.com.

Please note: the privacy of your information is important to me. I discourage the use of email to communicate medical information between clients and me. My email address is not encrypted and can be intercepted on its way to your email inbox, may not be delivered as intended, and can easily be accessed by others once it makes it in your inbox. Therefore, communication between clients and myself should be conducted in person during the appointed session and no 'counseling' will be done via text or email. Texts and emails are only checked periodically and should only be used for appointment scheduling and inquiries. If you have a medical emergency, please call 911 or use the other crisis numbers listed in the 'After Hours or In My Absence' section above. **Initial acknowledgement here_____**

SOCIAL MEDIA

I do not accept friend or contact requests from current or former clients on any social or professional networking sites. Adding clients as friend or contacts on these sites has the potential to compromise your confidentiality and our respective privacy. **Initial acknowledgement here**_____

COMPLAINTS

If you are unhappy with what is happening in therapy with me, I hope you will let me know. I will take such concerns seriously, and with care and respect. State of Washington Department of Health has a brochure entitled "Counseling or Hypnotherapy Clients" that describes client rights and responsibilities and acts that would be considered unprofessional conduct. If you believe my Supervisor or I have behaved in an unethical manner, you may complain about this behavior to the Examining Board for Psychology, Dept. of Health, Olympia WA 98504. Clients have the right to choose counselors who best suit their needs and purposes. If you have any questions or concerns that were not answered in this disclosure statement, feel free to let me know. Washington State law requires that the disclosure statement include the following two paragraphs:

1. WAC 308-109-040: "Counselors practicing for a fee must be registered or licensed with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, or necessarily imply the effectiveness of any treatment.

2. SHB 1828: "A record of the mental health care provided to you is kept in this office. You may ask to see and copy that record. You may also ask this office to correct that record if you believe the information within your record is in error. A copy of your correction to the office records will be placed in your record at your request. This office will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it at this office. **Initial acknowledgement here**_____

ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

I have read and understand the information presented in this disclosure statement and therefore consent to treatment. I have received a copy if requested.

CLIENT SIGNATURE: _____ DATE:_____

PRINTED NAME: _____

THERAPIST SIGNATURE: _____ DATE:_____

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Your Story Therapy

FINANCIAL POLICY

PAYMENTS AND PAYMENT ARRANGEMENTS

All fees are due at the beginning of each session.

INSURANCE POLICY

As a fully licensed therapist, many insurances will pay for a portion of your sessions. Your Story Therapy does NOT bill insurances. However, I am credentialled as "In-Network" with the list of insurance providers below. Upon request, I will provide a monthly 'superbill' for clients including diagnostic code which the client may submit to their insurance provider for potential reimbursement. In-Network insurance providers include: Premera, Blue Cross/Blue Shield, Lifewise of Washington, Lifewise of Oregon, and First Choice.

The information we receive is not a guarantee of the client's actual benefits and is subject to final processing by the client's insurance company. The client is responsible for all fees not covered by the insurance company.

Financial Hardship Arrangements. Your Story Therapy offers special financial reductions on a case-by-case basis for clients in a temporary hardship situation. Together we will negotiate a fee which will be reevaluated every 90 days for possible renewal or discontinuation. Simply call me directly to discuss your situation.

FORMS OF PAYMENT

Your Story Therapy accepts cash, check or debit card payments. In addition, we accept major credit cards for services payment but the 3.9% credit card processing fee will be added.

COLLECTIONS NOTICE: I understand that any and all accounts that are 90 days delinquent are subject to collections.

CLIENT FEE SCHEDULE

Psychiatric diagnostic interview (90791)	$170.00
Individual Session 30 min. (90832)	$85.00 16-37 minutes
Individual Session 45 min. (90834)	$112.50 38-52 minutes
Individual Session 53 min. (90837)	$155.00 53-60 minutes
Family Session w/ Client Present (90847)	$165.00
Family Session w/outpatient Present (90846)	$165.00

ADDITIONAL CLIENT SERVICES SCHEDULE

Forms and letters outside of appointment	$150.00/hour, billed in increments of 15 mins
Letters for attorneys billed at separate rate	$250.00/hour
Clerical fee for searching/handling records, per WAC	$26.00
Pages 1-30 (copying fee), per WAC	$1.17 per page
Pages 31+ (copying fee), per WAC	$0.88 per page
Editing of confidential information, per WAC	$150.00/hour
Returned check fee, plus original amount due	$35.00S
No show or late cancel fee for follow-up clinic visits	Equivalent to your appointment Charge

Clients are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement (WAC 246-810-031 (2) (iii)).

I have read and understood the above information and have been provided with a copy at my request.

_____ DATE _____

Client Signature or Parent/Guardian (if under 18 years of age)

_____ DOB _____

Client Name Client Date of Birth

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 document may be updated without notice so please review it each time you visit me. A copy of this statement is always available upon request.

All information revealed by you in a therapy session and most information placed in your file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral] is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in the disclosure statement.

USE OR DISCLOSURE OF THE FOLLOWING PROTECTED HEALTH INFORMATION DOES NOT REQUIRE YOUR CONSENT OF AUTHORIZATION:

1. Uses and disclosures required by law – *like files court-ordered by a judge*.
2. Uses and disclosures about victims of abuse, neglect, or domestic violence – *like the duties to warn explained in the Disclosure Statement.*
3. Uses and disclosures for health and oversight activities – *like correcting records or correcting records already disclosed.*
4. Uses and disclosures for judicial and administrative proceedings – *like a case where you are claiming malpractice or breech of ethics.*
5. Uses and disclosures for law enforcement purposes – *like if you intend to harm someone else.*
6. Uses and disclosures to avert a serious threat to health or safety – *like calling Probate Court for a commitment hearing.*
7. Uses and disclosures for Worker's Compensation – *like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim*.

YOUR RIGHTS AS A PATIENT UNDER HIPAA:

1. As a client you have the right to see your file, unless it would endanger your health or another person's health or safety. Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.
2. As a client you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies. A fee for a treatment summary may apply.
3. As a client you have the right to request amendments to your counseling/therapy file.
4. As a client you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees at $0.50 per page.

5. As a client you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

6. As a client you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Initial acknowledgement here_____

Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement and Consent of Treatment – both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement and Consent for Treatment. Your therapist will be happy to explain these documents further.

Initial acknowledgement here_____

I authorize access as required to my protected health information, under strict confidentiality standards, to Your Story Therapy, PLLC administrative staff, Dr. John Wilson, Pharm D., for the purposes of carrying out treatment, payments, and healthcare operations. **Initial acknowledgement here_____**

Can I leave a message on your home phone? _____Y/N or cell phone? _____Y/N

I acknowledge that I have received and read the Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights.

SIGNATURE OF CLIENT:_____DATE:_____

PRINTED NAME OF CLIENT: _____

If more than one individual (e.g., spouse or family member) is seeking counseling, please have each of the other's sign below. Signatures below confirm that each understands and accepts all the information contained in the Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights, and that each seeks and consents to treatment.

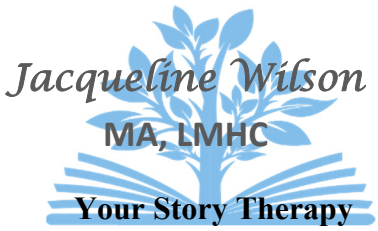
I will provide additional copies of the Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights upon request.

SIGNATURE OF CLIENT #2:

_____ DATE:_____

SIGNATURE OF CLIENT #3:

_____ DATE:_____



TELECONFERENCE SESSIONS—INFORMED CONSENT AGREEMENT

Policy. YourStoryTherapy™ strongly urges Clients to participate almost exclusively in face-to-face, in-person sessions at the YST counseling office in Kirkland, Washington. However, in certain infrequent and unforeseen circumstances under specific conditions below, the Client and therapist may agree to conduct confidential sessions via teleconferencing. Such teleconference sessions are encrypted, secure, private and HIPAA-compliant but must be mutually agreed to in advance by both Client and therapist. It is preferable but not required to conduct teleconferencing on computers or tablets rather than phones.

Circumstances and Conditions for Teleconference Sessions. The therapist will assess and agree to conduct each teleconference session only if judged clinically appropriate and effective, and only under the following circumstances:

a. **Office Unworkable.** The Client or therapist is ill or at risk for illness or at safety risk or is unable to get to the YST office for the normal in-person pre-scheduled office appointment(s). **Initial acknowledgement here_____**

b. **Advance Arrangements.** The Client or therapist arranges a teleconference session one day or at least three hours in advance of the pre-scheduled office appointment via phone or text communications where agreement is confirmed.
Initial acknowledgement here_____

c. **Client and Therapist Consent to Teleconference and Risks.** Both Client and therapist fully consent (under no force or coercion by anyone) to conduct the teleconference for oral information exchange only, instead of a normal in-person office appointment. The Client and therapist each have the right to withdraw consent at any time without affecting Client rights to future care or treatment. Teleconference risks include possible treatment failure, loss of more effective in-person communication and/or potential mid-session disruption or distortion by unpredictable technical failures that may cause frustrations, stress and immediate telephone re-contact and rescheduling.
Initial acknowledgement here_____

d. **Client Location Privacy – Washington State Only.** The Client and therapist will identify their exact locations (including Client address for unlikely emergency) which must be in a private secure place free from intrusions and distractions and audibly inaccessible to anyone else. Room doors must be closed for privacy. Wired earbuds are recommended if others are at the location. Client teleconference location must also be within the state of Washington.
Initial acknowledgement here_____

e. **No Harm Risks – Emergency Contact.** At the beginning of each teleconference session, the Client must: (i) confirm that he or she is NOT at risk of or planning harm to self or others; and (ii) give the phone number and name of a person to contact in an unlikely emergency. **Initial acknowledgement here_____**

f. **Client Payment.** The Client is pre-approved for a teleconference session by their insurer—or is able to cover the full session fee in cash payment via PayPal or other cash payment app in advance or at appointment start.
Initial acknowledgement here_____

g. **Teleconference Length.** Unless otherwise agreed to in advance, each teleconferencing session is limited to 53 minutes. Should a disconnect occur without reconnection, the therapist will immediately phone the Client and adjust the fee to cover full 10 minute intervals and reschedule as appropriate. **Initial acknowledgement here_____**

Minimum Technology Requirements

a. **Minimum Technology.** The Client must connect to the internet using sa computer or smart phone with a working camera and microphone and via a private internet service provider (ISP) at a speed of at least 10 mbps and preferably up to 30 mbps in order to minimize disconnects. Wired earbuds help ensure privacy if others are at the Client location.
Initial acknowledgement here_____

b. **Optimum Equipment Use.** To ensure best camera clarity and use, both Client and therapist should sit with eyes at camera level, place lighting in front of you and behind the camera (not behind or alongside you), angle lights to avoid glasses reflection, wear plain color clothing without plaids or designs, and focus eyes just below the camera lens.
Initial acknowledgement here_____

c. **Four Steps to Connect and Begin the Secure Fully Confidential Telemedicine Session.**

STEP 1: Be sure your microphone and camera are turned on and that no other computer (or phone) apps that utilize the camera and microphone are open.

STEP 2: Open the email sent directly to you from YourStoryTherapy about 10 minutes before the scheduled session. Find the emailed link https://doxy.me/yourstorytherapy

STEP 3: To enter the *"waiting room,"* click on the email activation link to then enter your name before clicking on the "Check In" button.

STEP 4: Be at your computer (or phone) at the scheduled time when your therapist activates the 2-Way private videoconference.

If a computer is not available, your smart phone can work as a substitute.
Initial acknowledgement here_____

d. **Secured Private Session – Recording Prohibited.** These sessions are secured, strictly private and ***NOT*** recorded. Handwritten notes may be made by therapist and Client if deemed helpful during sessions. Electronic tape recording of any session is prohibited without mutual consent by both therapist and Client. Since sessions are NOT recorded, the Client may choose to privately use a computer, tablet or smart phone belonging to another trusted person if desired (although not advisable) and do so only at Client risk.
Initial acknowledgement here_____

ACKNOWLEDGEMENT OF AND CONSENT TO YST TELECONFERENCING TREATMENT POLICY

I have read and understand the information presented in this teleconferencing policy and agree to above standards and conditions should my therapist and I mutually agree such session(s) may be appropriate now or in the future.

CLIENT/GUARDIAN SIGNATURE: _____ DATE:_____

PRINTED NAME: _____

THERAPIST SIGNATURE: _____ DATE: _____

Rev 1-01-2023v11